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Reducing recidivism rates among young offenders

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Current literature around young offenders and recidivism rates shown that in NZ there is a core group of young offenders that continue to reoffend despite going through the youth justice system. To combat this recidivism rate, in 2010 the Children, Young Persons and Their Families Amendment Bill proposed and implemented changes to the Children, Young Persons and Their Families Act (1989) to allow for tougher sentences (either community or residence based) for both young offenders and their families. This amendment increased the length of time young offenders could be sentenced to residence and/or supervision orders, and also allowed for mandated parenting education programmes for parents of young offenders and/or young offenders who are parents (Bennett, 2009). The amendment also emphasised the need for rehabilitation, mentoring, and support for young offenders and their families as a preventative measure towards reoffending. As a result there has been a strong push towards developing and implementing programmes that reduce recidivism rates of young offenders by targeting criminogenic needs and that also teach and promote pro-social skills. This paper will briefly review the literature and research on which these programmes are based with the goal of identifying effective and therefore best practice approaches to working with young offenders.

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Characteristics of Young Offenders

Young Offenders both in NZ and worldwide have more academic, cognitive and emotional difficulties compared to their same aged peers in the general population. Leone et al (2003) reported that young offenders are performing at the

low-average to average range in terms of general intelligence and that they have deficits in academic skills including reading, maths and written and oral language compared to their same aged peers in the general population. A proportion of the poor academic achievement seen in this population can be attributed to factors such as truancy, non-compliance at school and school drop-out. Not surprisingly, all three of these factors are common among the young offender population and are often the result of an accumulation of risk factors. These risk factors include but are not limited to low socioeconomic status, family problems, family substance abuse, personal substance abuse, poor parenting skills and ethnicity. In addition to the aforementioned behavioural (truancy and non-compliance) factors leading to poor academic achievement, cognitive deficits and specific learning disorders can also play a role in the poor academic performance of young offenders just as they do in the general population.

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Unfortunately for this population the statistics do not stop there; the majority of young offenders have experienced abuse, trauma and/or neglect at some point in their lives (Carrion & Steiner, 2000; McMackin et al 2002) and they have a disproportionately higher rate of mental health difficulties than their non-offending peers (Chitsabesan et al, 2006). Young offenders experiencing a mental illness (including trauma related anxiety) are more likely to reoffend than those without a mental illness, and in spite of this, research has found young offenders are not getting the referrals for assessment and treatment that they need (Townsend et al, 2010).

Whether poor academic achievement in young offenders is the result of behavioural problems, family problems, cognitive deficits or a SLD, it needs to be acknowledged and accounted for when planning and implementing interventions for reducing recidivism in order to help the engagement process and maintain motivation. Any treatment or intervention which is difficult to understand, meaningless or boring will fail to engage young offenders therefore it is imperative to ensure any intervention is tailored specifically for the target audience. Furthermore, when planning a intervention it is also important to consider and understand the mental health of young offenders in order to: a) begin to understand their world view and way of thinking; b) be better able to plan and implement an intervention for offending; c) ensure the safety of the young

person; and d) plan for their reintegration back into the community (if they are incarcerated).

So in light of this, what interventions should be considered when working with young offenders to reduce recidivism?

Group work with Adolescents

The most cost-effective and efficient way to deliver interventions to young offenders in residential facilities is in a group format. Furthermore, not only is group work practical, there is also a vast literature base supporting its effectiveness for use with anti-social adolescents and young offenders. However, as always this point has been debated and it is argued by some researchers that being in a group of similarly anti-social peers has a reinforcing effect on anti-social behaviour (Arnold & Hughes, 1999), whereas the other side of the fence contends that the positive effects of being involved in a group outweigh any possible negative outcomes (Rose, 1998).

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There is a large body of literature concerned with the iatrogenic or detrimental effects of anti-social or delinquent youths working together in a group format. The literature raises concerns around reinforcement of anti-social behaviours, negative role models and peer influences, and the formation of new friendships based on anti-social or delinquent behaviour. The main theme amongst this literature is that by joining anti-social or delinquent adolescents together in a group there is a risk of making the problems of those adolescents worse. However, recent research has found that the vast majority of feared iatrogenic effects of group work with adolescents are either non-existent or non-significant (Weiss et al, 2005). Weiss et al's (2005) research examined a number of previous reviews of iatrogenic effects of working with adolescent groups. Their work found that the majority of iatrogenic effects that had been identified did not hold up to statistical scrutiny and that although one review (Lipsey, 1992 as cited in Weiss et al, 2005) identified a study using a group work format that yielded a negative effect size, this alone was not evidence enough to determine an iatrogenic effect.

