

Quality of life promotion: The foundation of offender rehabilitation?

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There is increasing evidence demonstrating that offenders can make positive behavioural change. Furthermore, recent research has led to identifying components of successful offender rehabilitation programs.² Still, motivating offenders to actively participate in treatment can be difficult for practitioners and remains a critical issue within the corrections field. This article describes why many offenders may have little intrinsic motivation to work therapy as they enter the treatment program and how implementing a quality of life (QOL) approach into program delivery can help increase offender motivation at the beginning of the treatment process. QOL promotion is firmly rooted in the values of the helping professions and is compatible with current theoretical frameworks that describe behavioural change.

Successful offender rehabilitation efforts can be challenging for a variety of reasons. For one, many offenders seem to show little motivation to change. They often struggle to let go of the “thinking errors” that have become embedded in their perceptions. Other times they may say “the right things,” but their speech and actions are not always congruent. For many offenders motivation toward therapy may centre on completing program requirements, rather than actual self-improvement and lasting behavioural change. Indeed, there is a vast difference between “knowing” therapy and “working” therapy. If treatment is to reduce recidivism, we must help offenders to do the latter.

Another challenge for corrections professionals is this occupation involves working directly with individuals who have violated the established standards of society. Some of these people have done terrible things, and the emotional response that comes from this awareness is sometimes difficult to manage and can affect the communication process between practitioner and offender. It is common for professionals to intellectualize as a way to understand disturbing events, yet the reality of such knowledge may play out in subtle ways. For example, interpersonal dynamics include both conscious and subconscious components, and the “relationship messages” (vs. content messages) that human’s send each other during the communication process reflect both types of components. Because

of the subconscious components (e.g., body language, emotional expression, word selection) of communication that result from specific knowledge or attitudes, relationship messages can be given that were not intended to be sent.

These difficulties contribute to the mentality in criminal justice settings commonly referred to as “us vs. them,” which can be two-directional (offender to program staff and staff to offender). If we are to help offenders increase intrinsic motivation, and therefore experience lasting success from treatment, it is imperative to dispel the “us vs. them” mentality. It is possible that a continual awareness of the quality of life (QOL) construct can be utilized to help accomplish this task. Without a solid foundation built from QOL-related components in one form or another, offenders will remain reluctant to engage in the treatment process. Therefore, program delivery will be difficult for many staff members, and the entire rehabilitation effort will provide only limited effectiveness in terms of promoting lasting behavioural improvement and recidivism reduction.

Treatment assumptions

Before proceeding, it is necessary to examine some assumptions concerning offender treatment. Practitioners believe, with supporting evidence, that therapy produces benefits. These benefits can significantly improve the way individuals live their lives. Clinicians spend years obtaining education to develop skills needed to effectively help others. This makes perfect sense—to *us*. Do offenders hold these same views? Not necessarily. To *them*, their freedom has been greatly restricted; some may harbour perceptions of being victimized and the correctional system is largely their punishment. Mandated treatment may not be perceived as a benefit, something of personal value, or an opportunity for change, but as part of the punishment. Not only do cognitive implications of correctional therapy for the offender exist long before treatment actually begins, there are also emotional responses to consider. Offender treatment, paired with the correctional institution from which it is administered, can certainly be viewed as a case of classical conditioning and helps explain negative

affect and high levels of resistance present when many offenders enter therapy.

QOL and offender rehabilitation

QOL can be an effective method to debunk the treatment / “corrections is punishment” connection and perception. There is evidence that such an approach is associated with higher treatment completion rates in community-based corrections programming.³ With this particular approach, offenders meet with program staff for an orientation prior to beginning treatment programming. The beginning of the orientation consists of introductions and a short presentation of the program philosophy (which is to provide opportunities for QOL improvement) and the rules. Offenders are then asked to consider and discuss the few things that are *most* important to them, what they would like to accomplish over the course of a lifetime, and how they would like to attain personal growth. Notice that it is the offenders who take the lead in developing this discussion, which may decrease perceived control by the system while increasing personal empowerment from the beginning of the treatment experience. With minimal guidance, offenders tend to provide responses associated with QOL shown in Table 1.

Table 1

What do offenders want from life?
Relationship with family and friends
Adequate money
Job satisfaction
Health
Education
Freedom

Program staff members are also encouraged to participate in identifying their “most important things.” What becomes evident is, that as human beings, we all want the same important things—including close relationships with family and friends, adequate money for our needs, job satisfaction, health, and education. These variables are viewed as central to *desired* QOL, which requires constant work in order for them to be sustained and improved.

Crime and its consequences restrict opportunities for improvement on these variables, and help determine *actual* QOL. Although definitions of QOL vary within the clinical literature,⁴ from this functional context QOL is seen as “how much you have, in terms of quality, of life’s most important things.” With respect to desired QOL, a higher

quality than is currently experienced is the continual goal, while actual quality of life is what is experienced at a given time. It can then be shown how “thinking errors,” violence, and criminal behaviour largely determine actual QOL and can prevent progression toward desired QOL. The primary goal of rehabilitation is to provide offenders opportunities to reduce the gap between their actual and desired QOL via treatment. It is essential that both staff and offenders are ever conscious of this purpose.

