TAI AROHA – THE FIRST TWO YEARS

A formative evaluation of a residential community based programme for offenders // 2012

Psychological Services
Department of Corrections

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2012

By

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Psychological Services

Department of Corrections

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Executive summary

Background

1. Psychological Services led the research, design and development of the Tai Aroha Programme for high-risk offenders serving community sentences.

Design phase

2. The project manager oversaw the design work. A clinical psychologist led the design and a programme developer developed the programme. Both were private contractors. An advisory group provided them with expert advice and guidance.

3. The Tai Aroha therapeutic community was based on the hierarchical model described by De Leon (2000[1]). The format involved full residence (24 hours, 7 days per week) with an expected stay of 14 to 16 weeks. Offenders transitioned through 4 phases from orientation to full community living over the course of the programme.

4. The core programme (including skills training) was based on best practice principles in offender rehabilitation and adhered to risk, needs and responsivity principles. Cognitive behavioural and relapse prevention informed treatment. Elements of the Good Lives Model were incorporated to enhance programme responsivity.

5. Targets for treatment included: antisocial attitudes and offence-related thinking, antisocial and criminal associates, emotion and behaviour self-regulation difficulties, relationship problems (marital and family), impaired self-management and/ or problem solving skills, and alcohol and drug abuse.

6. The programme was based on open group membership where new residents joined as former residents exited. To graduate residents had to complete assignments associated with each core module and achieve programme learning objectives.

7. The design phase produced a complete group treatment programme containing 10 modules and related assignments. The modules were.
    1. Assessment
    2. Orientation (includes mindfulness and distress tolerance)
    3. Aspirations
    4. Life history and self-evaluation
    5. Acceptance of responsibility/restructuring problem and offence-related thinking
    6. Offence pathways
    7. Emotional management
    8. Substance abuse management
    9. Relationship management
    10. Relapse prevention.

[1] De Leon, G. (2000). The therapeutic community. Theory, model and method. New York: Springer Publishing Company Inc.

Background documentation included:

1. The design document
2. A review of the "what works" literature
3. Therapeutic community structures and processes
4. A training package for house staff, psychologists and facilitators
5. The Tai Aroha Policy and Procedures Manual
6. A resident handbook.

Implementation phase

8. **Residence**: The Tai Aroha residence is based in Hamilton, in accommodation previously known as Montgomery House. The Director of Psychological Services managed the implementation. The Policy and Procedures Manual informed all aspects of operating the house including its functioning as a therapeutic community.

9. **The implementation** began on 9 August 2010 and was due to end on 31 March 2011. Because of issues such as unsuitable referrals, fewer referrals over the Christmas period, attrition rates, staff difficulties in adapting to the therapeutic community model, and staff turnover, the pilot was extended to 31 December 2011.

10. **Communication plan**: The National Manager STU development prepared the plan. Meetings were held with stakeholders to build and strengthen relationships and provide regular forums for discussion and to provide information.

11. **Training:** This was provided for all house staff, psychologists and the programme facilitator before Tai Aroha opened.

12. **Criteria for entry**. Tai Aroha caters for male offenders serving community sentences who have been assessed as being at high-risk of serious re-offending (RoC*RoI 0.7 or greater). Men who have index or historical violent offences are eligible. Suitable community sentences are home detention and intensive supervision. Offenders must be aged 20 and over, although17–20 year-olds may be considered. They must be able to stay alcohol and drug free throughout the programme and have at least six months remaining on their sentences.

13. **Referral sources**: Most referrals were sourced pre-sentence from Community Probation Services. Psychological Services and occasionally Prison Services made some referrals later. Enquiries were also received from other sources.

14. **Assessment:** Suitable candidates underwent a comprehensive psychological assessment, including assessment of criminogenic needs to provide targets for intervention and potential responsivity barriers.

15. **First Intake:** Initially, five men were identified as suitable candidates and accepted onto Tai Aroha. Four identified as Māori, and one as Cook Island Maori. Ages ranged from 19 years to 28 years. Their convictions were for possessing and supplying cannabis, property offences, breaches of conditions, breach of intensive supervision and wilful damage. One of the five, whose motivation diminished, asked to leave the programme, and another absconded and was exited, leaving three participants.

16. **Participants**: Between 9 August 2010 and 31 December 2011, 34 men started on the programme. Twelve completed it successfully, 15 were exited and three pulled out voluntarily. By April 2012, 38 residents had attended the programme, 13 successfully completed, 20 were exited and five were currently in treatment. Seventy four percent of the residents were Maori. Compared with 45% in the broader community offender population. Fifty eight percent of the residents claimed gang membership, higher than in the general offender population (8%).

17. **Treatment programme staff**: Morning sessions for the Tai Aroha core programme were delivered four days a week by two co-facilitators, a programme facilitator and a senior psychologist from Hamilton Psychological Services. Two psychologists from Hamilton Psychological Services facilitated the afternoon sessions twice a week.

