The Impact of Treatment on Criminalized Substance Addicts

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ABSTRACT. The objective of this research is to evaluate the impact of a treatment program specialized with criminalized addicts. In all, 119 criminalized addicts were admitted to the experimental procedure (specialized treatment) while 30 were admitted to a comparison group (general treatment). Both groups were contacted at five, eight, and eleven month intervals following the onset of the treatment process. Results showed that both groups improved. Those admitted to the unspecialized treatment improved earlier (in the first five months) than clients referred

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to the specialized treatment facility, however, after eight months, the improvement was similar for both groups.

KEY WORDS. Impact, treatment, addiction, offenders, follow-up

THE IMPACT OF TREATMENT ON CRIMINALIZED ADDICTS

A certain number of studies that aim at measuring the impact of various treatment programs implemented for substance-criminalized addicts point to a discouraging prognosis regarding the impact of such practices.[1,2] This pessimistic outlook is attributed to the weak motivation on the part of the clientele to remain volunteers in a given program for as long as it takes to benefit from it.[2] When individuals remain in a treatment program on a consistent and sufficient basis, prognoses improve considerably.[2-5] The success of a given intervention seems to be related to the perseverance of individuals participating within that therapeutic program.[5-7]

There are various strategies in place that allow persistence in treatment. The most common of these strategies consists of the threat of penal measures (i.e., the risk of long sentences, the potential to return to prison . . .). Evaluative studies conducted in the United States on the efficiency of legal pressures demonstrate positive results in terms of retention in treatment and influence on relapse and recidivism.[1,5,8-11] An ethical debate, however, continues to revolve around this particular issue,[12-\14] within which one question is often put forward–with what right may one oblige someone else to embark upon such a change?

Other alternatives are, nevertheless, available. For one, an important determinant of perseverance in treatment programs and of their efficiency consists of a good matching strategy between clients' need and treatment's modality. The matching concept has been developing since the end of the 1970s.[15-19] According to this approach, addiction is a multidimensional problem that may present itself in a wide array of forms from one individual to the next. In consequence, the details that treatment programs take into consideration must include the diversity of the problem at hand and, therefore, must be able to adapt to the specific needs of their clients. It is in this manner that various forms of treatment

were developed by emphasizing the importance of variables, such as marital status, the seriousness of psychiatric problems,[20] the level of alcohol dependency,[21,22] or a combination of several variables. Criminalized addicts present a specific profile necessitating the establishment of more suitable services that allow the potential for such adaptable responses.

The notion of motivation, here, appears fundamental since criminalized addicts, according to clinicians, present the lowest motivational levels for efficient treatment.[23] The scientific literature clearly indicates that persistence in treatment may be influenced by the motivation that an individual presents in regard to an eventual behavioural change.[24] This motivation is a result of an ensemble of internal and external factors that lead an individual into adopting a particular behaviour. In fact, according to a study under progress (Bergeron et al.), it seems that motivation is a key element explaining the retention of a clientele. It appears that it is possible to act on the initial motivation of individuals under treatment in a manner that may increase and therefore favour persistence in the therapeutic process. Prochaska and DiClemente[25] studied the process of change in motivational levels. They successfully identified six stages of motivation.[26] During the first stages, an individual has little disposition to embark in any change, either because the addiction is not a self-perceived problem or because the client perceives more inconveniences than advantages in a behavioral change. However, once a superior motivational stage is reached, the individual is ready to relinquish his former behavioral characteristics and adopt new manners of responding to situations. The intention of an individual to embark upon a step towards change appears to be a function of the individual's attitude, subjective norms, and perception of control.[27-30] This multi-theoretical conceptualization of motivation was successfully applied to diverse problematic issues including the treatment of substance addiction.[31,32] Such studies have proved that it is possible to increase persistence in treatment programs by augmenting the initial motivational levels of the clientele. Assured by such results and within the framework of a matching philosophy, a group of clinicians established a program specially designed for criminalized addicts. This program integrates the current knowledge on motivation. The objective of the present study consists in verifying if a program specifically implemented to service a clientele of criminalized addicts results in a larger impact than more general programs that receive this same clientele within their regular services.