On the other hand, the research and literature in support of using group formats when working with anti-social and delinquent adolescents shows positive outcomes. Malekoff (1999) proposes that the group format is ideal for the adolescent in therapy as it allows for a sense of independence

from the family, yet a sense of belonging with peers, both of which are important for adolescents as they search for their identity. Rose (1998) adds that the group format is more enjoyable for the adolescent than individual therapy and that enjoyment is essential in finding motivation to change. Other key factors or benefits for adolescents working in a group format are mutual support from peers, new relationships, pro-social roles, promotion of teamwork, giving and receiving peer feedback and the opportunity to show leadership. In terms of empirical support, a meta-analysis by Waldron & Turner (2008) evaluated the effectiveness of various treatment modalities for working with at risk adolescents and concluded that using a group based intervention does no harm, is effective and is equivalent to using individual therapy with this population.

CBT with Young Offenders

There is little contention in the literature that Cognitive Behavioural Therapy (CBT) and its variants are the most effective treatment for reducing recidivism among both young and adult offenders (see review by McGuire, 2002). Various meta-analyses have been carried out to capture and evaluate the use of CBT in a range of formats and settings including with incarcerated young offenders both in groups and in individual sessions (eg Pearson et al 2002 and Wilson et al 2005). Results from such analyses indicate that CBT has been used effectively to reduce recidivism with individual offenders and groups of offenders as measured not only by recidivism rates but also by changes in thinking around offending and the law.

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The success of traditional CBT with the offending population led to an increase in the use of variations on CBT within the justice and rehabilitation area. These variants include Reasoning and Rehabilitation (R&R), cognitive-restructuring, cognitive rehabilitation, and moral reconation therapy (MRT). A study by Wilson et al (2005) found that of the most common variations of CBT used with the offending population, R&R and MRT were the most effective in terms of reducing recidivism. Contrary to this, Landenberger and Lipsey (2005) found that when controlling for participant and implementation variables there is no significant difference between the effectiveness of the different variations of CBT and rather it is the general CBT approach which yields such positive outcomes. However, Landenberger and Lipsey (2005) did find that when working within a general CBT framework, including anger control and interpersonal problem solving components in their

intervention increased positive outcomes whereas victim impact and behaviour modification components decreased positive outcomes.

In addition to the use of CBT yielding positive outcomes when working with young offenders to reduce recidivism, it is also worth noting the success CBT has yielded in other areas as we know offending is not the only issue facing young offenders. In the 1980's Beck conducted break through research on the use of CBT as a treatment for depression (Wills, 2009) which has since become well established and accepted. Since then CBT has also had success in the treatment of eating disorders, trauma, anger, psychosis, relationship difficulties and substance abuse (Westbrook, Kennerley, & Kirk, 2007). Furthermore, research has found CBT to be the preferred non pharmacological intervention for the treatment of anxiety in both children and adults (Stallard, 2009). One potential drawback for using CBT with this population however is the requirement of a certain level of cognitive ability in a client in order for them to fully engage in the therapy (Stallard, 2009). Due to the nature of CBT, if an individual is cognitively impaired or yet to develop appropriate cognitive skills, they are unable to effectively grasp the processes involved in the therapy therefore making CBT an ineffective form of treatment for very young children and the intellectually disabled or delayed. With this said, it is unlikely that the key problem for this population will be an inability to understand the content and processes involved in CBT, but rather that they will lack the motivation to try them if they deem it to be hard or confusing.

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Motivating young offenders

Motivation is an essential part of the therapy process that is often overlooked. If a client or consumer is unmotivated to change or move forward then any treatment or outcome goals that are set out will struggle to be met regardless of nature of the therapy or the skill of the therapist. In the general population, common reasoning suggests that clients or consumers who attend therapy have at least some motivation to change or move forward otherwise they would not be present at sessions. Within the young offenders population however, therapy and/or interventions are mandated and therefore not all attendees are at a point where changing their behaviour or way of life is something they are motivated to do. When this is the case, any therapy or interventions

implemented at this point are likely to encounter severe resistance, are unlikely to result in reduced recidivism and could potentially increase recidivism rates to higher than that of offenders who had not received any intervention at all (McMurran & Theodosi, 2007). Therefore, in order to increase the likelihood of successful treatment outcomes of Criminogenic Programmes (or any therapy or intervention), young offenders need to be motivated to change their behaviour before beginning the programme. One response to this problem is Motivational Interviewing (MI), a therapeutic technique that aims to move a person from a place of ambivalence about changing to a place where they are ready and committed to change (Rollnick & Miller, 1991). MI is being used more readily with the offending population as a precursor to treatment with the goal of increasing and maintaining engagement in treatment and motivation to change (McMurran, 2009).

