# Drugs and Crime

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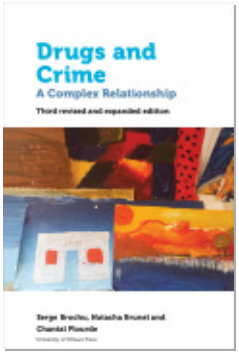


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Chapter 7

# Treating Addicts in the Criminal Justice System

In this chapter, we focus on the abundance of scientific documentation about treating drug-dependent adults in the criminal justice system and the issues involved. We will also look at key findings from studies on drug-dependent youth. Drawing on our review of the literature, we will highlight the ingredients for successful treatment, and we will conclude with a critical assessment of treatment available to addicts in the criminal justice system.

## Access to Treatment

Since the 1940s, tensions between the punitive approach and offender rehabilitation have shaped correctional systems. Publication of compelling data on the outcomes of these two approaches fuelled fierce paradigm wars (Gendreau and Ross 1987; Martinson 1974). Over the past twenty years or so, however, scientific studies have established the credibility of treatment by showing that repressive penal measures have a negligible impact on recidivism and that measures to rehabilitate and reintegrate offenders have a positive impact (Bonta and Andrews 2003).

Predictably, soon after repressive U.S. drug policies were introduced, courts were bogged down and prisons overcrowded. Not long after, things took an unexpected and alarming turn: recidivism among ex-convicts was very high. The authorities needed a better way to

deal with the many addicts for whom repression did not produce the desired effect.

As part of the effort to find that better way, many research projects showed that the presence of problematic drug use is a risk factor for criminal recidivism that can be offset by appropriate intervention (Andrews and Bonta 2006; Belenko 2006; Chandler, Fletcher, and Volkow 2009; Degenhardt and Hall 2012; Dowden and Brown 2002; Strang et al. 2012). This finding is valid for offenders who commit their crimes while intoxicated or to pay for drugs and those for whom the drug–crime dynamic is rooted in common underlying factors.

Services available to offenders with dependence issues are usually aimed at reducing criminal recidivism by enabling them to get their drug use under control. Although we are sensitive to the ethical issues surrounding correctional interventions, we agree with Chandler, Fletcher, and Volkow (2009) that not giving an offender the chance to treat a drug use problem is a missed opportunity to improve the offender's life as well as public health and safety.

We begin with a brief review of how the thinking on treatment in a correctional setting has evolved, and then dedicate the rest of the chapter to drug rehabilitation interventions for offenders who use illicit drugs. We will examine the impact of these programs on reducing crime as well as their limitations and other issues, particularly ethical issues.

## Punishment or Rehabilitation?

In the 1950s, North American prisons gradually took to the idea of rehabilitation. With humanist schools of thought dominating psychology, the corrections sector became more receptive to the benefits of clinical psychology, but it was not until the 1970s that the field of clinical criminology research emerged. It was the golden age of clinical criminology and offender rehabilitation. Professionals were playing a prominent role in North American prisons and penitentiaries and were determined to rehabilitate offenders using therapeutic tools borrowed from contemporary clinical psychology.

Then, in 1974, hitherto obscure American sociologist Robert Martinson published an explosive article titled "What Works? Questions and Answers About Prison Reform," in a journal called *Public Interest*.

### *"Nothing Works"*

In the article, Martinson (1974) examined the outcomes of measures to help offenders. His conclusion, entitled "Does nothing work?," made waves. In it, he posed a crushing question: "Do all of these studies lead us irrevocably to the conclusion that nothing works, that we haven't the faintest clue about how to rehabilitate offenders and reduce recidivism?" (p. 48). It was a harsh indictment. Earlier in the article, Martinson had written, "With few and isolated exceptions, the rehabilitative efforts that have been reported so far have had no appreciable effect on recidivism" (p. 25).

The "nothing works" finding associated with Martinson was due partly to flaws in the studies he examined and partly to severe clinical blindness to the reported success of therapeutic methods, which were clearly effective for a clinical psychology clientele but did not produce the expected results when used with offenders. Martinson was the first to expose the major limitations of offender rehabilitation programs. He served as a conduit for a number of perspectives, some diametrically opposed to others, but all critical of rehabilitation programs.

Martinson's article sparked sometimes heated debate between advocates and opponents of such programs. At the time, evaluative methodology was having serious problems clearly defining the positive and negative effects of the programs,[1] so it was difficult to draw valid conclusions about their impact. Because of economic realities and budget priorities, many programs were too short-lived to bear fruit. They were at the mercy of changes in management and policy and were very often compromised by administrative and security priorities.[2]

### *The Punitive Post-Martinson Era*

Proponents of punishment applauded Martinson's report, disseminating it widely in support of their tough-on-crime agenda. These law-and-order advocates claimed that it was impossible for offenders to change either their attitude or their behaviour and that harsh punishment for all criminals was the best way to protect society. Rehabilitation fell out of favour and was no longer the goal of the criminal justice system. Sentencing ceased to take into consideration the possibility of rehabilitation and was based solely on the severity of the crime.

Punishment was back in fashion. Courts imposed harsher and harsher sentences. American lawmakers believed that heavy prison sentences were the cure for all social ills.

Clinical criminologists, psychologists, psychosocial practitioners, doctors, and psychiatrists continued to believe that justice-involved and incarcerated individuals were entitled to the same health services as the rest of the population and that depriving them of psychological and physical care was out of the question. What to do? Did rejection of the rehabilitation model have to mean a wholesale takeover by punishment?

Martinson's conclusion that nothing worked to reduce recidivism spurred clinical criminology researchers to refine their methods and service providers to seek a better understanding of offenders' real needs and adapt their tools accordingly. Fortunately, the post-Martinson era was marked by a thorough re-examination of previous approaches and the implementation of what we now refer to as evidence-based practices.

The response from the field of clinical criminology was vigorous, methodical, and practical. In 1980, Ross and Gendreau published *Effective Correctional Treatment*, and Fréchette and LeBlanc's (1987) research on young offenders contributed a better understanding of delinquency issues that served as a foundation for better intervention.

### *"What Works?"*

The "nothing works" way of thinking gradually gave way to a "What works?" movement (Cullen and Gendreau 2001) in search of promising approaches to offender rehabilitation. Central to the movement's theoretical underpinnings is the notion that correctional interventions must be science-based if they are to be effective, and that they must target the causes and factors that lead to recidivism (Lalande 2004). Studies show that positive, constructive approaches that promote the development of new skills and capitalize on the individual's strengths work because they target the problems at the root of criminal conduct (Andrews and Bonta 2006; Cullen and Gendreau 1989; McGuire 2004; Ward and Maruna 2007). According to Andrews and Bonta (1994), effective intervention to reduce recidivism must be based on three core principles: *risk*, *need*, and *responsivity*. The *risk* principle means "match[ing] the level of service to the offender's risk to re-offend" (Bonta and Andrews 2007, 1); that is, providing more services to

higher-risk offenders and fewer or lower-intensity services to lower-risk offenders. The *need* principle involves "assess[ing] criminogenic needs [dynamic risk factors] and target[ing] them in treatment" (ibid.). The risk-need-responsivity model identifies seven major criminogenic risk/need factors, including drug dependence, that can be targeted in treatment (ibid.).

