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Barriers to implementing effective correctional drug treatment programs.

Farabee D, Prendergast M., Cartier J. et al.

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Expertly describes and evaluates the difficulties of mounting drug treatment programmes in prisons, drawing on the pooled knowledge and experience of leading US researchers on why real-world programmes sometimes fail to live up to expectations based on more ideal-world trials. Though focused on prison, much is relevant also to community sentences.

SUMMARY A leading US researcher on criminal justice treatment programmes has described how these "have tried to achieve two purposes – enforcer and social worker – and have found the polar nature of the two tasks often conflicting." Such difficulties were described and evaluated in the featured review, which pooled the knowledge and experience of US experts on why real-world programmes sometimes do not live up to expectations based on more ideal-world trials. Though focused on prison, much is relevant also to community sentences. The six barriers they identified are paraphrased below, along with their proposed solutions.

1 Client identification, assessment, and referral. The tendency for criminal justice systems to use limited criteria (eg, any lifetime drug use, small-scale drug sales, trafficking) to determine the need for treatment, and to exclude other offenders for reasons unrelated to their substance use problems (eg, having committed a sexual or violent offence), can mean many patients have low-level substance use problems and little scope for improvement. There is also a tendency for prisons to 'dump' problematic inmates at programmes in other prisons, regardless of treatment need.

One solution is to locate treatment services in each suitable institution and recruit patients only from that institution. That entails more and smaller programmes, which should be more manageable and more focused in their implementation. Treatment staff must be involved in the selection of new admissions to ensure their appropriateness and actively recruit participants from the general inmate population to avoid populating their programmes with less appropriate inmates in order to fill beds.

2 Recruitment and training of treatment staff. It is difficult to locate and recruit qualified and experienced staff in the remote areas where prisons are typically located. Also, counsellors suited for community-based programmes will not necessarily be effective in prison; over-familiarisation and resistance to rigid custody regulations are common among treatment providers who lack experience in criminal justice settings. High turnover rates and bans on employing recovering drug users exacerbate the situation. Common counselling techniques, such as mutual self-disclosure between counsellor and client, are limited in prison; even experienced community-based counsellors must learn to adjust their counselling styles to be effective in this environment.

Recruitment can be addressed by paying higher wages than in the community. Workload can be reduced by using recovering prisoners who have been through the treatment programme as counsellors and mentors. Mandatory, shared training for all treatment staff and programme-involved custody officers will help resolve their conflicting goals. Without this, custody goals will eventually eclipse treatment goals. Often both groups falsely assume treatment and control are mutually exclusive when in reality, both can be achieved simultaneously.

3 Redeployment of prison staff. Staff turnover undermines programme stability and effectiveness, yet in prison-based treatment programmes, turnover occurs by design to further professional advancement.

A written set of standards to guide the more subjective elements of the programme can maintain continuity despite staff turnover. This requires custody and treatment staff to work closely together before and during the initiation of the programme. Standards might, for example, cover: when inmate noncompliance merits an institutional versus a therapeutic response; how closely treatment and custody staff work together; and to what extent custody staff should be involved in the treatment process and treatment staff be allowed to carry out correctional duties. Another strategy for maintaining continuity among custody staff is to professionalise their treatment roles. Certification and financial incentives for officers who have a certain number of hours of cross-training and on-the-job experience with substance use treatment programmes would help retain staff and enhance their professional development and appropriateness for the treatment setting.

4 Overreliance on institutional versus therapeutic sanctions. In contrast to community programmes, in prisons noncompliance with treatment is often met with a correctional rather than a therapeutic response. Staff in the stressful and conflict-prone prison environment are often seduced by the immediacy of issuing formal disciplinary sanctions rather than relying on the therapeutic process. Conversely, treatment staff in prisons must also be able to invoke institutional sanctions (whether directly or through custody staff) with minimal delay. Research has found that one of the most significant barriers to successful implementation of treatment programmes is the providers' lack of authority to issue sanctions for noncompliance. To preserve authority and integrity, programmes must be able to remove inmates who violate rules or threaten other participants.

5 Aftercare. The importance of post-prison aftercare is widely recognised, and research shows that low rates of aftercare attendance and/or retention can seriously diminish the impact of prison-based treatment, yet several aspects of the criminal justice system prejudice effective aftercare. Many prisoners enter treatment involuntarily, and only a minority volunteer to continue with/stay with these services once no longer required to do so. Poor aftercare uptake may be symptomatic of an over-reliance on institutional controls in managing inmate behaviour, leading to an underestimation of the importance of internal motivation. Once institutional controls are removed, the former prisoner is unlikely to voluntarily enter aftercare. Also, community-based treatment providers can be reluctant to admit ex-prisoners, particularly those with a record of violent or sex offences. Thirdly, there is limited control over the type and quality of treatment available in whatever area the former prisoner goes to, making it difficult to ensure a continuum of care consistent with that in prison.

Efforts to strengthen engagement (eg, providing more individual sessions during the initial phases, demonstrating the success of previous graduates, motivational interviewing) should be basic elements of the programme. Because providing aftercare requires coordination between the prison-based provider, the community provider, and criminal justice agencies, the emphasis on post-release treatment participation should begin at least three months prior to the release date. External motivators for aftercare participation might also help, such as offering inmates early release from prison with residential aftercare required as a condition of parole, featuring frequent, random urine testing and close parole supervision.

6 Coercion. Participants in prison-based treatment are not always involuntary clients, but coercion undoubtedly plays a role for most. Many inmates with substance use problems are unwilling to volunteer for treatment because of the associated stigma, the additional structure and rules of a treatment programme, loss of institutional seniority, and reduced opportunities for work in prison.

Hence, denial is only one of a host of reasons why otherwise eligible clients choose not to enter treatment.

Overcoming these perceived – and often legitimate – barriers requires that programmes not only remove disincentives to participation, but incorporate meaningful inducements. Coercion alone is rarely sufficient. Possible incentives include early release, improved living quarters, enhanced vocational or employment opportunities, and reduced restrictions on parole. Also, the initial phase of treatment must emphasise problem recognition and willingness to change, before introducing the tools to do so.

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