Engaging offenders to change: Harness social science evidence (not 'boot camp')

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NSW Dept of Corrective Services
Overview

1. Policy

2. Principles

3. Practice
POLICY
Policy Statement 2004

• [A] comprehensive legal basis for Australia’s first compulsory drug treatment correctional centre... the CDTCC will target a hard-core group of offenders with long-term drug addiction and an associated life of crime and constant imprisonment... who have failed to enter or complete other voluntary or court-based treatment programs.

• The program sits at the end of the continuum of drug diversion programs in New South Wales aimed at breaking the drug-crime cycle.

• There will be intensive judicial case management of these offenders, in close partnership with the correctional authorities as well as health and other service providers.
Why Unique?

1. Drug Court Supervision
Judicial oversight throughout the sentence to parole (re-entry court)

2. Compulsory Treatment
No consent and no appeal

3. Drug Treatment & Rehabilitation
Model of treatment = abstinence + other offending behaviour (DCS + JH)
PUBLIC POLICY

Evidence

Ethics

Community Protection
Community Protection

- Punish
- Rehabilitate
- Incapacitate/Deter
Community Protection

- Incapacitate/Deter
- Rehabilitate
Boot Camp—Described

1. Boot Camp (or shock incarceration/intensive incarceration) = rigorous daily schedule = drill + ceremony + physical training.

2. Some boot camps = education + drug treatment + cognitive skills training

3. Swift punishment for misbehaviour = physical activity (e.g., push-ups).

(Campbell Systematic Review- Wilson, MacKenzie & Mitchell, 2008)
Boot Camp - Outcome

32 studies - with comparison group + post-program measure of arrest or conviction.

Overall “no difference” effect (i.e., boot camps don’t make offenders better or worse).

But, at what ethical/human rights cost?

(Campbell Systematic Review- Wilson, MacKenzie & Mitchell, 2008)
## Offender Rehabilitation Effect Size

### Comparative effects sizes for selected interventions

<table>
<thead>
<tr>
<th>Intervention</th>
<th>Target</th>
<th>Effect size</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aspirin</td>
<td>Risk of myocardial infarction</td>
<td>0.034</td>
</tr>
<tr>
<td>Chemotherapy</td>
<td>Breast cancer</td>
<td>0.08 - 0.11</td>
</tr>
<tr>
<td>Bypass surgery</td>
<td>Coronary heart disease</td>
<td>0.15</td>
</tr>
<tr>
<td>AZT</td>
<td>HIV/AIDS</td>
<td>0.23</td>
</tr>
<tr>
<td>Psychological therapy</td>
<td>Mental health problems</td>
<td>0.32</td>
</tr>
<tr>
<td>Treatment of offenders</td>
<td>Recidivism: overall</td>
<td>0.10</td>
</tr>
<tr>
<td></td>
<td>Recidivism: appropriate service</td>
<td>0.29</td>
</tr>
</tbody>
</table>

McGuire
Offender Rehabilitation

291 rigorous evaluations across US and other English-speaking countries over 35 yrs (statistically significant reduction in comparison to treatment-as-usual groups):

- 25 studies = general and specific CBT programs reduced re-offending (8.2%)
- 30 studies = modest reduction through:
  - employment training in the community (4.8%)
  - basic adult education in prison (5.1%)
  - correctional industries in prison (7.8%)
  - vocational education in prison N=3 (12.6%).
- 17 studies required further research:
  - case management for drug-related offenders in the community (zero)
  - regular supervision vs no parole supervision (zero)
  - works release programs (5.6%)

(Aos, Miller, & Drake, 2006).
Offender Rehabilitation cont

Summary of virtually all meta-analyses to date (Lipsey & Cullen, 2007):
1. Mean effect sizes showed 20% to 40% reductions in re-offending.
2. No study produced less than 10% reduction.
3. No effect size for sanctions and supervision was greater than the lowest effect size for rehabilitation.
4. Largest average effect based on better developed theories and research regarding behavior change (e.g., multi-systemic therapy, cognitive-behavioral therapy, and sexual offender treatment).

