Reducing treatment attrition within a sex offender treatment programme

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Abstract

As a result of a high treatment attrition rate two significant changes were made to the New South Wales Department of Corrective Services custody-based intensive treatment programme for sexual offenders (CUBIT) that directly reflect advances in the field of sex offender treatment. This paper outlines the rationale and outcomes of these changes. It is argued that the implmentation of an open-ended (rolling) group treatment format has significant advantages over a closed group treatment format. Secondly, we are now emphasising the importance of positive therapist characteristics within the treatment programme and in so doing have moved away from an overly manualised delivery of cognitive behaviour treatment. The positive outcomes produced by the changes are discussed.

The NSW Department of Corrective Services offers a range of assessment and treatment services to sexual offenders. Treatment programmes are provided in custody and the community. Custody based programmes range from a high intensity treatment programme provided in a self-contained therapeutic community (Custody Based Intensive Treatment; CUBIT) to non-residential treatment programmes provided in mainstream gaols (CUBIT OutREeach; CORE). Post-treatment custodial maintenance programmes are offered to sex offenders who have completed CUBIT or CORE and are yet to be released from custody. Community programmes include a non-residential treatment programme for lower risk sex offenders and a community based maintenance programme which aims to facilitate the transition from prison to the community for treated moderate and high risk sex offenders. The overall goal of these services is to reduce the likelihood that offenders will continue sexual offending upon their return to the community (i.e., reduce sexual recidivism). This article will focus on the CUBIT programme and two recent significant changes to its format and structure.

Custody Based Intensive Treatment (CUBIT)

CUBIT is a prison based residential therapy programme for men who have sexually abused adults and/or children. Offenders admitted to the programme are accommodated in a special, self-contained therapeutic unit located in the Metropolitan Special Programmes Centre at Long Bay Correctional Centre, Sydney. CUBIT operates as a therapeutic community which aims to promote pro-social thinking and behaviour in a supportive environment (see Baker & Price 1995). Participants are encouraged to practice new skills and behaviours within the therapeutic community, and to interact with other participants and staff in positive and constructive ways. The

setting is designed to help offenders work intensively on changing the thinking, attitudes and feelings which led to their offending behaviour.

The CUBIT programme is conducted by a multi disciplinary team including psychologists and custodial staff who are trained and committed to supporting therapeutic work by participants. Treatment is delivered within a group format with ten offenders and two psychologists per group. During the programme, participants examine the issues that led them to offend sexually, explore the impact of offending on victims, identify their offence pathway, and develop a detailed self management plan. They also develop a comprehensive set of knowledge and skills tailored to their individual needs.

CUBIT commenced operation in 1999 and has been running for over 8 years. The programme operated in an interim 20-bed unit from January 1999 to 2001 at which time it moved to its current permanent location as a 40-bed unit. To be eligible for the programme offenders must be: currently serving a sentence following conviction for a sexual offence, have a previous conviction for a sexual offence, or have a current or prior conviction for a non-sexual offence where the motivation is deemed to be sexual.

The CUBIT programme operated with a closed group format from January 1999 to August 2005. In September 2005, the treatment structure and format was changed to that are an open-ended (rolling) group format. This shift in operation was the result of an assessment of current practice in field, evaluation of attrition data, and consultation with other experts in the field (Bill Marshall, August 2005).

Effectiveness of the CUBIT Programme

The overall goal of CUBIT is to reduce sexual recidivism. It is well established that a follow-up period of at least 5 years is recommended when

evaluating sexual offender treatment programmes (Quinsey, Rice, & Harris, 1995). There are two main reasons for this time period. Firstly, the base rate of actual sexual recidivism is low. Contrary to public opinion the rates of sexual re-offending (even without treatment) are low compared to other offender populations (Hanson & Bussiere, 1998). As the base rate of re-offending is low, it is difficult to find any statistically significant relationship between the predictors and the outcome (recidivist vs. non-recidivist) without a very large sample of offenders. Secondly, given the intensive nature of sex offender group treatment, few offenders complete treatment each year (e.g., currently approximately 50 in the case of CUBIT). Treatment attrition, if high, decreases this number considerably. Consequently, any evaluation of treatment outcome requires large sample sizes and long follow-up periods (5-10 years). We have recently commenced a preliminary review of CUBIT's effectiveness. Data from a risk-band analysis conducting at CUBIT demonstrate that during a post-release follow-up period, treated offenders recidivated sexually at 8.5% compared with the expected 26% predicted by a risk assessment tool (STATIC-99; Hoy & Bright, manuscript in preparation).