Lastly, the *responsivity* principle means that, in addition to the first two principles, intervention models must consider the offender's ability to participate in suitable programs and the non-criminogenic needs at the root of the behaviour (Kennedy 2000; Tellier and Serin 2000). The responsivity principle takes into account certain individual characteristics, including motivation to attend treatment, personality, and cognitive limitations. Meta-analyses have shown that, when correctional treatment is based on these principles, significant (around 10 percent) reductions in recidivism and parole revocations are observed (Andrews and Dowden 2006; Cortoni and Lafortune 2009; Hollin and Palmer 2006).

## Treating Drug Dependence in Offenders

Over time, scientific discoveries have shown us that rehabilitation programs for drug-dependent offenders are economical and effective solutions that can be introduced at several points in the justice process. We will begin by looking at drug courts, which come into play between the time of arrest and sentencing. We will then examine post-sentencing treatment modalities available to offenders during incarceration, probation, and parole.

### *Drug Courts*

In recent years, increasing awareness of the enormous cost of incarcerating drug-dependent individuals has resulted in growing enthusiasm for an alternative to incarceration: drug treatment courts (DTCs). This initiative, which is popular in North America, involves diverting individuals into drug treatment prior to sentencing. DTCs are not themselves treatment programs, but their personnel, including judges, play an active role in referring offenders to specialized drug rehabilitation services. The goal is to help the legal system and rehabilitation agencies work together to get offenders into treatment and off illicit drugs (Brochu and Landry 2010). Offenders who do not comply with

the court's requirements are liable to sanctions ranging from official reprimands to prison sentences.

Despite the methodological weaknesses of research designed to evaluate the efficacy of DTCs (Gutierrez and Bourgon 2009; Slinger and Roesch 2010; Werb et al. 2007), data suggest that these services are promising and reduce criminal recidivism by about 10 percent (Bahr, Masters, and Taylor 2012; Belenko 2001; Brown 2010; Gutierrez and Bourgon 2009; Mitchell et al. 2012; Rempel, Green, and Kralstein, 2012; Werb et al. 2007; Wilson, Mitchell, and MacKenzie 2006). Programs targeting adolescents have smaller effects on recidivism (an odds ratio of 1.06, essentially null) (Mitchell et al. 2012, 64).

Courts with high completion rates that deal with non-violent offenders report greater success in terms of drug-related recidivism. According to Brown, Allison, and Nieto (2010), treatment failure is strongly associated with employability issues, low educational attainment, and polydrug use. Leukefeld et al. (2007) found evidence that participants in court-supervised drug treatment programs that included targeted employment interventions were more likely to find work. For example, those who remained in employment programs longer reported more positive effects on their drug use and criminality during follow-ups than those who left the program earlier or did not participate. Goyette et al. (2013) also showed that many studies found better recidivism reduction outcomes from DTCs that follow the risk-need-responsivity model (Bonta and Andrews 2007).

DTCs have come under fire, however. For one thing, they generally target addicts who are first-time offenders having committed non-violent crimes. In other words, DTCs deal primarily with people who would not be sentenced to imprisonment or who are low risk, which is contrary to risk-need-responsivity principles. For another, although some DTCs have experimented with a harm reduction approach, the emphasis on abstinence makes it difficult for therapists to talk about relapse prevention because, officially, relapse is not tolerated and can result in termination of the program and jail time. Offenders who agree to participate in a drug treatment program through a specialized court have to report on their progress to court authorities much more frequently and for a longer period of time than if they had gone through the regular judicial process (Werb et al. 2007).

Canada has far fewer DTCs than our neighbours to the south. In 2012, Quebec launched a program along similar lines but with some distinct features. Over a number of years, the Court of Quebec tried

several initiatives that culminated in the Programme de traitement de la toxicomanie de la Cour du Québec (PTTCQ).[3] By the late 1970s, the Court of Quebec was already factoring successful completion of a treatment program into sentencing in order to promote offender rehabilitation and social reintegration. In 2008, the Centre de réadaptation en dépendance de Montréal – Institut universitaire[4] began working at the Montreal courthouse to evaluate potential risks of withdrawal, assess problems related to drug use intensity, and identify services required to treat the condition (Goyette et al. 2013). The enactment of the *Safe Streets and Communities Act* (Bill C-10) led to the creation of the PTTCQ in November 2012. It took several years to develop the program, the details of which were the subject of several recommendations and reports (Justice Québec 2014). Our team (Plourde et al. 2014) evaluated the implementation of this new initiative and found that one of the strengths of the PTTCQ is that its proposed approach is offender-centred. In addition to offering a personalized approach to participating offenders, it pays special attention to psychosocial elements and does not focus solely on the sentence. It addresses factors associated with maintenance of both delinquency and dependence. A unique feature of this Quebec program is that it is available to clients who have committed more serious crimes and present heavier drug use patterns than similar programs in the rest of Canada and the United States. The PTTCQ's harm reduction philosophy may surprise some and may require fine-tuning, but it is nevertheless commendable. That said, it is important to consider issues related to prolonging placement within the criminal justice system when participants who relapse are returned to the traditional justice system (i.e., transferring cases to a judge, which can lead to imprisonment), in which case the program becomes punitive (Plourde et al. 2014). At the time of writing, Canada does not have specialized DTCs for youth.

### *Post-sentencing Treatment*

Adjudicated youth with substance use problems typically enter treatment by referral or by court order (Breda and Heflinger 2007; Diamond et al. 2006; Dow and Kelly 2013; Fickenscher, Novins, and Beals 2006; Wisdom, Manuel, and Drake 2011). Research on drug-dependent juvenile justice populations referred to treatment shows that, following treatment, they exhibit improvements in terms of both psychoactive substance use and delinquency, as well as in other spheres

of their lives, such as their studies (Bergeron et al. 2009; Bertrand et al. 2009; Brunelle et al. 2010). It is important to note, however, that greater initial involvement in delinquent behaviour is associated with poorer drug treatment outcomes among youth (Brunelle et al. 2013). Studies of drug-dependent adolescents focus less on types of treatment received than on pinpointing factors that contribute to their success. We will take a closer look at those factors later in this chapter.

For adults sentenced to short jail terms, addiction treatment availability is relatively limited, considering the needs of the correctional population. Constraints unique to managing short sentences limit services available such that only a minority of inmates receive them (Arseneault, Plourde, and Alain 2014; Belenko and Houser 2012; Brochu and Plourde 2012; Grella et al. 2007; Kivivuori and Linderborg 2009; Stewart 2008; Webster et al. 2007). Conversely, in federal penitentiaries (sentences of two years or more), drug-dependent inmates in Canada have access to an intervention program comprising several stages, from initial assessment to post-treatment follow-up, based on the research and recommendations of an expert panel (Hume 2001; Matheson, Doherty, and Grant 2008). It incorporates cognitive behavioural, motivational, emotional/rational, problem-solving, and relapse prevention interventions. In addition, opiate-dependent inmates can receive methadone maintenance treatment and, as of 2002, can initiate this treatment while incarcerated (Plourde et al. 2005).

> I wanted to quit using heroin because I was so sick, it was killing me, but I wanted to keep using coke because there was no . . . no reason for me to stop until I was in jail and I did some programs and I felt better. Then I realized that it was ruining my life. (Jane)[5] (Plourde et al. 2007)

Some of the factors that lead to increased treatment participation are unique to offenders, but others are organizational and structural (Belenko and Houser 2012; Fletcher et al. 2009). The latter include:

(1) separate budget from host penitentiary administration;
(2) administrative independence;
(3) being somewhat isolated from the regular penitentiary environment to recreate a therapeutic environment;
(4) establishing a set of rules and consequences for breaking them;

(5) staff who act as positive role models for inmates and see themselves as therapists who care about the well-being of the participants rather than as officers responsible for security;
(6) encouraging participants to acquire new skills (that they can use in the job market or to resolve family problems);
(7) regular follow-ups with people who have completed the program; and
(8) using services provided by community resources.

