

Treatment in Detention: Enhancing engagement and success

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Treatment in detention: The challenges

- Detention is a place of punishment
 - Detention does not provide a realistic environment for generalisation of learning
 - Outside problems seem smaller
 - Detention staff may not have a therapeutic orientation
 - Others in detention may pose a threat
 - The informal rules of prisons
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Treatment in detention: The opportunities

- They turn up
 - They are contained
 - Opportunities for reinforcing treatment gains outside the group
 - Opportunities for monitoring
 - Time to think and reflect
 - Time to try out new things in small/safe ways
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What affects treatment engagement?

- The demands & requirements of treatment
 - The treatment style
 - The detention context
 - Social and family context
 - The societal context
 - The offender's readiness
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Key issues for today's presentation

- What we have learned from treatment refusers about the relationship between detention and engagement (Part 1)
 - Improving the model of change for sex offender treatment and the consequences for engagement (Part 2)
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Part 1: Understanding treatment refusal

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Overview of Refusers project

- ❑ Literature review: reasons for resistance and refusal
- ❑ Pilot: unstructured interviews & qualitative analysis (n=)
- ❑ Structured interviews & quantitative analysis (n=100)
- ❑ Focus groups with men in treatment

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Three participant groups

- ❑ Deny-Refusers
- ❑ Admit-Refusers
- ❑ Admit-Acceptors

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Main findings

- ❑ Four types of factors contribute to treatment refusal
- ❑ The cause of resistance was more located in the system than in the refusing/denying sex offender
- ❑ The data favoured an "adaptational model" of denial and resistance.

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Four key areas related to refusal

- ❑ Negative experiences of the system
- ❑ Treatment beliefs and knowledge
- ❑ Offender characteristics
- ❑ Social and family system

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Negative Experiences of the System

- ❑ Lack of trust in key professionals is the most well established correlate of resistance in the general literature on resistance
- ❑ Key professionals are often seen as uninterested, lacking concern, disbelieving a patient's anxieties, and not providing adequate explanations of their recommendations

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Negative Experiences of the System

- ❑ Patients in institutions often feel negative about the atmosphere.
- ❑ Staff can overlook the need to understand treatment-related issues from the patient's perspective
- ❑ In some cases, staff can communicate attitudes that undermine the treatment approach

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Negative Experiences of the System

- ❑ All these issues were uncovered by the research
- ❑ The refusers said they had no contact with psychologists/probation officers, or they did not trust them, or they had a bad relationship with these staff.
- ❑ The accepters were more likely to feel their relationship was good.

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Negative Experiences of the System

- ❑ 60-70% of all those interviewed (Refusers and Accepters) had felt physically unsafe or psychologically vulnerable in prison because of their conviction.
- ❑ Many of these problems resulted from staff behaviour.
- ❑ E.g. bullying, intimidation, being belittled, verbal insults

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Negative Experiences of the System

- ❑ Half of all sex offenders saw prison staff as not believing in treatment.
- ❑ Between 30 and 60% had heard staff saying negative things about treatment
- ❑ Accepters were much more likely to have had treatment offered to them in a sensitive way, explaining why treatment would meet their needs.

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Treatment Beliefs and Knowledge

- ❑ The belief that treatment is ineffective influences treatment resistance.
- ❑ This can be exacerbated by the perception that treatment is too narrowly focused and does not take account of broader life goals and priorities

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Treatment Beliefs and knowledge

- ❑ Concern about side-effects common in non-compliance with medical treatment
- ❑ Concerns about side effects are often under-estimated by professionals.
- ❑ Negative side effects do not necessarily deter patients, but professionals must be willing to inform and discuss at some length.

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Treatment Beliefs and Knowledge

- ❑ We found that 17-44% of men had concerns about negative side effects.
- ❑ The vast majority were not aware of research into effectiveness - and many believed the rumour about America.
- ❑ The refuser groups indicated that seeing such research would lead them to feel more positive.

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Treatment Beliefs and Knowledge

- ❑ More than half the Admit-Refuse group would be more likely to accept treatment if they thought the aims were different.
- ❑ Both refuser groups were cynical about the aims of treatment e.g., thought it was offered to improve the public image of the Prison Service.

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Psychological Characteristics

- ❑ Under certain circumstances people react against attempts to restrict or control their decisions or choices.
- ❑ The Refuser groups had felt placed under pressure to accept treatment.
- ❑ They viewed the offering of incentives as suspicious.

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Psychological Characteristics

- ❑ Certain personality features may increase likelihood of treatment refusal, such as grandiosity or avoidant coping.
- ❑ Men who accepted treatment were more likely to cite "looking to the future" as their preferred coping method.