Why Have We Made Changes to Our Programme?

Sex offender treatment programmes have been continually evolving over the past 30 years. The content of programmes and the manner in which they are delivered is based on a large body of theoretical and empirical literature. Most sex offender treatment programmes use a cognitive-behavioural approach, with a specific emphasis on relapse prevention components (Laws, 1999). This has been the result of considerable theoretical and empirical advances in our understanding of sexual offenders (Ward & Siegert, 2002). These advances have led to the development of new etiological theories, better risk prediction procedures, new treatment targets and

techniques (*what* is targeted within treatment), and effective treatment methods and procedures (*how* these issues are targeted within treatment).

The *content* of the CUBIT programme has gradually evolved over the last eight years and now reflects these advances. By contrast, the changes we have recently made to the CUBIT programme relate to the *process* variables inherent in the group based treatment of sexual offenders (see Marshall et al., 2003 for review). There is now a large body of compelling research evidence, specifically relating to these variables. Evidence now exists that the features of therapists, quality of the therapeutic relationship, and models of group treatment delivery all contribute to the effectiveness of sex offender treatment (Marshall, et al., 2005).

We have made two significant changes to the CUBIT programme which we believe directly reflect advances in the field of sex offender treatment: (1) a change to an open-ended (rolling) group treatment format, and (2) an increased focus on positive therapist characteristics (and treatment strategies) that have been shown to be related to positive treatment outcomes (i.e., reducing treatment non-completion and ultimately the reduction of re-offending). As of August 2005, CUBIT moved to open-ended (rolling) treatment groups and our therapists have now been specifically trained and supervised in the importance of the positive therapist characteristics that are influential in reducing re-offending (it is worth noting that we believe our staff already displayed high levels of these skills, but only recently have these skills and abilities been specifically targeted as per our staff training, ongoing clinical supervision, and training/educating of other staff and professional agencies).

One impetus for the changes was CUBIT's relatively high treatment attrition rate prior to August 2005. A treatment programme's value should be measured not only by the success of those who complete it, but also by the number who refuse to

participate in the programme and the number who "drop out" or are discharged from the programme (Beyko & Wong, 2005). It appears that treatment attrition from sex offender programmes generally has tended to be high, ranging from 30-50% (Browne, Foreman, & Spielman, 1998; Miner & Dwyer, 1995), although this relates mainly to community based programmes. Treatment non-compliance is not limited to sex offender treatment programmes. In other areas of medicine, between one third and one half of patients do not comply with the treatment that is recommended to them (Melamed and Szor, 1999). Nonetheless we were greatly concerned that CUBIT was experiencing high treatment discharge rates. Approximately 33% of offenders participating in the CUBIT programme were being discharged early, or chose to leave the programme of their own violation. Offenders were discharged due to management difficulties (e.g. aggression), poor treatment progress (i.e., continued denial of responsibility), resistance to treatment, and/or the presence of mental illness. The high attrition rate was concerning for a number of reasons. First and foremost, treatment non-completion has been demonstrated to be a robust and significant predictor of sexual recidivism (Hanson & Harris, 2000; Hanson & Bussiere, 1998). Sexual offenders who failed to complete treatment have been considered to be more dangerous than untreated offenders (Marques, Day, Nelson, and West, 1994). Furthermore, offenders who dropped out of treatment tend to commit three times as many future offences than treated offenders (Miner and Dwyer, 1995). The high number of treatment discharges also resulted in too few high risk sexual offenders being treated. At the time, CUBIT was operating with a closed group format, whereby the treatment group would start on a given day and be completed approximately eight months later. Using this format, treatment discharges could not

be replaced. As an example of the significance of this, a treatment group with a high number of discharges may have started with 10 offenders and finish with only five.

Given that we were experiencing high numbers of treatment drop-outs and treatment discharges, we began to investigate the reasons for this. We found four main differences between treatment non-completers and treatment completers (Sleeman, 2002). Treatment non-completers had greater levels of denial and minimisation, had a higher risk of re-offending (as measured by the STATIC-99; Hanson & Thornton, 1999), were more likely to have adult victims, and had a shorter history of offending behaviours. Treatment non-completers also displayed fewer impression management behaviours, primarily used emotional coping strategies, or had a significantly high external locus of control focusing on powerful others (Bright, Shaw, & Pervan, 2004). We were also interested in whether our own treatment methods and procedures have contributed to these high discharge rates. Given the most recent literature, we now believe that to be the case.