Results

18. Results from the implementation were drawn from direct observation by the project manager; therapy staff notes and feedback; questionnaires completed by staff and residents; and, quality monitoring documentation.

19. **Offender referrals:** While there were ongoing difficulties in gaining enough referrals to fill the house (10 residents), this improved with the development of a 'road show' and regular visits to Community Probation Services sites in the region to provide information about the programme and encourage referrals.

20. **Therapeutic community:** In the early stages, the house functioned inconsistently as a therapeutic community. However, crucial structures and systems were in place, including full weekly schedules for residents, a well organised and structured induction process and a buddy system. As the programme progressed, some areas developed well (e.g. daily house meetings, incident reporting processes, case management reviews, privileges and sanctions, therapeutic community values and principles, and celebrations and rituals). Other concepts were less well-established but improved over time (e.g. role modelling change processes and feedback, relationships between staff and residents, education, training meetings, seminars).

21. **Group therapy programme:** Therapists reported that the programme content was sound and session and programme objectives clear. They delivered the manual content as intended but did note some difficulties:
    - Completing session content requirements when new residents joined the programme.
    - Time needed to deliver the orientation component to new entrants before they attended their first group sessions.
    - Participants found it difficult to understand and complete the assignments.
    - The programme had assignments but not workbooks. This was an issue as they were given no handouts or other material.

22. Initially core material was reintroduced in morning sessions when new men joined the programme. This became repetitive and participants complained that they had no opportunity for new learning. Therapy staff found that the amount of processing in afternoon sessions left little time for practicing skills. Participants had problems focusing in afternoon sessions, particularly when they had attended in the morning.

23. **Process issues:** Motivational and engagement levels varied across the programme and behaviours that interfered with therapy emerged. Therapists were unsure how best to facilitate the open/ rolling format.

24. Nonetheless, residents engaged in the process and generated a lot of discussion about content and process issues. They contributed to relevant games, artwork, role-plays, video analyses, poster work and group presentations. They told their autobiographical story either as a narrative, a poem or artwork. Participants who graduated completed the relevant assignments.

Changes made to the programme

25. **Session content:** Therapists took a 'key learnings' approach, condensing the material based on the responses of the group. The 'key learning' points were always in line with the session aims in the manual.

26. Assignments were revised and included a safety plan. The revised assignments were approved by project management as the official version. Workbooks were developed but were hard to manage with the rolling group format.

27. **Morning and afternoon therapy sessions:** Re-introducing core concepts and skills was transferred to afternoon sessions, with a corresponding reduction in processing 'in the moment'. More attention was placed on skills practice.

28. To counter fatigue, the therapy team reduced the time spent in core and skills group and had a longer break between therapy groups and other scheduled activities.

29. The programme facilitator developed a skills 'passport' which had to be signed off for men to progress through the programme. This was a useful and enjoyable resource and a great motivation for participants to actually think about and use their skills.

30. **Process issues:** These were addressed as they arose, considering the developmental stage of the group and programme content. The structure of the rolling aspect was altered: New participants attended orientation with the group and undertook some orientation exercises as homework tasks. They then began treatment with the module that the rest of the group was working on.

Questionnaire results

31. A self-rating questionnaire sought information from staff on the programme, The questionnaire looked at: cultural responsivity, house facilities and services, therapeutic community as method, the core programme and reintegration planning. Staff ratings were relatively positive across all categories, although reintegration planning needed improvement. While the house and facilities were rated as adequate; work and activity spaces were considered too small.

32. The participants' self- rating questionnaire looked at: the programme in general, the therapeutic community, relationships with other participants, programme and house staff, personal changes the participants made, and cultural experience and identity.

Only four men completed the questionnaire. No statistical analysis was possible but some patterns were identified. The respondents rated the core programme as helpful in reducing their risk of re-offending and preparing for their return to the community. Being part of a therapeutic community was important. Residents and staff worked together towards a crime-free and more positive lifestyle. They reported supportive and positive relationships with other participants, group therapy staff and house staff and said that the programme had helped them develop more pro social attitudes and behaviours and had met their cultural needs.

Statistical analyses of psychometric instruments administered to offenders

33. Psychometric instruments assessed risk of recidivism, risk of violent recidivism, antisocial attitudes, treatment responsiveness and general responsiveness. Psychometric data results are included in Appendix H of the main report.

34. The high proportion of residents identified as having personality disorders suggested that therapists and house staff will need training to help identify and manage personality issues.

Conclusion

35. Demographic factors and risk need variables indicated that appropriate offenders attended the programme; positive indicators suggested that they benefited from attending. Post-programme support in addition to standard services was seen as a critical step in helping offenders maintain their treatment gains.