Let us now take a more detailed look at the approaches that most treatments available to drug-dependent offenders are based on. Almost all the approaches or models are used within and outside of correctional institutions. Cognitive-behavioural programs and therapeutic communities are the primary intervention approaches in North American penal institutions.

### *Cognitive-Behavioural Programs*

In addiction treatment, programs based on cognitive-behavioural theories view the development and continuation of drug use in certain contexts as classical or operant conditioning rooted in individual problems, which are themselves influenced by developmental, cognitive, and environmental factors (Deas and Thomas 2001; Waldron and Kaminer 2004). The goal of *cognitive-behavioural treatment* of addicted offenders is generally to define and modify stimuli associated with drug use, transform thoughts about drug use and delinquent behaviour, learn problem-solving techniques, and develop relapse prevention strategies (Blume 2005).

Studies on cognitive-behavioural programs for justice-involved individuals, including those convicted of drug-related crimes, have shown promising results with respect to the elements targeted in treatment, including drug use and criminal recidivism (Bahr, Masters, and Taylor 2012; Crane and Blud 2012; Easton et al. 2007; Moore et al. 2008; Roberts-Lewis et al. 2009). Nevertheless, as Comiskey, Stapleton, and Kelly (2012) observed, although this type of treatment has a positive effect on criminality, benefits may not last more than a few months.

### *Therapeutic Communities and Boot Camps*

*Therapeutic communities* (TCs) are among the most stable correctional programs whose effects have been evaluated. In a prison setting, this type of intervention is one solution to *prisonization*,[6] a process by which inmates come to denigrate traditional social values (Peat and Winfree 1992). Participants often "receive a variety of treatment modalities, including cognitive therapy, individual counseling, group counseling, and 12-step programs" (Bahr, Masters, and Taylor 2012, 159). All TCs, whether they are inside or outside penal institutions, share certain basic principles, such as hierarchical community organization; confronting past values, attitudes, and behaviours; and the importance of community and peer support (Vandevelde et al. 2004). In hierarchical TCs, more senior members of the group show recruits and junior members the manual and psychological tasks to be done. Community life is an important element of these programs because it enables individuals to acquire social skills and show concern for other people. Participants confront individuals who exhibit an attitude or a behaviour that is against the community's values and try to persuade them to change the behaviour.

In TCs, individuals function as the main agents of their own change. Staff are, for the most part, former clients of the program. They keep domestic and therapeutic activities running smoothly and ensure that the community's values are upheld. When they intervene with community members, they do not adopt a client–counsellor approach (McCollister et al. 2003). The following characteristics are typical of the vast majority of TCs:

(1) in prison-based TCs, community members are relatively isolated from other inmates;
(2)activities are structured and regulated;
(3) privileges are earned gradually but are not irrevocable;7
(4) members must accept their personal and community responsibilities;
(5) members must make a constant effort to transform their values, change their lifestyle, and create an environment that supports the rehabilitation of all members;
(6) members must fit into a relatively rigid hierarchical structure;
(7) within that structure, more senior members act a role models for recruits;

(8) discipline is omnipresent, and failure to comply is punished severely; and
(9) members benefit from aftercare.

Despite the inherent limitations of evaluating treatment efficacy (Arseneault, Plourde, and Alain 2014), some of which have to do with challenges related to the prison environment, research on TCs has produced encouraging findings with respect to the rehabilitation of drug-dependent people in the criminal justice system. Hiller, Knight, and Simpson (2006) found that "a significantly smaller proportion of graduates were rearrested during the 2nd year after release compared to those who drop out of treatment or who do not receive treatment" (p. 230). They found no difference between the groups during the first year after treatment. In the vast majority of studies in the literature, two elements stand out as crucial to the success of these programs: treatment duration and therapeutic aftercare. We will take a closer look at these elements below.

In North America, more radical interpretations of TCs led to the development of *shock incarceration*, more widely known as *boot camp*. The first of these was set up in the United States in 1983,[8] and boot camps spread at a staggering pace. Despite ardent enthusiasm for the idea, it was not long before impact studies threw cold water on it (National Institute of Justice 2003b). At their peak, in the 1990s, there were seventy-five state and federal boot camps for adult offenders, thirty for juvenile offenders, and eighteen more in county prisons, with a total of nearly 10,000 participants (National Institute of Justice 1996, 2003b). In the 2000s, half were shut down, and the number of participants declined by a third. The programs have evolved somewhat, but the basic philosophy has not changed. Boot camp is physical and psychological intervention that lasts three to four months and is intended to instill strict discipline and bring about a radical lifestyle transformation (National Institute of Justice 2003b). This approach to rehabilitation employs some of the same techniques as TCs, but disciplinary measures are modelled after military boot camps. The idea is that individuals subjected to rigorous physical and psychological training will come to respect authority and embrace the values upheld by dominant social institutions. Although this military-style program aligns well with the American "war on drugs" mindset, studies show that it is not usually a winning strategy. Participants report positive attitude and behavioural changes in the short term, but these

changes do not reduce recidivism (ibid.). However, more recent work suggests that boot camps can reduce recidivism among the highest-risk participants, especially if they include an aftercare component (Bahr, Masters, and Taylor 2012). These findings contrast with earlier research that deemed boot camps ineffective.

### *Peer Support and Twelve-Step Groups*

*Peer support movements* (e.g., Alcoholics Anonymous, Narcotics Anonymous, Cocaine Anonymous) available to non-incarcerated individuals also have a strong presence in penal institutions. Members of these movements visit inmates regularly and base their interventions on the twelve-step model. They organize groups that encourage participants to share personal experiences and be abstinent.

Peer support movements view problematic substance use as a disease (Brown, Seraganian, and Tremblay 2001; Sheehan 2004) influenced by contextual factors. Offenders present drug-induced brain chemistry dysfunction that may interfere with their understanding of what is socially acceptable and, therefore, alter their behaviour (Sheehan 2004).

In the early 1990s, the National Institute on Alcohol Abuse and Alcoholism in the United States funded a research project that culminated in the *Twelve Step Facilitation Therapy Manual* (Nowinski, Baker, and Carroll 1992), standardizing the application of this treatment modality. To foster social skills, twelve-step programs are delivered in a group setting rather than on an individual basis (Sheehan 2004). The program employs various intervention strategies, including the following: (1) therapy that teaches new coping strategies and enhances motivation; (2) education about self-knowledge and social skills training; and (3) sponsorship by other program participants to provide social support.

According to Bahr, Masters, and Taylor (2012), "although 12-step programs are widely used, there has been . . . little . . . research evaluating their effectiveness . . . . Overall, the evidence suggests that 12-step programs are not as effective as other treatments in reducing drug use and recidivism" (p. 164).

### *Methadone Maintenance Programs*

The most common pharmacological treatment available in prison is methadone, a synthetic opioid analgesic that enables opiate-dependent

individuals to avoid withdrawal symptoms. It can be used as a replacement for opiate use or to help people stop using opiates entirely. According to Bahr, Masters, and Taylor (2012), "the objective is to . . . enable the addicts to live relatively normal lives." Despite some progress, methadone maintenance programs are still underutilized (Nunn et al. 2009), though they do exist in custody settings in Europe, the United States, Australia, and Canada.