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MI was originally used as an intervention in the addictions field and as a result the majority of research into the effectiveness of MI has been carried out in the area of addictions. However, recent literature and research is beginning to show positive results into the use of MI with the offending population as both a precursor to therapy and a standalone treatment for the offending population (McMurran, 2009, and Feldstein et al, 2006). Austin et al (2011) and Anstiss et al (2011) conducted studies with offenders incarcerated in New Zealand prisons and found that individual brief MI interventions resulted in increased motivation to change and lower rates of recidivism upon release. Furthermore, as hypothesised they found that MI followed by criminogenic based intervention was significantly more effective than criminogenic programmes on their own. However, somewhat surprisingly, Anstiss et al (2011) found that the use of MI, followed by a criminogenic programme was less effective than treatment consisting purely of MI on its own, indicating that perhaps helping a person to become motivated and committed to change has more of an impact than teaching them the skills required to make the changes.

As the research into the use of MI with young offenders is beginning to consolidate, the research into using MI in a group format with adolescents is only beginning to emerge. D'Amico et al (2010) found success when using MI in a group setting with adolescents who had committed a first time drug and alcohol offence, Bailey et al (2004) also used group MI in a pilot

study for youths with alcohol abuse and had promising yet methodologically flawed results, and Schmiege et al (2009) also had a positive outcome when using group MI with adolescents in a detention facility engaging in risky sexual behaviour.

Conclusions

The above research highlights the fact that young offenders have a higher rate of mental health problems, substance abuse disorders, learning delays, cognitive deficits, traumatic experiences and family history of offending than their non-offending same aged peers. These characteristics, in addition to experiencing "normal teenage angst" and the fact that they are mandated to attend therapy, make the task of engaging young offenders in therapy or treatment considerably more difficult than it is engaging a non-offending adolescent. Even once young offenders have been successfully engaged in therapy, the same characteristics can hinder a young offender's progress towards changing their offending behaviour as they may find it hard to concentrate on or understand a topic, have little or no motivation to change, be emotionally or cognitively unavailable, or lack confidence or self-belief in their abilities to change. These factors should be kept in mind when implementing an intervention for reducing recidivism among young offenders which is the goal of the 2010 Amendment Bill of the Child Young Person and their Families Act.

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According to the above research, the ideal intervention for this population is a CBT based programme conducted in a group format that emphasises problem solving skills (especially around anger) and interpersonal skills. The intervention should be simplistic in terms of concepts and language in order to accommodate any cognitive deficits or learning delays the offenders may have, and be interactive and relevant to teenagers in order to maintain interest and reduce drop-out. CBT is the therapy of choice for this population as not only is it known to be effective with this age range and for reducing recidivism, it is also a therapy that can be used effectively to deal with mental health issues, which as stated above are prevalent amongst young offenders. Using a group format for delivering such a programme is not only the most cost effective and efficient method, but it also offers the advantages of providing opportunities for peer feedback, leadership roles, mutual support, a sense of belonging, and new friendships.

A probably effective approach that still requires further research but is likely to add to such an intervention is the use of MI as a precursor to treatment in order to increase engagement and motivation to change. Current research about the use of MI with young offenders both on its own and as a precursor to treatment suggests that it decreases the rate of recidivism and increases the likelihood of an offender completing an intervention through increased motivation to make change. To date the research around using MI in a group format with at risk youths is promising but further research is needed to validate its use with groups, and in particular with groups of young offenders.

In addition to a Criminogenic Programme conducted in the above manner, in order to ensure we are adequately supporting young offenders and their families to make changes in relation to their offending, it is important that individuals also receive appropriate mental health and cognitive screenings and assessments, followed up by any necessary interventions. By doing this we can further reduce risk factors for recidivism and ensure we are taking a more holistic approach to reducing recidivism of young offenders.

Although the literature and theory around young offenders, recidivism, group work, CBT and MI all suggest that a criminogenic programme set out in such a format as described above is likely to be effective at reducing recidivism rates among young offenders, it is recommended that research into such an intervention is conducted in order to support this hypothesis.

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