Recommendations

1.	Note that Psychological Services has completed the design, initial implementation and evaluation of the Tai Aroha Therapeutic Community Programme for high-risk male offenders.	**YES/NO**
2	Note that changes made to the programme during the initial implementation phase are incorporated into the existing programme.	**YES/NO**
3	Approve that the programme should now be considered business as usual.	**YES/NO**
4	Approve the ongoing running of Tai Aroha as a residential programme for high-risk offenders serving community-based sentences.	**YES/NO**
5	Note that the following recommended changes will be implemented • Development of workbooks and handouts • Further development of the reintegration planning model • Training developed and delivered for managing offenders with severe personality disorders.	**YES/NO**
6	Approve the continued exploration of different models of delivery for the programme.	**YES/NO**

Initial Implementation for Tai Aroha Therapeutic Community

Introduction

1. Since October 2007, the number of community-based sentencing options available to the judiciary increased. This led to an increase in the number of offenders in the community requiring rehabilitative interventions. Although the range of rehabilitative options increased, very few programmes focused on the highest risk offender group. Community Residential Centres (CRCs), such as Montgomery House, were originally established to deliver services for high risk offenders in the community but rarely did so, leaving a service gap. In addition, offenders attending the CRCs were on temporary release from prison rather than being permanently in the community.

2. To address these issues, the Psychological Services of the Department developed and tested an intensive residential rehabilitation programme for male offenders serving community sentences.

3. In November 2008, the Executive Management Team (EMT) agreed that this programme would be an open rolling programme with content based on the 300-hour programme delivered in the Special Treatment Units in prison (particularly the Violence Prevention Unit) and the Medium Intensity Rehabilitation Programme. It included a specific focus on the needs of Māori offenders.

Project plan and project team

Objectives

4. The project had three main objectives:
   a. To research, design and develop an 'open' residential rehabilitation programme for high risk male offenders. The programme would be based on best practice principles that have been outlined in offender rehabilitation research and research into open therapy group programmes. It also included a strong reintegrative (or integrative) component.
   b. To design structures and procedures for a 'therapeutic community' and/or 'community of change'. This aspect of the residential programme was developed in parallel with the programme development.
   c. To conduct a pilot and evaluate the programme in its entirety.

5. Given the nature of the high risk offender population, the programme was designed to be delivered by clinical psychologists and a trained programme facilitator.

Programme design phase

6. An advisory group made up of specialist general and cultural advisors was established at the start of the design phase to provide expert advice and guidance to the designers. See Appendix A for membership.

7. The project manager oversaw the design work, which began with a review of relevant literature and resources, and consultation with experienced psychologists in Psychological Services. A clinical psychologist led the design and a programme developer developed the programme. Both were private contractors. A departmental psychologist finalised the pilot draft. The team is listed in Appendix A.

8. A Regional Relationships Manager from the Māori services team gave input at advisory group meetings to ensure that where appropriate, the programme reflected both western and Māori content and process. The advisory group continued to give feedback on the content of the programme until the pilot began in August 2010.

9. The Department's Māori Strategic Plan stresses the importance of considering Māori cultural values, philosophies and practices when developing effective programmes for Māori offenders. The Te Piriti outcome evaluation[2] highlighted the benefits of combining western psychological methods with tikanga. The team agreed that bi-cultural material would be required for male offenders. The inclusion of cultural elements in the therapeutic community and group treatment programme increased the complexity of the therapy approach.

10. The programme was developed module-by-module. The therapeutic community was designed once the core programme was completed. Advisory group members with relevant subject matter expertise reviewed the material. The group met periodically during the design phase to discuss and review the content and address issues as they arose from the design work.

Who is the programme for?

11. The programme targets male offenders assessed as being at high-risk of future serious offending and who are serving community sentences. Most offenders in this target group will have index or historical violent offences[3]; others will be referred because of other forms of serious offending. Suitable community sentences are home detention, supervision, and intensive supervision. Offenders serving parole, temporary release, and release on conditions are not eligible to attend the programme. The suitability (or not) of high-risk offenders serving a community-based sentence depends on the extent that the Tai Aroha programme addresses the offender's treatment needs, the offender's willingness (motivation) and capacity to engage in and benefit from the programme.

12. Although programme participants need to show some willingness and capacity to benefit from the programme, they are also expected to present significant psychological treatment readiness and responsivity challenges. High-risk offenders are generally difficult to engage in treatment and positive change is

[2] Nathan, L., Wilson, N.J., & Hillman, D. (2003). Te Whakakotahitanga: An evaluation of the Te Piriti special treatment programme for child sex offenders in New Zealand

[3] Some high risk offenders serving community sentences may have past convictions or undetected offences involving sexual violence against an adult. It is expected, however, that men with index sexual offences against an adult will receive a prison sentence and thus, under the existing criteria, would be ineligible to attend the programme.

typically slow and hard won (Serin and Preston 2001).[4] One of the objectives of the programme design was to adequately address treatment readiness and responsivity needs while managing the risk that programme members would engage in violent and other antisocial acts while in residence.

13. Some offenders would have already experienced treatment for offending or other related problems (e.g. drug addiction), leading to more variation in their treatment readiness and responsivity needs. For some, attending the programme might be their first significant attempt at change, while others may be referred after relapse (i.e. re-offending after completing another Departmental programme).