*Methadone maintenance programs* have yielded positive results (Bahr, Masters, and Taylor 2012; Canadian HIV/AIDS Legal Network 2008; Gordon et al. 2008; Hedrich et al. 2011; Plourde et al. 2005; Stallwitz and Stöver 2007) for treatment recipients, including reductions in drug use, repeat incarcerations, and serious drug-related crimes. Other studies have found that high methadone doses (over 60 mg) can contribute to better health, social stabilization, greater health services take-up (Stallwitz and Stöver 2007), and reductions in associated risk behaviours (Hedrich et al. 2011). Methadone maintenance programs offered in custody and post-release reduce mortality risk significantly (Degenhardt et al. 2014; Larney et al. 2014). It is therefore important for such treatment to begin without delay in prison (Larney et al. 2014) and to continue post-release (Degenhardt et al. 2014; Gordon et al. 2008; Kinlock et al. 2007; Larney et al. 2012; MacSwain et al. 2014). People who begin treatment in prison are more likely to pursue treatment upon release (Kinlock et al. 2007, 2008, 2009; MacSwain et al. 2014). Continuity of treatment initiated during incarceration is also crucial. Interruption pre- or post-release is associated with an increase in risky injection behaviours, such as sharing needles, which increases the risk of hepatitis C and HIV infection (Hedrich et al. 2011; Stallwitz and Stöver 2007).

Although some of the challenges related to organizing methadone maintenance programs in correctional settings mirror realities on the outside, it goes without saying that, as Mužinić et al. (2011) point out, some issues are unique to treating opioid-dependent people in prison. Length of detention, which is often unknown or variable, is one issue that can influence the decision to initiate treatment. Misuse and trafficking, which are common on the outside, present challenges that penal institutions lack the resources to address and that can affect security (Plourde et al. 2012; Plourde et al. 2013; Stallwitz and Stöver 2006). Nevertheless, it is important to note that methadone maintenance programs reduce demand for illicit opiates in prisons (McMillan, Lapham, and Lackey 2008).

### *Motivational Interviewing*

*Motivational interviewing* (MI) founders Miller and Rollnick define it as a directive, client-centred counselling style that strives to strengthen intrinsic motivation for change by exploring and resolving ambivalence (Miller and Rollnick 2002). MI is useful in all therapeutic contexts in which ambivalence and motivation are central to the desired change process.

According to Miller and Rollnick, client ambivalence is rooted in conflict between the pros and cons of various courses of action, which leads to an impasse regarding the possibility of change. MI practitioners view ambivalence as a normal process that can be resolved by exploring the client's values. MI guides help therapists work with clients to address their ambivalence (CSAT 1999; Miller and Rollnick 2002). One advantage of MI is its flexibility; it can be used together with other therapeutic modalities.

Studies of offenders with problem alcohol and cannabis use have shown that, in this context, MI is at least as effective as other types of addiction treatment if not more so, and is clearly better than no treatment at all. For individuals with problem use of other drugs, MI is more effective than no treatment and equal to other treatments for substance use (Lundahl and Burke 2009). One meta-analysis found that improvements associated with MI are maintained in the long term and that longer exposure to the approach has a positive influence on outcomes (ibid.). Another meta-analysis of MI with drug-dependent offenders showed that the approach "can lead to improved retention in treatment [and] enhanced motivation to change" (McMurran 2009, 83).

### *Co-occurring Mental Health and Substance Use Disorders*

The presence of co-occurring disorders complicates treatment of drug-dependent offenders. Not all correctional institutions are equipped to provide the rehabilitation services this clientele needs (Chandler et al. 2004). Fletcher et al. (2007) profiled offenders who participated in the U.S. National Institute on Drug Abuse's Criminal Justice Drug Abuse Treatment Studies: 40 percent of the people in the sample reported serious depression, serious anxiety, or major concentration problems at some point in their lives. Mental health problems are also associated with heavier drug use. Hills (2000) identified the following principles

that should be incorporated into treatment of offenders with co-occurring disorders no matter the treatment model employed:

(1) integrating treatment programming,
(2) simultaneously treating both disorders as primary,
(3) developing an individualized service plan to address specific symptoms and deficits,
(4) using medication when appropriate,
(5) tailoring intervention to the setting,
(6) continuing treatment when offenders return to the community, and
(7) providing support and self-help groups to assist reintegration into the community.

Cognitive-behavioural therapy and therapeutic communities are among the approaches that have been adapted to integrated treatment for individuals with co-occurring disorders (ibid.).

Integrated cognitive-behavioural therapy is especially suitable for individuals with a co-occurring psychotic disorder and sets out three primary objectives: (1) dispel misconceptions about psychoactive substances, (2) enable individuals to understand how drugs affect manifestations of their mental illness, and (3) help them recognize signs of psychosis relapse and find a solution to drug use (Rahioui and Karila 2006).

*Personal reflections* is a modified TC program delivered in a correctional setting for people with co-occurring disorders that addresses the individual's psychoactive substance use, criminal behaviours, and mental health disorders (Sacks et al. 2004). It includes cognitive-behavioural protocols, psychoeducational classes, and medication. Sacks and his collaborators (ibid.) found that this approach led to a reduction in criminal activity, particularly among those who receive aftercare.

## Ingredients for Treatment Success

Studies of drug-dependent offender treatment have revealed key ingredients and characteristics for success. These include screening and assessment, personalized plans, relapse prevention, motivation, and judicial pressure.

### *Screening and Assessment*

Screening for drug use problems is an important step in referring identified individuals for further assessment and placing them in a treatment program suited to their needs (CSAT 2005). Of course, addiction treatment practices in Canada vary from one province to the next with respect to screening, assessment, and treatment. In Quebec, the most commonly used screening tool for adults is the Assessment and Screening of Assistance Needs – Alcohol/Drugs (Tremblay, Rouillard, and Sirois 2004).[9] The most popular screening instrument for youth is the DEP-ADO (Germain et al. 2007).[10]

A greater understanding of the severity of problem drug use requires an in-depth assessment of the substances used, along with an assessment of several other dimensions, such as motivation to change, resistance to treatment, criminal behaviour, health, the presence of psychopathic and antisocial traits or psychiatric problems, and support network (CSAT 2005; CASA 2010). In the United States, the Center for Substance Abuse Treatment, or CSAT, recommends using the Addiction Severity Index, a scientifically validated instrument, to evaluate problem drug use in offenders (McLellan et al. 1980). Another instrument, the Global Appraisal of Individual Needs (GAIN) (Dennis, Feeney, and Titus 2013) is used to assess an individual's biopsychosocial profile and is recommended by the U.S. Substance Abuse and Mental Health Services Administration. Motivation to change can also be assessed using the University of Rhode Island Change-Assessment Scale (McConnaughy, Prochaska, and Velicer 1983) or the TCU Treatment Motivation Scales (Simpson 1992).[11] Instruments used to assess antisocial or psychopathic personality traits include the Psychopathy Checklist-Revised (PCL-R) (Hare 1991, 2003), the Millon Clinical Multiaxial Inventory-III (MCMI-III) (Millon, Millon, and Davis 1996), and the Minnesota Multiphasic Personality Inventory-2 (MMPI-2) (Butcher et al. 1989).

