

New directions in effective correctional treatment

Barbara Armstrong, and Guy Bourgon¹
Rideau Correctional and Treatment Centre,
Ontario Ministry of the Solicitor General and Correctional Services

Treatment programs for incarcerated offenders have historically been designed to address a single treatment need (such as substance abuse, anger management). In such a discrete needs approach to correctional treatment, treatment needs are first identified through appropriate assessment techniques. Offenders are then encouraged to participate in as many treatment programs as necessary to address each of their treatment needs. Problems with this model are discussed and an alternative approach, called the Integrated Service Delivery Model (ISDM), is presented. This model is designed to improve the provision of treatment in two ways. One improvement is to create more efficient treatment for both the offender and the institution. The integrated approach allows for multiple needs to be addressed within a single treatment program. The second improvement is to offer treatment more consistent with the principles of effective correctional treatment programming identified by Andrews.² In the integrated approach, the offender is assigned to a program based on factors such as the offender's risk to recidivate, the number and nature of his treatment needs, his motivation level, and his sentence length. This article focuses on risk and needs factors.

Developments at Rideau Correctional and Treatment Centre (RCTC)

A large body of outcome/evaluation research over the past two decades has demonstrated that treatment programming for incarcerated offenders is effective in reducing recidivism.³ Leaders in the field such as Andrews and Gendreau⁴ then took this analysis one step further and attempted to answer the question "what works best?" They compared various therapeutic approaches used with offender populations and were able to identify eight characteristics that appeared to distinguish between the most effective and least effective programs. Andrews outlines these attributes which include advocating for the need for behavioural or cognitive-behavioural therapies, the importance of targeting appropriate criminogenic needs, the importance of matching treatment with appropriate offender risk levels, and the need for including relapse prevention components. Research also indicates that the most effective use of treatment resources is to assign fewer resources to lower risk/lower needs offenders and more resources to higher risk/higher needs offenders.⁵ It should be noted that offenders who are classified to RCTC are, on average, high risk/high need

individuals as classified by the Level of Supervision Inventory (LSI-OR).⁶

Discrete needs model of program delivery

Several challenges face today's institutions in the delivery of programs guided by the empirical evidence of effective programming. Administrators faced with developing and planning programming are typically confronting groups of offenders who have different sentence lengths, varying risk levels, and a multiplicity of needs. Most offenders, in fact, present several needs, thereby requiring more than one treatment program. Discrete needs models of programming entail taking programs consecutively, often with changing group membership and program leaders, usually with some overlap of program content, and frequent delays while the offender waits for the recommended programs to begin. These factors also raise a plethora of institutional and practical issues such as inmate movement and management. Offender requests to accelerate or delay participation in programming before or after various hearings and requests for additional programming also accumulate. These issues tend to complicate the design and implementation of effective and efficient institution based correctional treatment.

Integrated service delivery model (ISDM)

Treatment at Ontario's RCTC is seen as a two-step process; assessment and treatment are both integral parts of programming. Assessment is designed to differentiate offenders assigned to each program based on the offender's risk and needs. Offenders with a lower risk to recidivate, fewer needs, shorter sentences, and, perhaps, little motivation for treatment, are assigned to a less intense and shorter program (5-week program). Residents with a higher risk to recidivate, more treatment needs, and longer sentences, are assigned to more intense and longer programs (15-week program).

This new treatment model is more integrated in that:

- each program addresses the basic treatment needs (anger management, substance abuse, and criminal thinking/lifestyle);

- the same counsellors deliver all treatment to an individual offender;
- the offender remains with the same group of offenders throughout his treatment.

The model is more efficient in that:

- several needs are addressed in the same program such that duplication of material does not occur;
- the offender's start and termination dates are set before he enters treatment;
- there is no waiting list for further programming;
- the same group leaders remain with the offenders throughout programming, eliminating the transfer of information to new therapists.