Therapeutic community

14. The design of Tai Aroha as a therapeutic community drew on overseas research. While there is little research relating to the effectiveness of therapeutic communities overall, a meta-analysis by Lipton et al (2002)[5] of therapeutic community programmes in correctional settings (predominantly prison-based) found a significant and 'moderate' strength treatment effect - a 10-11% reduction in recidivism outcomes for the therapeutic community group compared with no treatment/treatment as usual. Longer time in treatment correlated positively with effect on recidivism - 6% difference in recidivism outcome between five month and 11 month programmes. In that review, Lipton et al. noted that "enduring change in lifestyle and a positive personal-social identity requires a holistic approach focusing on lifestyle rather than drug abuse, criminality, or any one problem alone, and this takes time" (Lipton et al. 2002:65-66).

15. The design of Tai Aroha therapeutic community was based on the hierarchical model described by De Leon (2000)[6]. In a therapeutic community the entire community is the 'treatment'. Learning occurs through social learning mechanisms, social relationships, the structure of the day, and the different activities, which include group therapy. The aim is to help offenders learn new skills and pro-social values to improve their interpersonal effectiveness.

16. Nine concepts underpin the design of Tai Aroha Therapeutic Community. These are: participant roles, membership feedback, membership as role models, relationships, collective learning formats, culture and language, structure and systems, open communication, and community and individual balance. These concepts are described in detail in Appendix B.

17. At Tai Aroha, community as method includes members taking on various work roles in the community (e.g. administration, cooking etc) and longer-term residents becoming mentors. Regular resident seminars are also scheduled

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[4]. Serin, R. C. & Preston, D. L. (2001). Designing, implementing and managing treatment programs for violent offenders. In G.A. Bernfeld, D.P. Farrington, and A.W Leischied (Eds.) Offender Rehabilitation in Practice: Implementing and evaluating effective programmes, p 205 - 221. Chichester: John Wiley & Sons.

[5] Lipton, D., Pearson, F., Cleland, C. & Yee, D. (2002). The effects of therapeutic communities and milieu therapy on recidivism, In McGuire, J., Offender Rehabilitation and Treatment: Effective Programmes and Policies to Reduce Re-offending McGuire, Chichester: Wiley, Pgs 33-77; Rawlings, B. (1999). Therapeutic communities in prisons: A research review, Therapeutic Communities, 20.3, 177-193.

[6] De Leon, G. (2000). The therapeutic community. Theory, model and method. New York: Springer Publishing Company Inc.

18. Scheduled daily activities include morning and evening house meetings, attendance at core module group treatment four mornings a week, a skills module two afternoons a week plus homework assignments, culturally- based activities, resident seminar preparation and presentations, attending a gymnasium, meal preparation and clean up, shopping outings, some free time, and self-directed preparation for the upcoming week. Reintegration planning, external education-based training and agency seminars, weekend adventure- based activities and whanau visits and contact are also structured into the week.

Phases of the programme

19. The therapeutic community residential format required full residence (24 hours, 7 days a week), and on average participants were expected to stay for 14 to 16 weeks. This allowed them to transition to full regular community living over the course of the programme. Programme phases included:

    Phase 1: Orientation, approximately 3 weeks. Includes visits and initial meetings before entering full residence (depending on cultural procedures and processes established at the residence). No leaves given at this stage unless on compassionate grounds.

    Phase 2: Full residence, approximately 7 or 8 weeks. Includes only structured contact with family/whanau during set contact time and only structured staff supervised outings, either individually or with the group.

    Phase 3: Transition/Bridging, approximately 4 or 6 weeks. Continues to live at the residence but has unsupervised day leaves and weekend leaves.

    Phase 4: Through-care – 6 weeks -minimum criteria for exiting from this component; option to continue on voluntary contract. Full regular community living but ongoing structured contact with the programme such as attendance at relapse prevention/maintenance meetings.

20. A Case Management Team (CMT) comprising the Principal Psychologist (Hamilton Office), House Manager and a Community Probation Officer is an important quality control mechanism for Tai Aroha. The CMT's functions include:
    a. determining participant progress and keeping key staff and agencies informed about participants' performance
    b. providing a formal venue for addressing non-performance
    c. raising concerns about participants and highlighting any relevant therapeutic issues
    d. identifying dynamics for and between participants that programme staff need to address.
    e. making decisions about leave and ensuring that a comprehensive safety plan has been developed to help residents manage potential risks
    f. deciding consequences when residents break house rules
    g. providing a venue for participants to voice and address concerns.

Group treatment programme

21. The Tai Aroha group treatment programme also drew on overseas research[7], which has found that the most effective treatment programmes for reducing re-offending adhere to the principles of risk, need and responsivity[8].

22. The programme was designed to target: antisocial attitudes and offence related thinking styles, antisocial and criminal associates, (often involving gang membership and family ties), emotion and behaviour self-regulation difficulties, relationship problems (marital and family), impaired self-management and/ or problem solving skills, and alcohol and drug abuse.