As mentioned above, assessment of problem drug use varies tremendously across Canada. GAIN is becoming more popular in addiction rehabilitation facilities in Quebec and Ontario, but it is not used consistently across jurisdictions. Correctional Service Canada uses the Computerized Assessment of Substance Abuse for intake assessments and as needed thereafter (Correctional Service Canada 2003). It combines four instruments: the Alcohol Dependence Scale (ADS) (Skinner and Horn 1984), the Drug Abuse Screening Test (DAST) (Skinner 1982),

the Michigan Alcoholism Screening Test (MAST) (Selzer 1981), and the Severity of Dependence Scale (SDS) (Gossop et al. 1995). Services correctionnels du Québec uses the Level of Service/Case Management Inventory (LS-CMI) to assess its clientele, although the use of this instrument is currently undergoing review (Andrews, Bonta, and Wormith 2004). The LS-CMI assesses a series of criminogenic needs, including substance misuse, and is used to develop correctional intervention plans.

An ethical analysis of certain aspects of these assessment tools is entirely appropriate. In some cases, a lawyer or judge may recommend treatment for an accused even if his or her problem and needs have not been carefully evaluated by an expert, and in others, justice-involved individuals may be subjected to an addiction assessment even if they do not want one.

### *Personalized Plans*

After in-depth assessment of problem drug use, co-occurring mental disorders, antisocial traits, criminal attitudes, and motivation and readiness for change, the next step is treatment planning (CSAT 2005). The CSAT recommends that drug-dependent offenders be involved in every step of the process to ensure a comprehensive understanding of the circumstances surrounding their drug use and the full range of their needs to facilitate rehabilitation. If appropriate, treatment planning should also involve individuals from clients' social systems, such as family members and employers, as well as the full range of professionals involved, including those from the legal system. The CSAT (2005) also recommends that treatment plans be updated regularly. From a motivational perspective, treatment plans should be based on individuals' strengths rather than their weaknesses to reduce resistance and increase self-efficacy. Service intensity varies depending on several factors, such as the presence of psychopathic traits. Wanberg and Milkman (1998) identified some of the elements common to effective treatment plans: strategies that enhance motivation for treatment; and cognitive-behavioural methods, such as strengthening social-skills training, and developing coping strategies. Lastly, treatment plans must be informed by evidence-based practices (ACRDQ 2010; Blume 2005; CSAT 2005), some of which we discuss below.

### *Relapse Prevention*

Canada's Department of Justice (2003) recommends incorporating relapse prevention into treatment of drug-dependent young offenders to reduce their rate of recidivism. Relapse prevention is a treatment modality that includes a range of elements inspired by the cognitive-behavioural approach and aims to maintain psychoactive substance use cessation (Lukasiewicz and Frenoy Peres 2006). It requires an assessment at the beginning of treatment to identify factors that could trigger a relapse. Clients are given an opportunity to observe their behaviours and thoughts to better understand their risk factors and to delve deeper into certain aspects, such as risky situations, expectations about the effects of drugs, periods of withdrawal, lifestyle, and coping strategies (ibid.). Therapists can also use the assessment period to inform and educate clients about various aspects of their drug use. Then they can help clients analyze their reactions and automatic thoughts in risk situations, acquire new coping strategies, and try to enhance self-efficacy. They can also work on distinguishing missteps from a relapse, which is important because if a person uses again it can trigger automatic thoughts and negative feelings of shame and guilt. These feelings can be recognized and reframed using cognitive-behavioural techniques (ibid.). Since relapse prevention is usually just one component of a larger program, it is difficult to assess the outcomes of this modality in isolation. Studies that assess the overall impact of this prevention model on recidivism are inconclusive. However, a meta-analysis by Dowden, Antonowicz, and Andrews (2003) showed that some parts of the model, such as training someone close to the client and understanding the offence chain, have a significant effect on reducing recidivism.

### *Motivation*

People with a criminal record, or who have been referred for treatment through criminal proceedings, tend to have bad reputations with addiction treatment providers because clinicians often observe that they downplay their drug use problems. Acknowledging a problem is an indicator of motivation, one that addiction professionals associate with therapeutic success. According to many treatment providers, users who are aware of their problem and who feel affected by the consequences of drug use are more apt to take responsibility and

change their behaviour. In contrast, they see clients who have little or no awareness of the consequences, who often participate in treatment solely to fulfil release conditions, as likely to abandon the process in the absence of judicial constraints.

Motivation plays a fundamental role in the addiction recovery process (Gregoire and Burke 2004; Simpson, Joe, and Brown 1997). "Although complicated by physiological and psychological dependence, an abuser's motivation and intentions represent a critical part of the process of recovery and healing" (DiClemente, Schlundt, and Gemmell 2004, 103). Motivation was long considered a relatively stable personality trait, but we now know that it is dynamic (Miller 1985).

The transtheoretical model of change (TMC) (DiClemente 2006; Prochaska, DiClemente, and Norcross 1992) is based on this idea and matches clients to five dynamic "stages of change." Clients at the *precontemplation* stage do not recognize that they have a problem or that they need treatment. Those at the *contemplation* stage are aware of the problems their substance use is causing. At the *preparation* stage, they begin to consider the possibility of change and assess their courses of action, and, at the *action* stage, they make changes to achieve the desired improvements. *Maintenance* is when they consolidate those improvements.

Motivation is a regulatory process that can be either intrinsic or extrinsic. "Intrinsically motivated behaviours are what people do by choice" (McMurran and Ward 2004, 303). For a person beginning therapy for drug dependence, intrinsic motivation may be expressed as interest and curiosity about the treatment process (Ryan and Deci 2008). "Extrinsically motivated behaviours are under external control and are performed to acquire rewards or avoid punishment" (McMurran and Ward 2004, 303). It is also important to distinguish between motivation for treatment and motivation for change. The first has to do with the individual's readiness to seek help and engage in therapeutic activities (DiClemente, Schlundt, and Gemmell 2004), while the second refers to the importance an individual attributes to his or her difficulties and how he or she views the possibility of change (Miller and Rollnick 2002; Rollnick, Mason, and Butler 1999). Many studies (Bergeron et al. 2009; Breda and Heflinger 2007; Fickenscher, Novins, and Beals 2006; Schroder et al. 2009; Wisdom et al. 2011) define motivation for treatment as a dynamic driver of positive drug treatment outcomes. Wisdom et al. (2011) also note that external factors, such as long waiting lists that delay access to specialized services, can

enhance or detract from that motivation. In other words, both individual and organizational factors are involved. Unfortunately, these organizational factors are not accounted for in the majority of studies on this subject.

Some studies have focused on understanding the factors that boost motivation for treatment among youth. These include victimization, such as emotional abuse (Rosenkranz et al. 2012), and substance use severity upon entering treatment (Austin et al. 2010; Breda and Heflinger 2007; Rosenkranz et al. 2012). The most highly motivated young people are those who were victimized the most and who were the heaviest drug users. These characteristics are common to many youth in the criminal justice system. Austin and her co-investigators (2010) also showed that children perceive parents who use psychoactive drugs as providing less parental support, and less parental support is associated with lower motivation to change. Young people who perceive themselves as socially well integrated (sense of belonging to a group) at the end of treatment are more motivated to change their consumption habits or to maintain changes they have made (Wei et al. 2011).