Resident movement and treatment

Residents who receive treatment normally progress in three steps through the institution. Classification personnel first interview the offender and those offenders who agree to participate in treatment are then moved to the Assessment Unit (AU). A psychological test battery assessing factors such as motivation, personality, social desirability, hostility, and attitudes towards criminal behaviour are administered, files are reviewed, case management and clinical interviews are conducted, and a Risk-Needs Assessment Report is prepared. The program that the offender is assigned to is a function of his risk/needs assessment and available time remaining in his sentence. Three primary criminogenic needs (criminal thinking, substance abuse, and anger management) have been identified as having significant contribution to criminal behaviour.⁷ Residents who have more serious problems in the three treatment areas or who have additional treatment needs are assigned to the more intense and longer program.

Following assessment, the offender moves to the Treatment Centre. Each dormitory of the Treatment Centre functions as a program area in which clinical staff comprised of psychology and social work professionals are responsible for programming. They are also involved in daily institutional concerns. Correctional officers who function as case managers assist with discharge planning. The 5-week program involves approximately 100 hours of group counselling by the interdisciplinary team. Offenders are taught how to become aware of and recognize their thoughts and behaviours that promote problematic behaviours such as aggression and criminal behaviour with the emphasis on substance abuse. The 15-week program involves a minimum of 290 hours of group intervention. Treatment needs addressed include criminal thinking/behaviour, anger management, domestic violence, substance abuse and relapse prevention, and dysfunctional personal

relationships. Intensive small groups are provided for survivors of childhood sexual abuse, Adult Children of Alcoholics, and those confronting issues such as Post-Traumatic Stress Disorder, grief management, life skills, and parenting. Individual counselling is also provided when the need arises.

Programs are cognitive-behavioural in nature in that an important part of programming is the identification of thinking that promotes anti-social, negative behaviour, such as, using drugs, committing crimes, or acting aggressively, and learning how to replace such beliefs with more positive, pro-social thinking. Skill acquisition is also emphasized and the programs share the same language. Treatment is primarily conducted in a group format where a variety of techniques are employed (discussion/exercises, work-books, role-playing, videos, mentoring, journals). Moreover, the treatment milieu provides an opportunity for offenders to practice skills acquired through programming. A final report summarizes each offender's progress in treatment and makes recommendations for future case management.

Measuring treatment effectiveness

One hundred-twenty-eight offenders were selected for follow-up because they had completed programming and had been released for one year. Of this sample, 93 had completed the 5-week program and 35 had completed the 15-week program.

The average age of the offenders in the two treatment programs were not found to be different from one another. The groups, however, differed as expected on a number of demographic measures. Offenders with significantly more serious past offences and longer current sentences were assigned to the longer program. A significantly higher number of individuals who were multiple substance abusers, serious psychiatric disorders, and serious literacy difficulties were found in the 15-week program as compared to the 5-week program.

In differentiating between criminogenic risk and needs, this study used the overall LSI-OR score as the measure of criminogenic risk, while the subscales of the LSI-OR served as a broad measure of criminogenic needs. The majority of offenders in this sample fell in the high-risk range of the LSI-OR. The average score was 22.9. The average LSI-OR score in the 5-week program was 21.8, significantly lower than the offenders in the 15-week program who had an average LSI-OR of 25.8. Significant differences between the groups were found on the subscales measuring criminal history, family/marital issues, substance abuse, and antisocial patterns, indicating that the 15-week program participants had significantly more treatment needs.

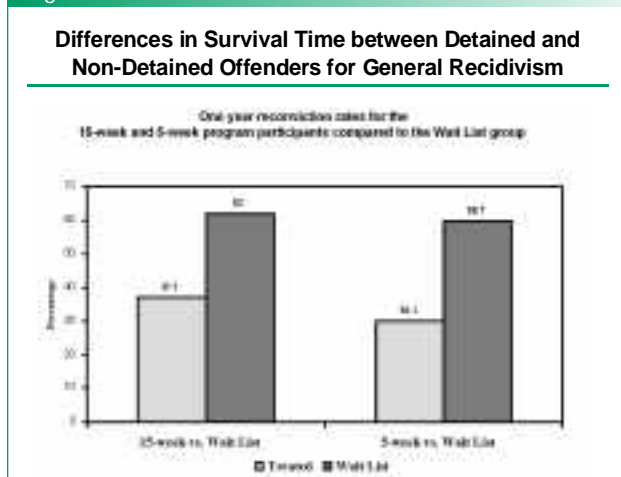
The comparison group consisted of 79 offenders who were formally assessed through the AU and subsequently placed on a waiting list to receive programming. The offenders, however, were discharged before programming commenced and thus, form a Wait List comparison group. These men were provided standard intervention (assistance with discharge planning in order to connect them to available treatment services upon their release).