23. In line with best practice, the Tai Aroha programme is based on cognitive social learning theory and relapse prevention. It encourages offenders to use existing (and new) pro-social skills to manage relapse prevention plans. Elements of dialectical behaviour therapy (DBT)[9] are also incorporated into the programme. DBT is a cognitive behavioural approach for treating individuals with severe emotional and behavioural dysregulation (including chronic suicidality, intentional self harm, and extreme and problematic impulsive behaviour). While these behaviours tend to be prevalent among women offenders, male offenders can also exhibit them. DBT uses strategies to enhance self-regulation, including targeting personal and environmental factors that reinforce maladaptive behaviours and prevent the development of new skills. It focuses on developing skills in emotional regulation, thought and behaviour, and aims to increase adaptive behaviours and "dialectical" (balanced) thinking, emotions and behaviours.

Rolling aspect

24. The Tai Aroha Programme has open group membership with new residents joining the programme as former residents exit through graduation or non-completion. The need to get the best from the open group model (e.g. having an individualised needs-based focus and progression, and programme members using their learning to help newer members or consolidate their own learning) is central to the Tai Aroha Programme design. The programme also aims to mitigate any negative impacts from rolling group membership on:

    a. the development of group cohesion
    b. the ability to get the best from group processes with high-risk offenders
    c. getting the 'right' balance of process and content with high-risk offenders
    d. length of treatment.

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[7] Andrews & Bonta (2010). The psychology of criminal conduct, fifth edition. New Providence NJ: Mathew Bender & Company Incorporated.

[8] The risk principle asserts that treatment intensity should match the level of risk, with the highest risk offenders receiving the most intensive treatment. The need principle relates to targets for treatment, and proposes that when certain dynamic risk factors (also called criminogenic needs) are altered through intervention, re-offending should reduce. The responsivity principle relates to the characteristics of programme delivery, and proposes that the most effective interventions are based on social learning and cognitive behavioural principles. It also states that the style of treatment should match the learning styles of offenders, and take into account their capability and characteristics.

[9] Linehan, M. M (1993). Cognitive behavioural treatment of borderline personality disorder. New York: The Guilford Press.

25. Each of the core modules has assignments (e.g. understanding offence pathway, developing perspective taking) which the men work on in and outside sessions. The assignments are reviewed by the group critiquing each other's progress and deciding whether someone has done enough to progress to the next assignment. Group sessions focus on session content, and process issues brought by participants. Completion of the programme depends on participants completing the required assignments and achieving the programme learning objectives.

26. Adopting an open programme model means adopting learning-focused rather than time-based progression through the programme. Research on the optimal length of treatment with high-risk offenders suggests that treatment duration is positively, but not perfectly, correlated with effectiveness. Although providing sufficient treatment is important, simply providing longer treatment does not necessarily bring success (see Polaschek & Collie 2004). [10]

27. Factors considered in deciding on the length of treatment for Tai Aroha included:

    a. The amount of treatment received in a given day/week. With Tai Aroha treatment occurs 24 hours a day, 7 days per week. This affects intensity of treatment more than overall duration.
    b. Providing longer treatment has significant implications for the number of offenders who can be treated by the programme over a year.
    c. Treatment at Tai Aroha is one phase or episode in an offender's rehabilitation and is augmented by through-care in the community.
    d. Through-care programming is important and traditionally a weak area of reintegration.

28. The preferred length/ duration for stay at Tai Aroha was set at 14 – 16 weeks.

Final programme details

29. Tai Aroha is based on therapeutic community principles articulated by De Leon (2000)[11] and includes a cognitive behavioural therapeutic group treatment programme for high-risk male offenders. The programme has 10 modules:

    a. Assessment
    b. Orientation (includes mindfulness and distress tolerance)
    c. Aspirations
    d. Life history and self-evaluation
    e. Acceptance of responsibility/ restructuring problem and offence-related thinking
    f. Offence pathways
    g. Emotional management
    h. Substance abuse management
    i. Relationship management
    j. Relapse prevention.

30. Documentation produced in the design phase includes:

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[10]; Polaschek, D. & Collie, R. (2004). Rehabilitating serious violent adult offenders: An empirical and theoretical stock take, Psychology, Crime and Law, 10.3, 321-334.
[11] De Leon, G. (2000). The therapeutic community. Theory, model and method. New York: Springer Publishing Company Inc.

a. The design document
b. A review of “what works”
c. Therapeutic community (structures and processes)
d. A detailed programme manual outlining the contents of each session including facilitator notes
e. Rationale and theory for components
f. Guidance aspects of programme content
g. Group psychotherapy skills
h. Assignments for participants to use during the programme
i. Instructions for initial assessment phase of programme
j. Training package for house staff, psychologists, facilitators
k. Tai Aroha Policy and Procedures Manual
l. Resident handbook

Pilot phase

30. Tai Aroha residence is based in Hamilton and was previously known as Montgomery House. The house was redecorated and refurbished in 2010. This project was managed by the Director of Psychological Services in conjunction with Tregaskis Brown Ltd. The Policy and Procedures Manual informed all aspects of the operations of the house, including its function as a therapeutic community.