(Lipsey & Cullen, 2007; McGuire & Priestley, 1995).
PRINCIPLES
But, what is “offender rehabilitation” exactly?
Offender Rehabilitation

Identifies causes for offending and reduces re-offending by changing thoughts, feelings, and behaviors

(Ashworth, 2006)
Purpose of Offender Rehabilitation


“To assist the rehabilitation of offenders through the adoption of productive, law-abiding lives in the community” (p. 2) and

Provide “…opportunities to address their offending behavior and actively encouraged to access evidence-based intervention programs, education, vocational education and work opportunities” (p. 12)
COMMUNITY PROTECTION
Offender Rehabilitation

COMMUNITY RIGHTS
Manage Risk
Justice Principles
= Risk-Need Model
COMMUNITY PROTECTION
Offender Rehabilitation

COMMUNITY RIGHTS
Manage Risk
Justice Principles
= Risk-Need Model

OFFENDER RIGHTS
Meet Needs
Therapeutic Principles
= Good Lives Model
COMMUNITY PROTECTION
Offender Rehabilitation

RISK-NEED MODEL
Manage Risk
Justice Principles

GOOD LIVES MODEL
Meet Needs
Therapeutic Principles

THERAPEUTIC JURISPRUDENCE
Justice Principles + Therapeutic Principles
Offender Rehabilitation: Human Rights Model

1. Legal Rights
Prescribed by particular laws.

2. Social Rights
Guaranteed by a social institution (e.g., the correctional system)

3. Moral Rights
Based on a moral theory or set of principles

Ward & Birgden (2007)
Ward & Birgden (2007)
Offender as....

Rights-Violator

Rights-Holder
ENHANCED COMMUNITY PROTECTION
Offender Rehabilitation
Human Rights = Values Stance

MANAGE RISK
Community Rights
Risk-Need Model

MEET NEEDS
Offender Rights
Good Lives Model

MANAGE RISK + MEET NEEDS
Community Rights + Offender Rights
Therapeutic Jurisprudence

(Birgden, 2008)
PRACTICE
Compulsory Drug Treatment Correctional Centre Act (2004)

4 Objectives

1. Provide a comprehensive program of compulsory treatment & rehabilitation under judicial supervision.

2. Treat drug dependency, eliminate drug use while in the program, and reduce likelihood of relapse on release.


4. Promote reintegration into the community.
Who gets directed to the CDTCC?

Step 1: Eligibility (required)

Drug Court
- Males sentenced to 18mths-3yrs (non-parole period)
- Two convictions in the past 5 years
- No sexual or serious violent offences, firearms offences or drug trafficking.

Multidisciplinary Team
- Long-term drug dependency
- Drug-related offending
- No serious mental condition.
Who gets directed to the CDTCC?

cont

Step 2: Suitability (considered)

Multidisciplinary Team

• History of offending
• Level of drug dependence
• History of drug treatment
• Mental health issues
• Domestic (family) violence
• Motivation & attitude (but not an exclusion criterion)
Compulsory Drug Treatment Order

Directing the eligible convicted offender to serve a sentence by way of detention

CDTO Personal Plan

A plan that imposes conditions on the offender re drug treatment and rehabilitation

Rewards & Sanctions

Meeting conditions of the Personal Plan are rewarded, and not meeting the conditions of the Personal Plan are sanctioned
Offender Rehabilitation: Evidence-Based + Ethical

Assessment
Determines the function of offending
► not only risk of re-offending.

Treatment
Determines interventions that will support behaviour change
► meeting all treatment needs.

Management
Determines supervision and monitoring required to maintain behaviour change
► developing a ‘therapeutic alliance’.

(Ward, Gannon & Birgden, 2007; Birgden, 2008)
Principles

1. Assume drug use effects behaviour.

Assessment

2. Analyse drug use and other offending behaviour.

Treatment

4. Target dynamic risk factors.
5. Support physical/social/psychological well-being.
6. Tailor treatment to meet individual need.
7. Provide adequate treatment dose.
8. Ensure continuity of care.

Management

10. Establish a treatment community.
11. Reward behaviour change.
12. Offer a helping relationship.
13. Provide long-term support for a pro-social life.
14. Collaborate with other agencies.
15. Ensure ongoing monitoring and evaluation.
Assess Risk
CDTCC Assessment
(Risk Factors + Human Needs)

- Substance use
- Physical and mental health needs
- Emotional & psychological needs
- Thinking & feeling patterns
- Family, peer & social supports
- Accommodation needs
- Employment & education needs
- Criminal thinking & behaviour
- Treatment readiness