Brunelle et al. (2010) reviewed the results of five Quebec studies of drug-dependent adolescents conducted in the 2000s and made the following observations regarding motivation for treatment and change: (1) youth are not very motivated to change their drug use (and still less to cease it entirely), (2) motivation increases over the course of treatment, and (3) many of them credit a good counsellor–client therapeutic alliance with improvements in both motivation and drug use.

### *Judicial Pressure*

Very interestingly, research has shown that individuals who begin treatment by court order may reduce their psychoactive substance use as much as those who enter treatment voluntarily and that it may have a positive effect on both drug use and criminal recidivism (Landry et al. 2009; CASA 2010; Schaub et al. 2010).

Many people who work in criminal justice agree that, in court, the tacit threat of prison is the foremost motivator for drug-dependent people to agree to therapy. Brochu and his fellow researchers (2006) studied five Canadian addiction rehabilitation centres and found similar results, though they highlighted some important distinctions

with respect to treatment retention and outcomes. Our results showed higher treatment retention among people who are awaiting charges, trial, or sentencing; who are under pressure to commit to treatment; and who have not yet entered the correctional system. It is therefore reasonable to conclude that the threat perceived by offenders has the impact desired by the courts in terms of diverting offenders toward therapy. It is important to note, however, that this impact is observed only at the pre-sentencing level. Probationers and parolees seem less fazed by the consequences of not participating in court-recommended treatment. All the same, treatment retention is not necessarily associated with improvements in substance use problems in this study, at least not with respect to drugs. We can assume that perceived judicial pressures have a positive effect on treatment initiation and retention for some offenders, but that does not necessarily translate into better outcomes vis-à-vis substance use problems. Pre-sentencing judicial pressure gives therapists an opportunity to initiate a therapeutic alliance, which is key to the offender participating in treatment in the absence of judicial constraints. Without a therapeutic alliance, offenders are highly likely to drop out. On the other end of the judicial or, rather, correctional spectrum, Tétrault and her collaborators (2007) observed especially high motivation for treatment and change among men in halfway houses or on parole.

Qualitative studies improve our understanding of what motivates offenders to accept addiction treatment. A Belgian study (Vandevelde et al. 2006) explored the expectations, needs, and motivations of incarcerated and released offenders. It identified both extrinsic and intrinsic motivations among participants. The most frequently reported extrinsic reasons for entering and remaining in treatment were hoping to be released sooner, not wanting to be sent back to prison for another drug crime, and social network pressures.

Intrinsic motivations included the desire to make something of their lives, to limit the impact of their actions on loved ones, and to improve their social network (ibid.). The qualitative component of a study by Stevens and his collaborators (2006) of people entering "quasi-compulsory treatment" (treatment for drug dependence ordered by the criminal justice system) in five European countries showed that this can be an opportunity for clients to engage with treatment services even if they might not have done so absent judicial pressure. Some of the participants had been waiting for treatment prior to their arrest; others did not perceive the coercive aspect and

took ownership of the decision to begin treatment and their treatment goals. However, for clients with less favourable therapeutic outcomes, motivation seemed to have more to do with not being incarcerated than with intrinsic motivation for treatment. Treatment staff interviewed for the study talked about client ambivalence and the difficulty evaluating motivation because some clients choose to report intrinsic motivators even though their true motivators are extrinsic (Stevens et al. 2006). A qualitative study of twenty-seven Montreal child protection agency clients (Magrinelli Orsi 2011) showed that some perceived the controlled environment provided by the agency as a motivator to try to change drug use habits; others did not consider the environmental constraints to have affected them. Magrinelli Orsi (2011) suggested that it might be best to avoid labelling troubled youth as motivated or not motivated to change their drug use habits because perceptions about the need to make changes and the opportunity to do so vary so much from one youth to the next.

It appears that individuals compelled to be in treatment can reduce their drug use (Stevens et al. 2006), and that not everyone under judicial pressure feels forced to enter treatment (Brunelle et al. 2014; Magrinelli Orsi and Brochu, 2009). A court order to enter treatment does not necessarily mean involuntary participation. In fact, Fickenscher and her collaborators (2006) found that drug-dependent adolescents' degree of concern about legal pressure, not the presence of legal pressure itself, was related to treatment completion. Once again, we see that it is important to consider how social actors perceive their circumstances.

> Being here [in a treatment centre] was really good for me. . . . I was lucky to get in, and it helped me. . . . Personally, I've started working on myself. . . . I didn't even know I had all these tools. (Achille) (Brunelle et al. 2014)

Thus, we find no black or white here, only shades of grey. The good news is that motivation is flexible, mutable. Data suggest that pressure from the courts may be effective in eliciting sufficient extrinsic motivation for individuals to agree to treatment prior to sentencing. However, for offenders to remain in treatment beyond the first few sessions, therapists must form an alliance with them. This means that therapists have an important role to play in bringing about change in their clients' motivation.

## The Therapeutic Relationship

We know that certain therapist characteristics influence the development of the relationship and the change process for people with dependencies. Therapists must have certain qualities identified by Rogers (1957), such as empathy, authenticity, warmth, and respect, to form a therapeutic alliance starting at the screening and referral stages (Arseneault 2009; Brunelle et al. 2015; Diamond et al. 2006; Hawley and Garland 2008; Mee-Lee, McLellan, and Miller 2010).

Therapeutic alliance means that the therapist and the client agree on treatment objectives and work well together (Wanberg and Milkman 1998). According to Fitzpatrick and Irannejad (2008), developing a personalized treatment plan and reviewing it periodically with the client is an important part of creating a therapeutic alliance. Bordin (1979) defines it as an emotional bond arising from active collaboration between the client and the therapist that includes agreeing on a change-focused goal and identifying tasks involved in achieving that goal. Thus, three key features must be present: the bond, the goals, and the tasks.

> Well, he [the caseworker involved in the referral] was always humane, he was understanding, and he suggested this [the treatment] to me, by sort of suggesting a decrease in my use, but not total abstinence. (Berthe) (Brunelle et al. 2015)

The first of these, the bond, involves the emotional aspect of the alliance, the client–counsellor relationship. Confidence, caring, and engagement are central to the relationship (Baillargeon and Puskas 2013). Full confidence and bonding are vital to gaining access to the client's inner experience (Bordin 1979). The second, goals, depends on mutual agreement and collaboration between the therapist and the client regarding treatment goals. The third, tasks, relates to treatment modalities and agreement between the client and the therapist about the steps to be taken. Baillargeon and Puskas (2013) explain that tasks must match the client's expectations, must not make the client uncomfortable, and must be related to the goals. These three key features of the therapeutic alliance are interdependent. A key finding of the literature review by Meier, Barrowclough, and Donmall (2005) is that early therapeutic alliance promotes subsequent engagement and retention in treatment. The therapeutic alliance is related to previous

treatment experiences and the client's degree of motivation. For adolescents in substance abuse treatment, lack of social support and antisocial personality traits are associated with difficulty establishing a good therapeutic alliance (Garner, Godley, and Funk 2008). However, those with more severe drug use upon entering treatment develop a better therapeutic alliance during treatment (Bertrand et al. 2013a; Garner, Godley, and Funk 2008).