31. Tai Aroha pilot programme began on 9 August 2010 and was due to be completed on 31 March 2011. However issues relating to the implementation of the pilot meant that this deadline was not met and an extension to 31 December 2011 was sought and approved The issues included:

    a. unsuitable referrals
    b. decreased rate of referrals over the Christmas period
    c. participant attrition rates
    d. staff difficulties in working according to the philosophy of the therapeutic community
    e. staff turnover (house and therapy staff) and core programme roll out issues.

32. Before Tai Aroha opened, the National Manager STU Development prepared a detailed communication plan, identifying stakeholders, analysing their influences, interests and attitudes towards the project outcomes and outlining a process for engaging with them. Meetings were held with stakeholders to build and strengthen relationships, provide regular forums for discussion and ensure that information was passed on. The communication plan is set out in Appendix C.

33. All house staff, psychologists and the programme facilitator received training, which was developed by the Senior Psychologist, based on best practice principles in offender rehabilitation. It included information on therapeutic community principles, social learning and cognitive behaviour therapy principles, relapse prevention, and the skills therapeutic and house staff needed for the programme.

Group programme

34. The Tai Aroha core programme was designed to be delivered by two co-facilitators four mornings a week. A programme facilitator was seconded to co-facilitate with a departmental psychologist, who had experience in group programme facilitation.

35. Psychologists from Hamilton Psychological Services co-facilitated afternoon sessions, two days a week. The afternoon sessions delivered more core component delivery and participants practiced behavioural coping skills.

Obtaining appropriate referrals and assessment

36. Tai Aroha caters for male offenders, who are serving community sentences and have been assessed as being at high-risk of serious re-offending (RoC*RoI 0.7 or greater). This includes men with index or historical violent offences. Suitable community sentences are home detention and intensive supervision. Offenders must be aged 20 years and over (but those aged 17–20 years are considered on an individual basis). They must be capable of remaining alcohol and drug free throughout the programme (and are subject to drug testing), and have at least six months remaining on their sentences.

37. Most referrals for the Tai Aroha pilot were sourced pre-sentence from the Community Probation Services. Subsequent referrals were made by Psychological Services and occasionally by Prison Services, although enquiries have been received from other sources.

38. Men identified as suitable underwent a comprehensive psychological assessment covering social factors, offending and related problems areas, and a thorough assessment of criminogenic needs (dynamic risk factors) that are likely to lead to re-offending and provide specific targets for intervention. Assessment information was obtained through:
    a. File review
    b. Clinical interview (Including assessment of dynamic risk factors and responsivity barriers)
    c. RoC*RoI
    d. Additional psychometric instruments as outlined in Appendix D.

39. This assessment was intended to be part of the standard assessment process once the programme is rolled out to business as usual.

40. Initially, five men were identified as suitable candidates and were accepted onto Tai Aroha. Four identified as Māori, and one as Cook Island Maori. Ages ranged from 19 to 28 years. Their convictions included possessing and supplying cannabis, property offences, breaches of conditions, breach of intensive supervision and wilful damage.

41. The programme pilot began on 9 August 2010 with the five participants. One client whose motivation diminished asked to leave the programme; another absconded and was exited, leaving three participants.

42. Between 9 August 2010 and 31 December 2011, 34 men started on the programme. Of those 12 successfully completed, 15 were exited and three pulled out voluntarily.

Pilot group programme delivery

43. Treatment providers negotiated delivery roles for each component of the programme and for the morning and afternoon sessions. Typically, the responsibility was shared equally between co-facilitator pairs for the delivery of all aspects of the programme. The programme facilitator took main responsibility for delivering the cultural component assisted by the psychologist facilitators.

44. Facilitators for the core (morning) and afternoon programme met weekly to discuss session content for the following week. They wrote a daily plan of what was to be covered in each session. Facilitators met at the end of each group session to debrief, and discuss what issues needed to be addressed in the following sessions. They also discussed the rolling format and how to best deliver this. All programme facilitators attended supervision on a weekly basis.

45. The intention for the rolling/ open group therapy format was that all participants would begin with the orientation component. While they would be physically in a group with participants doing other components, they would still need to move through the modules sequentially.

46. Some of the afternoon sessions were dedicated to helping participants with aspects of their orientation and learning the basic cognitive behavioural skills they would need to be able to function adequately in the core and afternoon sessions.

Results from the pilot

47. Results from the Tai Aroha Pilot were drawn from several sources:
    a. The project manager visited Tai Aroha on a number of occasions. On each visit he observed the daily functioning of the house and interviewed house and therapy staff and residents
    b. Therapy staff kept comprehensive notes and gave feedback on therapeutic community aspects of Tai Aroha and group treatment including the programme content, group processes and offender progress.
    c. House and therapy staff completed questionnaires relating to the pilot,
    d. Tai Aroha underwent a quality monitoring process in May 2011[12]. Final documentation from the quality monitoring was available for this report.