HYPOTHESES

Consequently, it is expected that: (1) the criminalized addict clientele[a] will benefit from a treatment presenting an important improvement in the seven spheres of life, as measured by the Addiction Severity Index (ASI); (2) the clientele that is regrouped in accordance with the addiction-judicial issue and oriented towards a complete program conceptualized specifically for them, including a motivation work group, will: (a) manifest more perseverance during treatment and (b) improve more than a offender clientele oriented towards regular treatment programs.

METHODOLOGICAL FRAMEWORK

Description of Evaluated Programs (Independent Variables)

Since clients of treatment centers do not reside in sealed off units and discussions regarding the interventions they are receiving may be conducted with other clients, it was crucial that all forms of such interactions were to be avoided. Hence, two different centers situated in separate regions were selected as sites. The two participating centers developed a philosophy and practical approach that extends from a bio-psycho-social conceptualization of addiction. Moreover, the two centers selected participated throughout the year preceding this research in a similar study aimed at arriving at more suitable definitions for those services that may be offered to criminalized addicts.[33] One may assume that the differences between the two centers may affect the ability for results to be compared. However, findings from a previous study of three treatment centers demonstrated that, in terms of services, clientele, and results on the Addiction Severity Index, more common points were found between the centers than differences.[34] In brief, the differences between these two centers under study were minimum and less important than the potential problems that would have taken place if only one center was taken as the exclusive setting for the entire study.

The General Treatment Program

The offenders clientele[b] that was referred to the general treatment (GT) program was oriented across various regular readaptation services. These services developed from eight principal lines: (1) welcoming the client and an initial evaluation of the problem at hand; (2) restoring the

client's physical conditioning; (3) acquiring and maintaining substance abstinence; (4) modifying individual dynamics that contributed to the development and maintenance of the dependent state; (5) researching alternatives to the consumption of psychoactive substances; (6) improving one's knowledge and self-esteem; (7) developing social competence (group-family-milieu); and (8) social reintegration and supervision. Interventions aimed, above all, at assuring that the client remained in his own milieu so that change may be provoked from within. External services were therefore always privileged and intervention via the family and other significant people in one's life occupied a predominant aim in order to favor social-psychological integration and the maintenance of a client's acquired attributes. No toxicological screening is done.

The Specialized Treatment Program

Exempted services in the specialized treatment (ST) programs were registered at three levels. To begin, an initial meeting with the client was required in order to explain the program's content while, at the same time, gathering clinical-based information that would optimize the clinician-client pairing. Depending on the client entering the program, various types of services could be exempted. The first type concerned adaptation services. Four kinds of activities were offered in this type of service: (1) individual interviews; (2) workshop conferences made up of a series of educational and informative meetings; (3) a group whose goal it was to elaborate the approach established during the workshop conferences by allowing the client to explore his personal past, the impact of this past on the manner he established relationships with others, and the links that combine such factors to his addiction and criminal history; and (4) experimentations within the milieu. The second type of service, readaptation, was made up of workshops and meetings. The development of competence (social skills) were taught while aiming for strategy elaboration and relapse prevention. In sum, such an approach allowed for suitable relationship between the expectations and needs of clients and the nature of those services offered. No toxicological screening is done.