All offenders were followed for one year post-release by accessing information from the Offender Management System (OMS) of Ontario. Recidivism was measured by reconviction rates. For the offenders in the 15-week program, the reconviction rate was found to be 37.1% at one-year post-release. For the Wait List comparison group, the reconviction rate was 62% at one year post-release. Despite no significant difference between the 15-week and Wait List comparison group on criminogenic risk as assessed by the LSI, reconviction rates were significantly different from one another.

In order to compare the 5-week program participants and the Wait List control group, 17 subjects with very high scores on the LSI-OR were dropped from the analyses leaving a subset of 62 offenders as the comparison group. This subset had a one year reconviction rate of 59.7% which was found to be significantly higher than the 5-week program participants who were reconvicted at a rate of 30.1%. There were no significant differences noted between these groups on the LSI.

Finally, reconviction rates of the two treatment groups were not statistically different from one another. One-year reconviction rates for all groups are portrayed in Figure 1.

Figure 1



Conclusion

Program evaluation results suggest that the treatment model used at RCTC is an effective and efficient mode of treatment programming for incarcerated offenders. It was possible to differentiate offenders for participation in the 5-week and 15-week program based on their risk to recidivate and their treatment needs. Higher risk/higher needs offenders were assigned to a higher intensity program while lower risk/lower needs offenders were assigned to a less intense and shorter program. In addition, the developments in the service delivery method allowed an increase in the number of offenders completing treatment from 226 to 334 per year indicating a more efficient means of treating offenders.

Results demonstrate that significant differences in reconviction were obtained between treated offenders and the comparison group. Treated offenders had significantly lower recidivism when compared to the untreated comparison group. Results also illustrate that reductions in the reconviction rate for the higher and lower risk/needs groups were comparable. The two groups were found to have different risk and needs levels prior to entering treatment. Participation in either of the appropriate treatment program led to findings that indicate both treatment groups demonstrated significant and similar reductions in reconviction rates relative to their counterparts who served in the comparison group. Thus, results illustrate that correctional treatment derived from empirical findings is an effective and efficient means of reducing recidivism. ■

- 1 4707 Donnelly Drive, Merrickville, Ontario K0G 1N0. The authors must also acknowledge the help of K. Ricciuti, E. Yates, S. Boudreau, J. Finn, B. Goguen, K. Morton, E. Rivera, O. Simonyi, K. McFarlane, V. Mowat-Leger, L. Robertson, & C. Holmes.
- 2 Andrews, D. A. (1995). *Assessing program elements for risk reduction: The Correctional Program Assessment Inventory*. Ottawa, ON: Carleton University.
- 3 Lipsey, M. W. (1992). Juvenile delinquency treatment: A meta-analytic inquiry into the variability of effects. In T. D. Cook, J. Cooper, D. S. Cordray, H. Hartmann, L. V. Hedges, R. J. Light, T. A. Louis, & F. Mosteller, (Eds), *Meta-analysis for explanation* (pp. 83-127). New York, NY: Russell Sage Foundation.
- 4 Andrews, D. A., Zinger, I., Hoge, R. D., Bonta, J., Gendreau, P., & Cullen, F. T. (1990). Does correctional treatment work? A clinically relevant and psychologically informed meta-analysis. *Criminology*, 28, 369-404. See also Gendreau, P., & Andrews, D. A. (1990). Tertiary prevention: What the meta-analysis of the offender treatment literature tells us about "what works." *Canadian Journal of Criminology*, 32, 173-184. And see Gendreau, P. (1996). Offender rehabilitation: What we know and what needs to be done." *Criminal Justice and Behavior*, 23, 144-161.
- 5 Andrews, D. A., & Bonta, J. (1998). *The psychology of criminal conduct*. Cincinnati: Anderson.
- 6 Andrews, D. A., & Bonta, J. (1997). *The Level of Service Inventory — Ontario Revision*. Ontario Ministry of Correctional Services.
- 7 Andrews & Bonta (1997).