This approach is relatively simple, but can be powerful. It facilitates offender empowerment from the beginning of the program. It illustrates that as humans, we all want the same important things throughout our lives. The responsibility of the program is to provide tools to dismantle criminal thinking patterns, help the offender work through negative emotional states and past traumas, and adopt an overall lifestyle that leads to QOL improvement. Since each individual is ultimately responsible for his or her QOL, it is the offender who shoulders the responsibility of personal change. This approach also underscores the fact that effort toward personal improvement does not stop at treatment termination, but must continue for a lifetime. The goal for the offender is not program completion, but a lifetime of personal improvement and increased life satisfaction. The general “tone” of the treatment experience is positive, and it is possible that transference-countertransference dynamics that contribute to relationship messages in communication are less likely to impede the therapeutic process. For many offenders there is shift from extrinsic motivation to complete treatment (to escape control of “the system”) to an intrinsic motivation for improved QOL and lasting behavioural change.

It is important that the QOL concept is not discarded after a one-time service, but conscientiously nourished by program staff throughout the treatment process. Treatment goals should be based on the “most important things” identified at program orientation; progress should be directed to areas of most importance identified by the offender. The clinician, in planning treatment objectives, largely decides what type of therapy will likely result in the best progress. Offenders then journal or report on how they are specifically applying treatment content to improve QOL. Treatment goals, set at orientation, may be relatively general; however, at the end of each treatment session specific goals, leading to progress toward treatment goals, are developed based on application of content from the session. Therefore, QOL becomes the “thread” that

continually weaves through program content and makes it applicable, understandable, and desirable. It also provides opportunities for positive reinforcement from both offenders and program staff, since participants regularly report on how they have applied program content to work toward long-term goals and improved QOL. It is recommended that at treatment completion offenders evaluate with staff how treatment has been utilized to improve QOL and that ideas for continued improvement are planned.

QOL promotion reflects core principles and values of the helping professions. It is a constant reminder the difference between humans—who have inherent goodness and worth—and a collection of behaviours, which when observed within the criminal justice system often reflects a clinical disease or disorder. If offenders are to adopt and maintain positive changes, practitioners must treat the “whole person” not simply characteristics of a clinical disorder. QOL, then, is consistent with the strengths perspective⁵ and a solution-focused paradigm⁶ that have been recently promoted in offender rehabilitation.

The utilization of QOL at the beginning of the treatment process is also an important consideration from the framework of the Transtheoretical Model (TTM), which postulates that behaviour change is a process characterized by sequential stages of change readiness.⁷ It is believed that although many rehabilitation programs expect action (observable behavioural change), a significant percentage of offenders are likely to be in the precontemplation stage of change—thus, they are not motivated to change. By illustrating common human values that comprise QOL, the incongruence of actual and desired QOL, and the goal of treatment being to improve QOL; offenders may see that treatment may indeed have something to offer them, thereby initiating the change process from precontemplation and a step closer towards action. Since for many offenders a motivational

shift begins to take place from extrinsic to intrinsic rewards with QOL exposure, change that follows is more likely to be of longer duration.⁸

Conclusion

While the relevance of QOL to offender rehabilitation seems to be “common sense,” if it is dismissed as such, it may not be promoted sufficiently for offenders to initially trust program practitioners. Nor would a strong classical conditioning response from pairing treatment with the correctional institution (which some offenders may equate treatment being part of their punishment), be unlocked and such faulty perceptions discarded. For these reasons QOL promotion is essential when working with offenders and may need to be amplified within many programs in order to effectively engage clients in therapy.

We propose that those working to help rehabilitate offenders search for their own assumptions about offender treatment and program delivery and ask themselves whether or not their clients share the same assumptions. If assumptions appear to be different, the following questions might be asked: How might these perceptual differences affect the treatment process? and What can be done to find a more “common (therapeutic) ground?” In such a case, the long-standing social work principle “begin where the client is” is particularly relevant—and as practitioners we *begin from the assumptions of the client*. A more rigorous interjection of QOL into programming just might be a viable answer to finding that common therapeutic ground.

In this paper we have offered some suggestions regarding how a QOL approach may guide offender rehabilitation efforts. There may certainly be some differences as to how QOL is implemented within programming, but we maintain that effective offender rehabilitation must have a strong and visible QOL foundation. ■

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⁵ Van Wormer, K. (1999). The strengths perspective: A paradigm for correctional counselling. *Federal Probation*, 63(1), 51-58.

⁶ Clark, M. D. (1997). Interviewing for solutions: A strength-based method for juvenile justice. *Corrections Today*, June Issue, 98-102.

⁷ Prochaska, J. O., and Velicer, W. F. (1997). The transtheoretical model of health behavior change. *American Journal of Health Promotion*, 12(1), 38-48.

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