Dependent Variables

McLellan et al.[35] Addiction Severity Index constituted the principal instrument measuring the program's impact. The validity and reliability of this psychometric tool has been steadily verified,[35,36] as has the

French adaptation (Indice de Gravité d'une Toxicomanie) used in Quebec.[c,37-39] The Addiction Severity Index covers seven important dimensions of substance addiction that made up the study's dependent variables: the seriousness of problems linked to alcohol, drugs, one's psychological state, medical condition, legal situation, family and social environment, and employment context. Scores elaborated from specific questions permitted the evaluation of the seriousness of the individual's situation for each scale. Derived from a complex mathematical calculation, scores ranged from 0 to 1. The more a score neared 1, the more important is the problem.[d] The impact was observed in terms of the subjects' improvements and was therefore operationally defined as the lowering and maintenance of their composed scores to substantially lower levels than from the onset of treatment following a pre-/post-estimation of repeated measures with group comparisons. After the initial contact preceding the actual therapeutic process, subjects were followed-up on three occasions–that being at five months, eight months, and eleven months after the onset of treatment that they may or may not have pursued.

Subjects

Subjects were contacted during their admission process by a research agent. All contacted were entirely free to participate in the study and were told that their therapy would not be affected in any way by their decision to or not to participate in the study.[e] Of the 218 (GT: 50; ST: 168) persons who agreed to participate, 4 clients (all from ST) were discarded at the initial stage due to a lack of complete and valid information in their files. This resulted in a total of 214 eligible participants (GT: 50; ST: 164). Of these, 11 subjects (5.1%) withdrew from the study for various personal reasons (GT: 2; ST: 9) and 54 (25%) were not reached for all three follow-up periods despite efforts made by members of the interviewing team (GT: 18; ST: 34).

In all, 149 subjects (GT: 30; ST: 119) were contacted three times (at 5, 8, and 11-month follow-up intervals) after the onset of the treatment process. All accepted to collaborate with the interview procedure, hence establishing a 70 percent follow-up rate. Subjects are described in the result section.

Statistical Analyses

In order to arrive at a global evaluation of the program's impact without compromising one of the basic principles of the ASI–the indepen-

dence of scales[35,36]–a series of seven repeated analysis of variance (ANOVA 2X4) were carried out in order to observe the differences between treatment types (2) and time periods (4). In the case where multiple comparisons were needed, the Bonferroni method was used to control for type I errors for the multiple tests.

RESULTS

Differences Between the Initial Group of Subjects and the Follow-Up Sample

In order to perform rigorous analyses, certain preliminary checks were deemed necessary. Since not all of the subjects were contacted for the three follow-up periods, it became crucial to compare their sociodemographic profiles, their initial ASI levels, and the number of hours spent in treatment (Table 1 presents the average length of time for each of the activities offered) between our sample and those clients who were not contacted for the three follow-up periods (see Table 2). This comparison yielded two differences. First, the follow-up sample included more women (followed: 13.42% women; non-followed: 7.94% women). Second, the follow-up sample spent more time in treatment than those subjects that were not followed-up (followed: mean = 15.79 hours, s.d. = 20.10 hours; non-followed: mean = 8.46 hours, s.d. = 9.86 hours). At the time of admission, no differences were observed on ASI levels between the two groups.

Description of the Follow-Up Sample

It was also necessary to compare sociodemographic profiles between subjects assigned to the two treatment conditions. Only age significantly distinguished subjects who went to the ST (mean = 35.07 years, s.d. = 7.32 years) from those who were admitted to the GT (mean = 31.73 years; s.d. = 9.9 years). The other variables did not significantly distinguish the two groups at the initial stage. The follow-up group was composed of 129 men and 20 women. The mean age was 34.4 years (s.d. = 7.98 years). The majority of subjects (70%) were out of the job market for some time. From a matrimonial standpoint, 27.6% of the subjects had spouses while 72.4% were either single, widowed, or divorced. In regard to schooling, 19.5% of the subjects in the study sample had more than a grade 12 education. Substances constituting the