Changing From a Closed Group to Open-Ended Group Format

CUBIT changed from a closed-group format of treatment to an open-ended (rolling) group format in August 2005. We will briefly describe an open-format treatment group, and then discuss what we see as its advantages over closed group formats. Typically in closed groups, all offenders begin the treatment programme together and progress simultaneously through all of the treatment modules (i.e., disclosure, victim empathy, relationship skills, etc.) eventually completing treatment within a predetermined period. As an example a treatment group might start with 10 specific offenders on 1 January and be completed on 30 August. If there were no treatment drop-outs/discharges – those same 10 offenders would complete the programme on 30 August, irrespective of their individual treatment gains or deficits.

An open-ended group (or "rolling") is structured differently. Offenders within the group do not start treatment at the same time, although they will complete the same treatment modules. Consequently, at any one time, different offenders within the group may be working on different modules (i.e., disclosure, victim empathy, or relationship skills). An offender's progress through these treatment modules relates specifically to his own individual treatment progress and needs. Offenders are required to complete module assignments/tasks to a certain standard of competency before being progressing to the next module. This means that therapists can spend more time on the specific treatment targets that each client needs the most, thereby providing a highly individualised treatment. The duration of time spent within treatment will therefore vary for each offender. Those offenders who have been assessed as having a higher risk of recidivism (i.e., need more intensive treatment), or who have a higher amount of criminogenic needs (treatment targets; Andrews & Bonta, 1998), or who need more practiced, varied and/or rehearsed demonstrations of treatment (i.e., those with lower intellectual functioning and/or other responsivity issues) may progress through the treatment programme at a slower pace than other offenders. Offenders may remain in treatment until they have accomplished their treatment goals or until such time that it is deemed that any future efforts are unlikely to be effective. Offenders who are consistently behaving problematically or inappropriately can be suspended for short periods of time to re-join the treatment group at a later stage. This could not happen in a closed format programme. An offender would commence within this treatment group as soon as a space becomes available as a result of someone completing the requirements of the programme. The programme is therefore able to operate continuously throughout the year.

Although we are unaware of any research specifically demonstrating the benefits of open-ended groups in comparison to closed format groups, we see a number of distinct advantages in the use of open-ended groups, notably in terms of resource co-ordination, treatment process, and for the therapists who facilitate them. These advantages have been reviewed elsewhere (see Fernandez & Marshall, 2000; Marshall, Marshall, Serran, & Fernandez, 2006) and we will summarise these as follows, with particular reference to the CUBIT programme.

- One of the difficulties inherent in treating offenders is the timing of treatment (Fernandez & Marshall, 2000). Some sexual offenders may receive short sentences, or may not have been referred to a sex offender treatment programme until they are soon to be released. In contrast to closed format groups which offenders can only commence treatment at pre-determined dates, open-ended groups allow for the inclusion of referrals on a regular basis. Urgent referrals can therefore be managed more responsively.
- There is also the potential for larger numbers of offenders to be treated compared to closed groups. We believe that we will treat approximately 55-60 sexual offenders over the next 12 months within four open-ended treatment groups. If these groups were closed format and therefore starting and finishing on pre-determined dates, we would only have 40 offenders completing treatment.
- Managing repeatedly disruptive and unresponsive sexual offenders within group treatment settings is often a difficult process (Mann, 2000). As a last resort, often after repeated and clearly unsuccessful behavioural intervention, offenders may be suspended or discharged from programmes. Suspension is difficult within a closed group format, as these offenders may miss critical (and often not repeated) opportunities. Discharge is often seen as the only available option. Within an

open-ended format group, suspensions are a viable and powerful tool for those offenders who are repeatedly behavioural problematic. The only consequence of a suspension within an open-ended format group is that the offender will necessarily take longer to achieve his treatment goals. This is often a potent motivational tool, particularly for those offenders who are nearing their parole eligibility date. Discharges are therefore far less likely (but still possible) within an open-ended group.