Literature about the therapeutic alliance for drug-dependent individuals in the criminal justice system is limited (Meier, Barrowclough, and Donmall 2005). Joe and his fellow researchers (2001) showed that the presence of a good therapeutic relationship, regardless of satisfaction with or duration of treatment, is related to lower rates of illegal activity and problem drug use. Cournoyer and his co-investigators (2007) separated individuals beginning drug treatment into three groups: those with criminal justice involvement, those with mental health problems, and those with neither. They found that people in the first group were more resistant and had a more negative attitude toward treatment than members of the other two groups, but that a therapeutic alliance with those in the first group was more likely to develop if the therapist was perceived as involved and understanding.

### *Adequate Treatment Duration*

Several studies have shown that longer treatment duration for those who need it and treatment completion generally produce better outcomes (Best et al. 2008; Lang and Belenko 2000; Moos and Moos 2003; Zarkin et al. 2002). According to Laudet, Stanick, and Sands (2009), treatment retention "is associated with stabilization and/or improvement in protective resources that, in turn, bolster the long-term effects of treatment" (p. 182). Huebner and Cobbina (2007) analyzed the results of drug treatment given to probationers. Participants who completed treatment were less likely to reoffend than those who failed to complete treatment.

Certain factors may predict better treatment retention (Casares-López et al. 2013; Lang and Belenko 2000). These include a better social support network, fewer difficulties with loved ones in the months preceding arrest, intrinsic motivation, and few or no psychiatric problems or personality disorders. Individuals with aggressive-sadistic, narcissistic, or borderline personalities, or with hypomania, are more likely to drop out of treatment. Best and his collaborators (2008) showed that

drug-dependent offenders with a history of heavier drug use prior to entering treatment and with fewer periods of incarceration were more likely to persevere.

We believe that accumulation of services for people with chronic dependence issues may satisfy the requirement for adequate exposure to treatment. A Quebec study of drug-dependent adults found that the cumulative effects of multiple treatment episodes had a positive impact on their rehabilitation trajectories, particularly for individuals recruited in courts (Brunelle et al. 2015).

### *Aftercare*

It is well established that a transition between correctional programs and community-based aftercare is desirable and that service continuity promotes successful social reintegration and lower recidivism compared to prison-based treatment alone (Bahr, Masters, and Taylor 2012; Grella et al. 2007).

A number of studies have shown that offenders who participated in therapeutic community treatment while incarcerated reoffend less, and that post-release treatment continuation significantly improves their behaviour and the likelihood of successful social reintegration (Bahr, Masters, and Taylor 2012; Burdon et al. 2007).

Burdon's team examined whether post-prison treatment intensity affected therapeutic success. Their findings were interesting in that, contrary to what they expected, they observed that "subjects benefited equally from outpatient and residential aftercare, regardless of the severity of their [substance use] problem," although they did not define the intensity of either type of aftercare (Burdon et al. 2007). Their work indicates the need for a sophisticated assessment of the individual's needs and the treatment intensity level required, for an evaluation of services provided by treatment centres, and for a continuum of care that recognizes progress made in prison-based treatment.

According to the National Institute on Drug Abuse's thirteen principles of drug abuse treatment for criminal justice populations, community-based treatment is essential to sustaining gains achieved in prison (Fletcher and Chandler 2007). Bahr, Masters, and Taylor concur that "effective treatment programs . . . include an aftercare component" (2012, 155).

## Extension of Social Control

Offering therapeutic services outside correctional settings may entail an extension of social control that treatment providers sometimes refuse to take on. In their regular practice, most of them are not in the habit of spying on their clients, and they have no intention of taking on a supervisory role for this population. When rehabilitation centres accept legally mandated clients, that is just one step removed from making participation in treatment mandatory or in addition to incarceration, or from making it a condition for release.

This raises the very real risk of blurring the line between punishment and rehabilitation. Rehabilitation becomes punishment, and the possibility of substantial extension of official control beyond what would otherwise exist emerges. This opens the door to punitive measures having less to do with offences committed than with the probability of reoffending. Can we in good conscience accept this?

For criminology researchers and practitioners, the discussion around drug treatment for the criminal justice population is a lively one that goes well beyond determining whether prison-based treatments are effective. Is it possible to truly assess drug dependence within that population? What limitations are there on the power and the right to intervene in a coercive environment? Would it not be best to wait until offenders have served their sentences and then recommend they sign up for a treatment program in their home community?

For people deprived of their liberty, a coercive environment is certainly not conducive to cooperating with those responsible for supervising them. In many cases, offenders may believe that their own interests clash with the goals of the criminal justice system (such as public safety and security).

Justice-involved individuals typically look for the best way to make the process as quick and painless as possible. Some try to convince judges that they are not fully responsible for their criminal actions because they have a serious drug problem. Their goal is to serve their sentence in a treatment centre where discipline is less harsh than in prison or to get a suspended sentence. Another strategy, which seems counterintuitive at first glance but actually makes sense for convicted offenders, is to deny the existence of a drug problem so as to be granted parole as soon as possible. Offenders understand that correctional authorities associate drug dependence with recidivism,

so they try to avoid being labelled as addicts. Justice-involved individuals often feel the need to obfuscate and withhold full cooperation from those responsible for helping them.

### *The Real Client*

Many other important questions bear asking. Who is the real client? To whom is the treatment provider accountable? The person in the provider's care or, as is often the case, the institution that refers the person for treatment? What drives intervention requests? A true desire for change or the desire to make the right impression on corrections officials and those responsible for granting parole? How should a treatment provider approach clients who were referred by prison officials and could be transferred or denied parole if they drop out of or fail treatment? Do providers have the right to exert pressure to elicit change, and what kind of pressure is appropriate? By whom and by what standards is change deemed positive? How should pressure be exerted? What tools should be used?

Do some prison-based therapeutic actions violate the individual's rights? Does a coercive setting taint interventions? Do some of the existing programs reinforce abuse of authority?

Can a person seeking treatment be denied it? Can providers abdicate their responsibility to offer suitable health care? To guard against offenders being forced to take steps toward change, should they bear full responsibility for their own lifestyle change with no therapeutic support whatsoever? Is there any reason to believe that offenders will maintain their desire for change post-release if no support was provided during incarceration? Will they have the determination to withstand the pressure of a new institution (a treatment centre) having recently regained their freedom?

It is also important to talk about what motivates treatment providers to work with people who have experienced prison socialization and who seem disinclined to help themselves. Some clients may try to recreate a known environment by reproducing elements of the prison code, which interferes with the traditional therapeutic process by discouraging people from opening up and accepting divergent viewpoints. This can affect the creation of a therapeutic alliance with the offender, which reduces the likelihood of positive treatment outcomes. Some clinicians even believe that admitting individuals from the criminal justice system, who may be recalcitrant and can have a

negative impact on the group therapy environment, can obstruct the therapeutic process for all clients.

### *Boundaries and Bridges*

Rigid boundaries between security and rehabilitation priorities and clear expectations on the part of everyone involved are key to preventing the aforementioned ethical issues from cropping up. Some professionals who work with drug-dependent criminal justice populations agree with the authorities not to write reports about their clients' progress. They do this in part because they do not want their clientele to be made up solely of individuals who just want to make a good impression on prison officials and in part because they want to provide some reassurance to clients who might hesitate to open up for fear that doing so could affect how long they remain under judicial supervision. This approach recognizes that offenders have a fundamental right to expect that information they disclose during the therapeutic process will be kept confidential. This is why, in some countries, public health intervention falls under the jurisdiction of health services, not corrections. Interdepartmental bureaucracy ensures the integrity of that boundary. On the surface, that integrity seems easier to ensure when the criminal justice system refers offenders to drug treatment centres located outside prison environments (Sullivan et al. 2007).