TABLE 1. Average length of time for each of the activities offered

Activities	Hours
Pre-initial meeting	0.50
Initial meeting group	2.00
ASI	1.50
Pre-residential group	1.00
Nursing data collection	1.00
Reevaluation of initial meeting, initial evaluation and orientation	0.50
Medical interview (including psychiatric interview)	0.75
Criminal status evaluation or psychiatric evaluation	1.00
Psychological evaluation	2.00
External Rehabilitation Group I	2.00
Personal external interview or personal internal rehabilitation interview or transition plus interview with psychologist	1.00
Follow-up nursing interview or nursing data update	0.50
Clinical telephone call	0.10
Administrative telephone call	0.10
Internal rehabilitation group I	1.00
Personal internal rehabilitation interview I	0.75
Matched groups or target groups or RIII groups plus optional external groups plus couples group	2.00
Internal rehabilitation II matched groups	2.50
Post weekend group or internal rehabilitation II weekend planning group	1.50
Internal rehabilitation II home environment group, other groups and seminars	2.00
Transition group	0.75
Community supper	2.50
Family and couple interview	1.50
Meeting over coffee	1.00
Other home environment activities	3.00
Back to the outside world group	1.50
Relaxation group	1.00
Acupuncture	0.50
Intensive weekend	6.00
Help yourself group	1.00

TABLE 2. Sociodemographic comparisons between follow-up and non-follow-up subjects

	Follow-Up		Non-Follow-Up		Total	
	N	%	N	%	N	%
Sex						
Male	129	86.58	58	92.06	187	88.21
Female	20	13.42	5	7.94	25	11.79
Missing			2		2	
Net income						
Less than $12,000	105	71.43	45	73.77	150	72.12
$12,000 or more	42	28.57	16	26.33	58	27.88
Missing	2		4		6	
Type of occupation						
Full time job	26	18.06	9	14.52	35	16.99
Part time job (regular hours)	3	2.08	1	1.61	4	1.94
Part time job (irregular hours)	7	4.86	2	3.23	9	4.37
Seasonal work	7	4.86	3	4.84	10	4.85
Student	1	0.69	1	1.61	2	0.97
Retirement/invalidity	5	3.47	-	-	5	2.43
Unemployment	5	3.47	2	3.23	7	3.40
Institution	7	4.86	3	4.84	10	4.85
Welfare	68	47.22	35	56.45	103	50.00
At home	1	0.69	1	1.61	2	0.97
Unstable	14	9.72	5	8.06	19	9.22
Missing	5		3		8	
Completed years in school						
1 to 7	16	10.88	5	7.94	21	10.00
8 to 10	53	36.05	27	42.86	80	38.10
11-12	50	34.01	23	36.51	73	34.76
12 and +	28	19.05	8	12.70	36	17.14
Missing	2		2		4	
Marital status						
Single	77	52.03	26	41.27	103	48.82
Partner	31	20.95	14	22.22	45	21.33
Married	10	6.76	2	3.17	12	5.69
Separated	30	20.27	21	33.33	51	27.96
Missing	1		2		3	

TABLE 2 (continued)

	Follow-Up		Non-Follow-Up		Total	
	N	%	N	%	N	%
Current living situation						
Institution	44	29.53	17	26.98	61	28.77
Single	38	25.50	20	31.75	58	27.36
Parents	18	12.08	8	12.70	26	12.26
Live-in partner + children	17	11.41	7	11.11	24	11.32
Live-in partner only	14	9.40	6	9.52	20	9.43
Friends	2	1.34	-	-	2	0.94
Children	3	2.01	1	1.59	4	1.89
Family	7	4.70	2	3.17	9	4.25
Unstable	2	1.34	2	3.17	4	1.89
Co-location	4	2.68	-	-	4	1.89
Missing			2		2	
Age	X 34.40	s.d. 7.98	X 34.0	s.d. 7.32		

major problems for most subjects were alcohol and cocaine, with 44.97% of subjects stating that they had experienced problems with both alcohol and drugs. Looking about criminality, comtempt of court was the major infraction (57.2%) for which subjects have been charged followed by driving while impaired (52.0%), theft (47.4%), mischief (46.1%), major driving violations (44.1%) and assault (42.8%). Tables 3, 4 and 5 provide a sociodemographic description of these subjects in accordance with the types of treatments to which they were referred.