- The amount of time an offender spends in treatment is ultimately determined by his own treatment needs (so offenders with higher numbers of identified criminogenic needs [treatment targets] can spend longer in treatment (Andrews & Bonta, 1998). Conversely those with fewer treatment needs can progress through the programme more quickly. This reduces the risks of treatment over-prescription, whereby it is suggested that too much treatment can be counterproductive (Marshall & Yates, 2005).
- Certain offenders require more intensive and extensive targeting of certain treatment areas. For example, a small proportion of sexual offenders have pervasive sexual fantasies and a preoccupation with sexual imagery/fantasy (O'Donohue, Letourneau, Dowling, 1997). Within open-ended groups, the therapist can expand, and elaborate upon, certain treatment modules for offenders if needed.
- The format of an open-ended group encourages the use of a range of specific therapist skill sets which have been shown to maximise treatment changes (Marshall et al., 2005). These skill sets are discussed within the next section.
- An open-ended group requires flexibility on the part of the therapist. This allows the therapist to address responsivity issues such as the client's cognitive abilities

as well as day-to-day fluctuations in mood in a responsive manner (see Looman, Dickie, & Abracen, 2005 for review). In contrast, therapists running closed groups have often complained to us that they have felt pressured to achieve certain goals during given time periods to the point where they have felt unresponsive, rigid, and overly prescribed.

- In our experience, the nature and process of an open-ended group results in high levels of group cohesion and a sense of universality (see Yalom, 1995). We see these elements as important considerations when attempting to reduce treatment attrition.
- Open-ended groups allow offenders who have made progress to assist others and model appropriate responding. This is also a desirable attribute of group therapy (Jennings & Sawyer, 2003). In particular, the more senior members of the group are in a position where they can model active participation and positive rewarding interactions between group members. They can also empathise with the new group member's fears and reluctance to engage into the treatment context.
- The structure of an open-ended treatment group means that offenders receive many repeated opportunities to learn vicariously from others (i.e., victim empathy may be targeted in some manner every week, as opposed to only within a distinct block of time in a closed group). Most importantly, within the context of the positive therapist characteristics espoused within our CUBIT treatment groups, offenders develop an identification with the positive coping success of others.

Enhancing the Expression of Positive Therapist Characteristics

At CUBIT, we have increasingly focused our attention on the influence of therapist characteristics on treatment outcome. We believe that this focus more broadly reflects a focus on working more positively with sexual offenders (see

Marshall, Ward, Mann, Moulden, Fernandez, Serran, & Marshall, 2005). These changes were essential given that one of the main features of any open-ended group format is an emphasis on the role of the therapist (Marshall et al., 2006). In emphasising the importance of the therapist within the treatment programme, we have moved away from an overly manualised delivery of cognitive behaviour treatment where we relied extensively on the actual treatment procedures to induce change. This allows our therapists to be more flexible and to increase their focus on *process* issues as well as their therapist style. Our decision to do so was also influenced by theoretical and empirical research which indicates that characteristics of the sex offender therapist may have a significant influence in the changes (or lack thereof) that an offender makes in treatment. This makes intuitive sense and is consistent with the extensive body of *general clinical psychology* literature on the influence of therapist variables (see Marshall, Fernandez, Serran, Mulloy, Thornton, Mann, & Anderson, 2003 for review). Marshall and colleagues completed their own empirical research on the influence of the therapist in *sexual offender* treatment. In a series of studies using videotaped treatment sessions of a highly manualised cognitive behavioural programme conducted in a number of English prisons, they examined the relationship between therapist characteristics and treatment changes on a variety of psychometric questionnaires (i.e., self-esteem, coping, attitudes, etc.). They found that two sets of therapist features had an influence on treatment changes over and above the influence of the treatment procedures and techniques.

Firstly, they found that an aggressively confrontational style of challenging sexual offenders did *not* produce any consistent treatment benefits. It was actually more likely to produce a negative effect. Low interest in the offender and any therapist expression of anger or hostility were also found to be negative therapist

characteristics. We welcome these findings as it has long been clear to us clinically that aggressively confronting a sexual offender is unlikely to produce any immediate (or long term) benefits. Aggressive confrontation was, however, perceived as critical within the treatment of sex offenders until the late 1990's (and may well still be in some current treatment programmes). For instance, Salter (1988) argued that "…the [treatment] group must be confrontative." (p114) and "an offender who insists his offence was not premeditated… should be told that he is extremely dangerous" (p175). Both of these statements reflect what would now be labelled as an excessively punitive treatment approach. Historically, this approach was adopted almost without question by therapists. Unfortunately the very nature of a sexual offence often results in the perpetrators presenting in typical ways – all of which often can evoke a desire to confront and challenge. For example, they will often deny, minimise, blame others, become hostile when challenged, evade direct questioning, and can sometimes be interpersonally aggressive. We would, however, argue that each of these behaviours is best seen as a dynamic and natural process which the therapist can effectively target without confrontation (see Mann, 2000).