► Clinical case formulation.
## CDTCC Assessment

<table>
<thead>
<tr>
<th>Category</th>
<th>Assessment Tools</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family and Social Supports</td>
<td>Risk-Need (LSI-R) Quality of Life Scale</td>
</tr>
<tr>
<td>Emotional &amp; Psychological Needs</td>
<td>Risk-Need (LSI-R) Quality of Life Scale Self Rating Form (+ IQ)</td>
</tr>
<tr>
<td>Accommodation</td>
<td>Risk-Need (LSI-R)</td>
</tr>
<tr>
<td>Employment</td>
<td>Risk-Need (LSI-R)</td>
</tr>
<tr>
<td>Criminal Thinking &amp; Behaviour</td>
<td>Risk-Need (LSI-R) PICTS Crime PICS II</td>
</tr>
<tr>
<td>Thinking &amp; Feeling</td>
<td>Social Problem Solving Inventory Self Control Scale</td>
</tr>
<tr>
<td>Treatment Readiness</td>
<td>Treatment Readiness Tool</td>
</tr>
<tr>
<td>Substance Use + Offending</td>
<td>Risk-Need (LSI-R) Drug Taking Confidence Q’aire Paulus Deception Scale</td>
</tr>
<tr>
<td></td>
<td>► Clinical interview</td>
</tr>
</tbody>
</table>
# CDTCC Treatment - Stages 1, 2 & 3

## Manage Risk
- Gradual methadone withdrawal (not rapid detox)
- Drug & alcohol testing (abstinence model)
- No-contact visits
- Monitor phone calls
- Cell and person searches (+ dogs)
- E-monitoring
- Drug Court monitoring
- Approved family, peer & mentor contact

## Meet Needs
- Group readiness & psychoed programs.
- Intensive D&A + offending program
- NA-AA-GA/Spiritual/Mentor support
- Health & mental health
- Education & work readiness followed by employment/education in the community
- Social and leisure programs
Criminal Conduct & Substance Abuse Program  
(Wanberg & Milkman, US)

Elements (or why we chose it)
- Designed for drug use + offending behaviour.
- 6 month intervention (right dose/intensity).
- Abstinence-based approach.
- Integrates correctional and therapeutic treatment.
- Uses motivational interviewing techniques matched to treatment readiness.

3 goals of therapy
1. Prevent recidivism into criminal thinking and conduct.
2. Prevent relapse into substance use and abuse.
3. Live a meaningful and responsible life.
Assess

Treat

Manage
Responsivity Principle

1. Internal Responsivity
Offender characteristics = motivation, age, learning style, culture, and various barriers to participation

2. External Responsivity
Setting characteristics = prison vs community
Staff characteristics = an engaging style (not boot camp!)
Management Approaches

1. Due Process

2. Motivational Interactions

3. Contingency Contracting
1. Due Process

• Due process = participation, dignity & trust = listening to their story
  ► greater compliance with the law/CDTCC rules.

• Community meetings with staff and participants
  ► support autonomous decision-making.

• Individual case management review meetings
  ► Legal aid lawyers advocate + Judge oversights.
2. Motivational Interactions

Techniques to increase the likelihood that participants will enter, continue, and comply with active change strategies (matched to treatment readiness).

Custodial officers- 'Motivational Interactions'- brief interactions to engage the participant to move toward change (& co-facilitate treatment readiness group).

Program staff- Motivational Interviewing techniques- clinical strategies.

► Director = leads by example.
3. Contingency Contracting

Increased motivation to change using a systematic method of consequences (*rewards* + *sanctions*)
► carrots and logical consequences.

No punishment- withdraw privileges, lock up, “1 or 3 strikes & you’re out” etc
► sanctions are rationally justified.

Sanctions are monitored by the Judge
► due process.
<table>
<thead>
<tr>
<th></th>
<th>Stage 1</th>
<th>Stage 2</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Reward</strong></td>
<td>Reward menu + Progress</td>
<td>Social programs + Progress</td>
</tr>
<tr>
<td><strong>Sanction</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Level I</td>
<td>No reward (list)</td>
<td>No reward (social programs)</td>
</tr>
<tr>
<td>Level II</td>
<td>Charge + no reward (zero)</td>
<td>Charge + no reward (zero)</td>
</tr>
<tr>
<td>Level III</td>
<td>Delay Progress OR Revoke</td>
<td>Delay Progress OR Revoke</td>
</tr>
</tbody>
</table>
Consequences (N = 15,000 urine tests)

- Revoked (25%)
- Regressed (20%)
- <1% Illicit Use
Healthy functioning
Being safe

Choices
Intimate r’ships
Competence & mastery

Family & social supports
Meaningful work & education
Leisure activities

Physical Needs

Community Safety

Social Needs

Psychological Needs
Offender Rehabilitation: Evidence-Based + Ethical

A balanced approach
Uses a values base to balance offender needs and community needs (managing risk of the offender for the community and meeting needs with the offender for the offender).

A humanistic approach
Forges a therapeutic alliance based on an ethic of care and a concern for offender + community well-being.

An interdisciplinary approach
Collaborates with other disciplines and agencies (no “turf wars”).

(Birgden, 2008)