Studying the Changes

The general hypothesis is that both treatment have an impact on their clients. Moreover, ST clients should persevere more and experience a greater impact than GT clients. This implies that ST subjects should have been smaller composite scores on each scale as measured by the ASI at the five, eight, and eleven months follow-up periods than at the onset of treatment (time effect). This also means that ST subjects should have improved more than their GT counterparts (group $\times$ time interaction).

TABLE 3. Comparisons between follow-up and non-follow-up clients for addiction-related information

	Follow-Up		Non-Follow-Up		Total	
	N	%	N	%	N	%
Main problem substance						
Alcohol	42	28.19	18	29.51	60	28.57
Cocaine	11	7.38	9	14.75	20	9.52
Alcohol and drugs	67	44.97	25	40.98	92	43.81
Polydrugs	20	13.42	4	6.56	24	11.43
Other	9	6.04	5	8.20	14	6.67
Missing			4		4	
Numbers of times treated for alcohol and drug related problems						
None	33	22.30	20	31.75	52	25.12
One	36	24.32	19	30.16	55	26.07
Two or more	79	53.38	24	38.10	103	48.82
Missing	1		2		3	

For one, ST clients stayed in the program, on average, 16.7 hours (s.d. = 21.6) compared to 12.13 hours (s.d. = 11.89) for GT clients, but this result was not statistically significant ($p = 0.72$ after logarithmic transformations were applied in order to adjust for the asymmetric distribution of the numbers of hours in treatment).

Table 6 presents the results of the ANOVA carried out with the two subject groups for the four time periods. An interaction effect, between being part of a treatment group and the time of measure, was observed for alcohol ($F = 3.87$; $p < 0.01$), psychological ($F = 3.92$; $p < 0.01$), and legal ($F = 2.98$; $p < 0.01$) scales. The presence of these three interactions prevented a direct interpretation of the main effects as to the subject groups and the time of measurement, even though some did prove significant.

First, the breakdown of the alcohol composite score for each group revealed where the pre/follow-up differences were situated (see Table 7). Both groups improved after T1, however, GT subjects improved more and their mean ASI alcohol score (0.09) was significantly lower than the mean ST subjects' score (0.25) at T2 ($T = 4.63$; $p < 0.001$). This dif-

TABLE 4. Sociodemographic comparisons between ST and GT clients

	Specialized Treatment (ST)		General Treatment (GT)		Total	
	N	%	N	%	N	%
Sex						
Male	103	86.55	26	86.67	129	86.38
Female	16	13.45	4	13.33	20	13.42
Net income						
Less than $12000	87	74.36	18	60.00	10	71.43
$12000 or more	30	25.64	12	40.00	42	28.57
Missing	2				2	
Type of occupation						
Full time job	20	16.81	6	20.00	26	18.98
Part time job (regular hours)	0	0.00	3	10.00	3	2.19
Part time job (irregular hours)	7	5.88	0	0.00	7	5.11
Student	1	.84	0	0.00	1	0.73
Retirement/invalidity	4	3.36	1	3.33	5	3.65
Unemployment	3	2.52	2	6.67	5	3.65
Institution	5	4.20	2	6.67	7	5.11
Welfare	59	49.58	9	30.00	68	49.64
At home	1	0.84	0	0.00	1	0.73
Unstable	8	6.72	6	20.00	14	10.22
Missing	9		1		10	
Completed years in school						
1 to 7	14	11.97	2	6.67	16	10.88
8 to 10	44	37.69	9	30.00	53	36.05
11-12	38	32.48	12	40.00	50	34.01
12+	21	17.95	7	23.33	28	19.05
Missing	2				2	
Current living situation						
Institution	38	31.93	6	20.00	44	29.53
Single	30	25.21	8	26.67	38	25.50
Parents	13	10.92	5	16.67	18	12.08
Live-in partner + children	13	10.92	4	13.33	17	11.41
Live-in partner only	9	7.56	5	16.67	14	9.40
Friends	6	5.04	0	0.00	6	4.03
Children	3	2.52	0	0.00	3	2.01
Family	5	4.20	2	6.67	7	4.70
Unstable	2	1.68	0	0.00	2	1.34
Missing	11		1		12	
Age	0	s.d.	0	s.d.		
	35.07	7.32	31.73	9.90		