In this context, intervention must bridge the realm of criminal justice on the one hand and that of treatment on the other. Regardless of the services available to offenders while incarcerated, they must have every opportunity to use treatment services in the community. Bridging the criminal justice world and the health and social services arena reinforces the necessary boundaries between helping and controlling, roles that prison and penitentiary personnel are all too often expected to fulfil simultaneously. Collaborative initiatives such as the one between the Centre de détention de Québec[12] and the rehabilitation unit at the Centre intégré universitaire de santé et de services sociaux de la Capitale-Nationale,[13] which provides in-house services, seem to work very well (Arseneault 2014; Ferland et al. 2013; Plourde et al. 2015). Building these bridges takes work because criminal justice and health and social services are two separate worlds, each with their own culture. One is focused on public safety, and the other on health and personal development. One is naturally suspicious, while the other is more trusting. Nevertheless, dealing with a

justice-involved drug-dependent individual calls for expertise from both worlds.

A recent American study (Friedmann et al. 2012) on the effectiveness of collaborative behavioural management (CBM) offers a concrete illustration of just how vital collaboration between criminal justice and addiction treatment partners is. The researchers observed a positive effect on both drug use and delinquency among cannabis users on probation. CBM involved an initial session between the drug-dependent offender and his or her parole officer and treatment counsellor, as well as twelve weekly sessions with the parole officer in which the treatment counsellor participated periodically. Sessions included a review of expectations and the consequences of failing to meet expectations, negotiation of a weekly behavioural contract (not socializing with drug-using friends, looking for work), reinforcers and incentives (verbal congratulations, gift certificates), and sanctions (more frequent reporting to parole officer) for failure to abide by the contract.

Healthy collaboration between the correctional system and treatment centres can be key to successful rehabilitation, but it comes with some major issues and challenges (Brunelle, Cousineau, and Ledoux 2012; Nissen 2006), such as clarifying the roles of custodial institution and treatment centre personnel, developing a prison-based psychoactive substance intervention philosophy that all staff understand and apply, and providing ongoing professional development for custodial institution and treatment centre staff (Brunelle, Cousineau, and Ledoux 2012). Healthy collaboration between the correctional and drug treatment systems rests on an agreement about the responsibilities of each, about the information to be shared, and about access to sensitive information (ibid.). One way to address confidentiality concerns is to have the drug-dependent offender sign a document detailing when and for what purpose information can be shared and whether the offender must be present at the time. It should also explain and remind clients of the limits of confidentiality (Brunelle and Bertrand 2010).

It is also important for all parties involved, including the client, to agree on what can be included in reports. All of the professionals working with the offender throughout the rehabilitation process should be able to decide what is relevant to the progress report and should notify the offender of any sensitive information to be included. All parties should sign a pre-treatment agreement specifying (1) at

what point in the therapeutic process a report may be written, (2) for what purpose and for whom it will be written, and (3) which elements will be reported and how they will be reported. This protects the offenders' right to confidential treatment of what they say during therapeutic sessions, reduces the risk of seduction or rebellion in guard/inmate relationships, and encourages drug-dependent individuals to open up and work on the most difficult areas of their lives. Intervention in a criminal justice context involves erecting necessary boundaries and building appropriate bridges.

* * *

Problem substance use is prevalent within the criminal justice population because of drug laws and drug law enforcement, and because of crimes committed while intoxicated or to acquire drugs. The legal process provides a good opportunity to reach many people with drug dependence. They are entitled to the same health care services as the general population, so providing them with appropriate treatment is important. While this population presents complex cases, certain interventions do reduce criminal recidivism, which is a very good reason to provide addiction treatment services to offenders. As we have seen, effective practices exist and are well documented, but implementing them remains a challenge. In their study of how widespread evidence-based drug treatment practices are in the American justice system, Friedmann, Taxman, and Henderson (2007) found that fewer than 60 percent of the treatment modalities in most programs were best practices. Clearly, there is room for improvement.

All the approaches to rehabilitation and elements of effective treatment discussed in this chapter owe a significant measure of their success to good assessment of the client's situation, and to multimodal service offerings matched to the individual's profile and needs. Interest in the role that motivation plays in the treatment of drug-dependent clients in the justice system is growing. Numerous intervention programs and techniques have been developed in the past two decades, and many of them include motivational interviewing. Even traditional treatments and those based on specific models, such as cognitive-behavioural approaches, include elements borrowed from motivational methods in their philosophy and techniques.

Now that we recognize the clinical importance of motivation, we can see how coerced intervention can have a downside. Motivation

for change is a major issue for drug-dependent offenders participating in treatment under coercion. Nevertheless, studies have shown that even though intrinsic motivation seems to produce better clinical outcomes than extrinsic motivation, in some cases judicial constraint can create the right conditions for intrinsic motivation to develop and improve treatment retention. Judicial involvement in and of itself does not create ideal conditions for the therapeutic process, and offenders' immediate interests (avoiding conviction and sentencing, possibility of release) are not necessarily aligned with the goals of the criminal justice system (public safety and security). Even so, therapists who base their intervention on up-to-date knowledge about motivation for change can help clients progress regardless of the context. Therapeutic alliance is another factor strongly correlated to treatment success when relationships are built with clients themselves (justice-involved or incarcerated individuals) and the client behind the client (the legal and correctional system). Given that therapeutic alliance in drug treatment may be related to reduced problem drug use and criminal activity, more research on this approach and on other elements that have the potential to counter risk factors is in order.

As we have seen, for clients in a correctional context who are deprived of their liberty, treatment effects and efficacy criteria are not the only rehabilitation issues to consider. We must also consider the moral and ethical aspects of these interventions. One of the main issues we must contemplate in connection with drug treatment in legal and correctional contexts is the disconnect between the goals and priorities of the criminal justice system and those of drug rehabilitation. On the one hand, security is paramount, but on the other, the individual's right to optimal, confidential care is essential. The concept of coercion has highly subjective connotations, so giving due consideration to how it is used in treatment is important. One question remains at the end of this thought process: should treatment be provided by the criminal justice system, by specialized external organizations, or via an integrated shared services or co-intervention model involving judicial/correctional and treatment partners? One thing is clear: this management approach requires collaboration and alignment between two levels of service that have dramatically different philosophies.

## Notes

1. Interventions were typically implemented without any evaluation component. In cases where evaluation was carried out, program implementation rarely allowed for the use of research designs appropriate to this context.
2. Ethical problems of all kinds, difficulty protecting confidentiality, administrative priorities that required transferring inmates before the end of treatment, lack of funding, difficulty complying with admission criteria, lack of program independence, and so on.
3. A Court of Quebec addiction treatment program.
4. In 2015, the centre (Montreal Addiction Rehabilitation Centre – University Institute) became part of the Centre intégré universitaire de santé et de services sociaux du Centre-Sud-de-l'Île-de-Montréal (South-Central Montreal Integrated University Health and Social Services Centre).
5. All names were changed.
6. See Vacheret and Lemire (2007) for a discussion of prisonization.
7. TCs make extensive use of positive reinforcement and punishment.
8. In Georgia.
9. DÉBA-Alcool and DÉBA-Drogues.
10. Detection of Alcohol and Drug Problems in Adolescents.
11. Texas Christian University.
12. A provincial prison in Quebec City.
13. Quebec City Integrated University Health and Social Services Centre.