Offender referrals

48. Before the pilot began, the Principal Psychologist from Hamilton Psychological Services met with Community Probation Service and judiciary staff to explain the

[12] A STU Principal Psychologist conducted the audit and compliance component of the monitoring. The therapeutic community and programme integrity monitoring was conducted by an independent monitor experienced in the operation of corrections-based therapeutic communities and in the delivery of therapeutic rehabilitation programmes within such communities

service description for Tai Aroha, including eligibility criteria. However, there were ongoing difficulties with insufficient referrals and the house manager, and a liaison probation officer, developed a 'road show' and made regular visits to Hamilton, Rotorua, Tauranga, Paeroa, and Taumaranui Community Probation Services to provide information about the programme and encourage referrals. The Probation Officer also sent out an email about the programme to all staff at Community Probation Services. .The judiciary and some Probation Services teams attended Tai Aroha open house days to learn more about the programme. A Senior Communications Advisor kept up regular communication by including articles in the Connect newsletter.

Therapeutic community

49. In the early stages, it was expected that the functioning of the house as a therapeutic community would be inconsistent. This proved to be the case with few of the nine principles being translated into practice. Crucial structures and systems relating to full weekly schedules were in place although it took some time to organise some activities (e.g. off-site adventure-based activities) The structured week schedule is included in Appendix E.

50. A structured induction process was developed and implemented for new entrants into the therapeutic community. Induction procedures familiarised participants with the unit facilities, culture, routine, health and safety matters, staff members, and the various aspects of assessment and therapy. Staff reported that this process helped new participants reduce their anxiety levels and develop realistic expectations about the programme's outcome. It was also an opportunity to address responsivity barriers (e.g. lack of motivation to change unhelpful attitudes and behaviours). The key induction activities and staff member responsibilities are outlined in Appendix Table F

51. House staff reported that the buddy system was operational but this was mainly reflected in sleeping arrangements, with the more senior residents sharing rooms with junior residents to provide support and guidance during the programme. When new residents struggle on the programme, they are teamed up with Phase III residents.

52. As the pilot progressed, some areas of the therapeutic community developed. Schedules showed that the psychological, emotional, spiritual and whanaungatanga needs of individuals and the community were being addressed through out of house activities such as gym visits, shopping and adventure-based therapy. All residents had duties to perform on a rotating basis (e.g. helping with cleaning, preparing meals, washing, gardening, etc). Staff had regular handover routines, including written records of resident and house activities. They met before each shift change to debrief, hand over and identify any issues for residents and the house.

53. In accord with therapeutic community principles several forums were available to residents and house and therapy staff to influence the life of the therapeutic community. They included daily meetings, opportunity for daily reflection and motivational and problem solving forums.

54. Formal processes including case management reviews and the determination of consequences, particularly for breaking the therapeutic community's rules, were in place,

55. The four phases of the programme included privileges and sanctions. Successful progression through each phase led to additional 'freedom'. Transgressions led to restricted freedom or an assignment and seminar related to the transgression.

56. While Tai Aroha is in its infancy as a therapeutic community, the principles and values were evident in the physical environment (posters were on display in the group room and public areas), and in the rituals carried out at the house.

57. Celebrations (e.g. birthdays, graduations) and rituals (e.g. seating, language, karakia) reinforced house and individual progress.

58. Some therapeutic community concepts such as member roles and membership feedback were less well established. Residents expressed ambivalence and inconsistently applied role modelling and feedback. They attributed this to the staff's expectation of maturity on the one hand, but a lack of scope to express it on the other.

59. Staff believed that quality professional relationships between staff and residents were pivotal in change taking place. Residents, on the other hand, were suspicious about authority and mistrusted staff. House staff tended to fall back on punitive and regimented ways of interacting with residents. Some staff had difficulty communicating with each other but the quality of interaction improved following supervision and training around more helpful ways to engage with each other and residents.

60. Community and individual needs have to be balanced. This means that the community has to have a capacity for self- criticism by examining the behaviour and attitudes of staff as well as residents. Staff and residents, are responsible for confronting, affirming and correcting the community. While staff were encouraged to give appropriate feedback to residents, the residents found it more difficult to give constructive feedback to staff. This improved with the implementation of democratically-appointed combined community meetings where the feedback process was reciprocal. The meetings also provided a reliable forum for managing tensions and disputes and facilitating a sense of kinship and connection between residents and between residents and staff.

61. Apart from group therapy, jobs and some meetings and some recreation, other collective learning formats such as education and training and seminars, were not in place at the start of the pilot. Over time daily morning and evening house meetings were established along with resident seminars, delivered inconsistently. For their seminars residents were required to prepare and present seminars or workshops relating directly to therapeutic community principles, core programme skills, resident interests and hobbies. Preparing and presenting the seminars was sometimes a consequence of breaking house rules.

Group Therapy Programme

62. Individual treatment plans should have been developed for each participant from assessment information. The plans document how specific criminogenic needs will be targeted in the programme. Therapy staff reported that treatment plans were developed inconsistently in the early stages of the pilot but this improved over time.