TABLE 5. Comparisons between ST and GT clients for addiction-related information

	Specialized Treatment (ST)		General Treatment (GT)		Total	
	N	%	N	%	N	%
Main problem substance						
Alcohol	27	26.05	11	36.67	38	26.21
Cocaine	11	9.24	0	0.00	11	7.59
Alcohol and drugs	54	45.38	13	43.33	67	46.21
Polydrugs	16	13.45	4	13.33	20	13.79
Other	7	5.88	2	6.67	9	6.21
Missing	4				4	
Numbers of times treated for alcohol and drug related problems						
None	62	52.10	19	63.33	81	54.36
One	15	12.61	7	23.33	22	14.77
Two or more	42	35.28	4	13.32	46	30.87

TABLE 6. ANOVA results for 2 groups and 4 time periods

	ANOVA						
	Alcohol	Drugs	Psycho	Medical	Job/Res	Legal	Fam
Group	2.36	1.74	5.84*	1.37	1.71	1.76	0.31
Time	15.44***	10.49***	6.60**	2.79*	1.73	7.12***	9.28***
G × T	3.87**	1.87	3.92**	2.03	1.06	2.98*	0.30

*: $p < 0.05$ **: $p < 0.01$ ***: $p < 0.0001$

ference between ST and GT at T2 eradicated itself at T3 and T4 when both groups showed improvemenpts compared to their initial alcohol scores (see Table 7).

The second interaction dealt with the psychological composite score. Overall, the resulting structure stayed the same as for that of the alcohol composite score. Hence, both groups revealed significant decreases in the severity of psychologically-related problems after T1, with, once again, GT subjects showing greater improvement and their mean ASI

TABLE 7. ASI scores according to the treatment group and the follow-up period

ASI Scores		Alcohol		Drug		Psychological		Medical		Job/Resources		Legal		Family	
		ST	GT	ST	GT	ST	GT	ST	GT	ST	GT	ST	GT	ST	GT
T1	–	.31	.35	.14	.13	.32	.26	.16	.21	.79	.67	.27	.32	.25	.24
	(S.D.)	(.24)	(.24)	(.12)	(.13)	(.20)	(.18)	(.30)	(.31)	(.27)	(.30)	(.23)	(.25)	(.24)	(.19)
T2	–	.25	.09	.11	.05	.29	.12	.23	.20	.78	.71	.27	.19	.15	.11
	(S.D.)	(.25)	(.13)	(.12)	(.06)	(.23)	(.13)	(.35)	(.27)	(.27)	(.29)	(.30)	(.22)	(.20)	(.17)
T3	–	.22	.17	.08	.07	.23	.21	.20	.34	.74	.71	.25	.15	.14	.12
	(S.D.)	(.23)	(.22)	(.12)	(.07)	(.22)	(.19)	(.32)	(.33)	(.29)	(.30)	(.28)	(.19)	(.23)	(.19)
T4	–	.18	.13	.08	.07	.21	.16	.21	.31	.71	.66	.21	.13	.11	.12
	(S.D.)	(.25)	(.17)	(.10)	(.09)	(.23)	(.17)	(.35)	(.37)	(.30)	(.27)	(.27)	(.18)	(.21)	(.12)

psychological score (0.12) resulting in a significantly lower score than for ST subjects (0.29) at T2 ($T = 5.33$; $p < 0.001$). As with alcohol scores, this difference between ST and GT mean psychological scores at T2 was eliminated at T3 and T4 when both groups revealed improvements in comparison to their initial scores (see Table 7).