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Social and Family System

- ❑ Individuals from ethnic minority groups may perceive that treatment is not relevant to their needs or will not understand their experiences.
- ❑ All interviewees from minority ethnic backgrounds were concerned about this.
- ❑ Concerns strongest in the Deny-Refuse group

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Social and Family System

- ❑ Families may collude with denial of a problem, fear of treatment or concerns about stigma.
- ❑ The Deny-Refuse group knew or thought that their families believed in their innocence.
- ❑ The Admit groups knew or thought that their families believed in their guilt.

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Social and Family system

- ❑ Clients may be concerned about lurid cultural stereotypes associated with their problem behaviour.
- ❑ Men who refused treatment perceived their status among peers as higher.
- ❑ They were more likely to believe that surviving would be harder if in treatment

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Focus Group Findings

- Should be more, better quality, individual time spent with potential participants before treatment is offered.
- Quality written and video information should be widely available.
- Non-treatment staff need to be better informed about treatment.

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Focus Group Findings

- Application of incentives needs to be examined.
- Wanted a safe, therapeutic, respectful environment outside of the treatment group.
- Name of the programme
- Use treatment graduates to motivate and encourage

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Some solutions?

- Listen to refusers
- Recognise the offender's perspective and experience
- Enhance personal relationships between non-treatment staff and prisoners
- Identify and counter myths
- Communicate strengths-based aims

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Some more solutions?

- Make referrals quickly with sensitivity and respect
- Offer clear and transparent information about treatment methods and outcomes
- Ensure risk assessments take account of strengths and progress
- Educate non-treatment staff

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Some more solutions?

- Clear leadership to promote pro-social modelling and supportive environment
- Work with families and support network
- Use intrinsic motivators and avoid extrinsic motivators
- Utilise treatment graduates

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Some more solutions?

- Provide choice
- Explore and monitor the motivations of treatment staff.

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Part 2. Model of change

Mann, Carter & Thornton, 2010

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What should SO treatment address?

- Sexual preoccupation
- Any deviant sexual interest
- Offence supportive attitudes
- Emotional congruence with children
- Lack of intimacy
- Lifestyle impulsivity
- Poor cognitive problem solving
- Resistance to rules
- Grievance & hostility
- Negative social influences

(Mann, Hanson & Thornton, 2010)

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Protective factors

- Healthy sexuality
- Constructive occupation (including employment)
- Motivation to desist
- Hope
- Agency
- Positive identity
- An intimate relationship
- Healthy social support (a place within a group)
- Sobriety
- Being believed in

(Maruna, 2010)

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What does SO treatment address?

- Offence responsibility/victim empathy/social skills/intimacy skills (USA)
- Intimacy skills/victim empathy/emotional regulation (Canada)
- Attitude reconstruction/victim empathy/self regulation (UK)

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The apparent model of change...

- Change occurs when
 - The offender takes responsibility for his offending (= gives an account that matches the victim account, does not involve any external attributions of cause)
 - The offender recognises the harm he caused

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What the treatment client hears

- Confession is the organising principle of treatment

(Blagden, 2010)

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An alternative model of change

- A bio-psycho-social model of change for the treatment of sexual offending
- Clear articulation of the organising principles of change avoids informal rules governing therapist/client behaviour
- Treatment aims to build biological, psychological and social resources.

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Understanding the BPS causes of sexual offending and desistance

- Biological: Early disruption of neuro-development underlies the development of many criminogenic factors and also affects responsivity
- Psychological: Early disruption of psychological development
- Social: Social capital is a strong protective factor against sexual offending

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Organising Principle #1

- ***Treatment will be delivered in a way that makes it accessible to participants whatever their biological, psychological, and social circumstances.***
- By the use of active multi-modal, visual, audio & kinesthetic methods
- By understanding and working with each participant's aspirations
- By individualizing the type and order of activities that each participant undertakes
- By helping participants understand themselves in a way that makes change seem realistic and appealing

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Organising Principle #2

- ***Treatment will strengthen biological resources such as neuro-cognitive functioning.***
 - By drawing on techniques considered effective in the neuro-cognitive rehabilitation literature
 - E.g., Mindfulness training
 - Diet and exercise

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Organising principle #3

- ***Treatment will strengthen psychological resources, such as cognitive and emotional flexibility and empathic relating.***
 - By using exercises and therapeutic interactions in which these ways of functioning are repeatedly experienced and so strengthened
 - By running treatment so that it simultaneously generates relevant emotional and cognitive activation (allowing learning at the schema level)

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Organising principle #4

- ***Treatment will strengthen social resources such as social capital***
 - By using group process and deliberate coaching to develop the skills and attitudes necessary to build, connect with, and maintain pro-social networks and intimate relationships.
 - By assisting participants to join real social networks

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Conclusions

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Making treatment more engaging

- We can better engage participants if we understand their personal and social world and their experience of detention
- We can better engage participants if we are focused on building biological, psychological and social strengths as our organising principles of treatment

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Thank you for listening

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