The second set of therapist features identified by Marshall and his colleagues were positively related to beneficial treatment change. The most important influencing features were appropriate levels of empathy and warmth, rewarding offenders for their achievements, and the provision of some degree of directiveness. Empathy and warmth are most usually viewed as critical factors within psychotherapy (Rogers, 1957) and rewardingness and directiveness are well established as important in cognitive behavioural treatments (Beck, 1976). A number of other therapist characteristics were observed to be influential in treatment. Appropriate use of body language, encouragement of participation, appropriate amount of therapist talking and

tone of voice, use of open-ended questions within treatment all had an impact on various measures of treatment change ranging from increased coping skills, perspective taking, to improved relationships skills. Although these therapist behaviours appear to reflect the presumed necessary and sufficient therapy conditions outlined by Carl Rogers (1957), we note that therapists themselves are not necessarily good judges of this (Orlinsky, Grawe, & Parks, 1994).

As a result of this research we now stress the importance of the role of the therapist even whilst using a treatment manual and highlight a number of specific therapist characteristics, shown to be related to positive treatment outcome, in our daily work at CUBIT. As mentioned previously, although we believe that therapists working at CUBIT have always employed these strategies, it was not emphasised as such an important component of treatment until recently. In summary and in brief, we now focus on the following:

- Eliminating the use of confrontation from our treatment of offenders.
- Behaving in a respectful manner towards offenders and their current circumstances
- Working collaboratively with offenders towards the development of shared treatment goals (Mann & Shingler, 2006)
- Supporting the offender's self-efficacy and self- belief in his ability to change (instilling positive expectations and hope)
- Being appropriately directive and challenging (particularly when offenders are not taking responsibility for their sexually abusive behaviours)
- Providing appropriate levels of empathy and warmth towards offenders and their current circumstances

- Developing high levels of offender trust towards therapists and custodial staff, which as Drapeau (2005) has pointed out is a necessary component for effective treatment
- Encouraging active participation by the offender within treatment
- Encouraging the expression of emotions (through therapist modelling)
- Appropriate levels of therapist self-disclosure
- The use of open-ended Socratic questioning (Overhoulser, 1993)
- Emphasising the setting of approach goals compared to the more traditional strategy of specifying a list of avoidant goals (i.e., "you must not do this"). Approach goals are easier to achieve than avoidance goals (Emmons, 1996) and reflect a more positive approach to self-management.
- Being flexible as it has been shown that different offenders and the same clients at different times appear to respond differently to the same therapist skills (Marshall et al., 2003), and
- Most importantly a treatment culture where we rely heavily on the use of positive reinforcement as the main change agent rather than models based upon punishment contingencies.
- Structuring our treatment to reflect the good lives rehabilitation model (Ward & Stewart, 2003) whereby it is strength based and concerned with promoting offender's goals alongside with the management of their recidivism risk.

Evaluations of These Changes

We have yet to formally evaluate these changes, but intend to do so in conjunction with our long term treatment outcome research. Anecdotally, we have sufficient, albeit short term, evidence of positive changes in a number of different

areas, notably systemic, offender, and staff related changes. These are listed as follows:

- We now have 40 offenders in treatment consistently. Previously, at times we had only 20 of 40 beds within the unit filled.
- There has been a greatly reduced drop out rate since the implementation of open-ended groups in August 2005. Currently, our treatment drop out rate is less than 2%.
- Higher functioning or highly motivated offenders are moving through treatment stages faster than would be permitted by closed group modules (e.g., 6 months rather than 8-10).
- Offenders who have previously dropped out of CUBIT have returned to complete treatment and to focus only on those areas that still require work rather than having to redo all treatment components.
- The environment within individual treatment groups and within the CUBIT unit as a whole appears to be far more supportive. Open-ended groups means that there are not large numbers (e.g., 10 to 20) of untreated offenders entering treatment at any stage (as used to occur in the closed group system).
- Staff have reported that they feel far more effective and positive in their work. We believe that these changes have lessened the risk of staff "burn out" or distress.
- Staff have also reported that there is less "pressure" on therapists to achieve change within rigid parameters (closed group modules). Open-ended groups allows change (e.g., victim empathy) to occur over the whole of treatment rather than over the 3-4 week module of victim empathy under a closed group system

- There is also a clearly enhanced focus on offender individual responsibility for change as opposed to therapists and staff feeling responsible for making sure that offenders “get it”.

In conclusion, we believe that the changes we have made to the CUBIT programme will significantly reduce our problems with treatment attrition and increase our effectiveness at reducing re-offending.

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