Finally, the third interaction involved the legal composite score. The breakdown of the legal score for each group once again exposed where the differences lay (see Table 7). However, contrary to the two previous interaction effects, the ST group did not improve ($F = 2.46$; $p = 0.06$) following T1, while GT subjects did ($F = 6.19$; $p = 0.002$).

Since the interaction involving these three dependent variables broke down, it became possible to interpret the main effects. There was one main group effect. This was observed for the psychological composite score and was mainly due to differences between GT and ST at T2 (GT = 0.12; ST = 0.29). However, it was also observed that their scores at T1 were almost statistically different ($T = 1.7$; $p = 0.09$).

Tables 6 and 7 clearly demonstrate the difference between pre- and post-tests on the majority of dependent variables (for alcohol: $F = 15.44$, $p < 0.0001$; for drugs: $F = 10.49$, $p < 0.0001$; for psychological status: $F = 6.6$, $p < 0.01$; for medical: $F = 2.79$, $p < 0.05$; for legal: $F = 7.12$, $p < 0.0001$; and for family: $F = 9.28$, $p < 0.0001$). Only the employment status scales did not change. It must be noted, however, that changes in this aspect may be difficult to achieve considering the economic recession affecting the Canadian job market. On the other hand, this composite score was computed from a small number of items, thus reducing the scale's sensitivity.

DISCUSSION

It is interesting to note that clients improved their situations during the follow-up periods compared to the time when they were admitted into the treatment program. These changes are particularly impressive in areas targeted by the rehabilitation process: namely, alcohol and drug consumption. However, due to the absence of a control group, it is impossible to attribute these changes to the treatment process.

A treatment grouping all offenders in one program and that is developed to respond to the needs of this clientele (motivation rehearsal) does not affect perseverance throughout treatment, nor does it do so more effectively than within a comparable regular addiction treatment program which is also based on the bio-psycho-social principle. In fact,

offenders in regular addiction treatment programs progress more rapidly–as if grouping all offenders together would result in a slowing effect on the therapeutic process. It may be that the offender's mentality is more difficult to correct when it is upheld by other patients participating in the same treatment program. However, the fact that groups are not drawn from the same geographic region, having the advantage to reduce potential contamination of one program on the other, could introduce regional differences in the clientele treated in each region. We did not observe any important differences between both group from the variables we have measured but it is possible that other variables (e.g., a better social support found in smaller cities; availability and costs of drugs . . .) could have affected differently one of these groups.

Our results do not support matching addicts to treatment programs with the simple reasoning that they are or are not offenders. Instead, offenders seem to experience a variety of problems that are more important than breaking the law. Preliminary analysis of a study in progress clearly indicates that these criminalized addicts suffer from a variety of socio-psychological problems. It might therefore be more important to match them with treatment programs that could adequately and specifically answer to their most important problems than to group them simply in accordance with their judicial status.

Matching clients with particular treatments is a complex process. It has to reach further than a simple match according to the most important associated problem. It should, in this sense, take into account the addiction problem's intensity and the congruence between client style and therapeutic approaches.

NOTES

a. The term 'criminalized addict' clientele was defined by the clinical participants in the study. This notion regroups two clientele categories. The first group is a clientele that has no actual contact with the judicial system, but presents a persistent criminal profile. It is made up of individuals who were charged with at least four offenses (in the Canadian Criminal Code) of at least three separate natures. The second clientele category is made up of individuals who present themselves to the program while they are within the judicial process. These clients, at the time of their request for aid, are in the midst of judicial proceedings, at the sentencing phase, or on probation, parole . . .

b. Please note that the definition of criminalized addict is constant for both programs.

c. The French adaptation was used in this study.

d. Thirty-eight people refused to participate in the research and an additional twenty-three people were not reachable for their initial contact with the interviewer.

e. Thirty-eight people refused to participate in the research and an additional twenty-three people were not reachable for their initial contact with the interviewer.

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