Programme content

63. Tai Aroha therapists found the programme content sound and session and programme objectives clear. They adhered to the manual content as it was intended to be delivered but did note some difficulties:
    a. It was sometimes difficult to get through programme content because new residents needed a lot of processing time.
    b. Therapists suggested that the men should attend a separate orientation component on their first day at Tai Aroha. House staff with suitable skills could facilitate the component with the help of residents in advanced phases of the programme. Resident seminars have also been used for orientation purposes.
    c. Programme participants found it hard to understand and complete the assignments that had been prepared pre- pilot phase.
    d. It was originally intended that Tai Aroha have assignments but not 'workbooks' as provided in other programmes (e.g. MIRP, STUs). This was identified as an issue as programme participants received no handouts or other material.

Morning (core programme) and afternoon therapy sessions

64. In the morning sessions, issues were processed as they arose and core concepts and skills were introduced. When new men attended the programme, morning therapists would re-introduce core concepts and skills. This became repetitive and participants complained that they did not have the opportunity for new learning.

65. The afternoon sessions were designed to provide more 'in the moment' core skills training and practice (e.g. men role-played problem situations, using new skills; perspective taking, DEAR). Therapy staff said that too much processing took place in the afternoon, leaving little time to practice skills.

66. Participants had problems focusing in afternoon sessions. Therapy staff noted that when men attended both morning and afternoon sessions, they had five hours of therapy in one day, which was a lot of hours when the structure of the sessions was similar.

Process issues

67. Motivational and engagement levels varied across the programme. Behaviours that interfered with therapy (e.g. resistance, conflict) emerged across the

programme. Group function and dynamics also varied depending on whether the group was in a storming or working phase).

68. The rolling aspect of the programme meant that following an induction process, participants were to complete therapy programme content in sequence, while at addressing process issues. Therapists and participants at a more advanced level would help newer participants in the therapeutic process. However, therapists found it difficult to decide how to facilitate this format.

69. Therapy staff reported that the programme operated in a 'storming phase more often than not'. They lost time and felt frustrated from having to revisit basic orientation skills when a new resident attended group. Some of the more established residents felt "stuck" or were frustrated because they didn't learn new material. Such difficulties appear to be common in rolling/ open group therapy programmes.

70. Despite these caveats, residents engaged in the process and generated a lot of discussion about content and process issues. They contributed to relevant games, artwork, role-plays, video analyses, poster work and group presentations. They told their autobiographical story either as a narrative, a poem or artwork. All group members completed this work.

Changes made to the programme

71. As a result of the difficulties outlined some changes were made to the programme.

Session content

72. Completing session content requirements - therapists took a 'key learnings' approach condensing the material based on group responses. The 'key learning' points were always in line with the session aims in the manual.

73. Assignments prepared pre-pilot phase - these were revised and staff found the newer versions much clearer and more user friendly.

74. Workbooks were developed.- the workbooks in their current form were hard to manage with the rolling group format.

Morning (core programme) and afternoon therapy sessions

75. Re-introducing core concepts and skills - this was transferred to afternoon sessions.

76. Too much process occurring in afternoon sessions - more attention was placed on skills practice.

77. Participants losing focus in afternoon sessions - the therapy team reduced the time spent in core and skills groups by 15 minutes each group and provided a

longer break between therapy groups and other scheduled activities. Afternoon sessions were changed to focus mainly on skills training and practice.

78. The programme facilitator developed a skills ‘passport’ which had to be signed off in order for men to progress through the programme. For participants, this was a very useful and enjoyable resource and a great motivation to think about and use their skills.

Process issues

79. Variability in motivational levels and engagement: Issues relating to motivation, engagement, group dynamics, therapy interfering behaviours and group conflict, were openly discussed in the group and actively managed by the facilitators, with contributions from group members.

80. Process issues were addressed as they arose. Facilitators used strategies such as exercises and Socratic questioning, to focus the group on the group process. The group was encouraged to recognise, examine, and understand process. Group members were encouraged to study their interactions, relate these to what they were learning and integrate their experiences. Attention to process issues will be a necessary part of the business as usual delivery of Tai Aroha. Where possible the programme content has been designed to allow this to occur

81. The structure of the rolling aspect was altered: New participants continued to attend orientation with the group and undertook some orientation exercises as homework but they began with the module that the rest of the group was working on. While this changed the starting point, therapists recognised that offenders would still work through components in sequence to complete all modules.

82. Group functioning in the ‘storming phase’: Over time, the entry of new men onto the programme became less problematic and members settled into the new group dynamic relatively quickly. It is reasonable to assume that improvements in functioning were in part a consequence of therapists becoming more skilled in facilitating the rolling aspect of the programme.

83. Therapy staff thought that the rolling aspect of the programme is crucial. It helps offenders develop important life skills as they will experience constant change in life. In both therapy and the house, staff emphasise that participants need to be able to make changes while accepting themselves and others and their world as they are in the moment (Linehan, 1993).

Other problems identified

84. Staffing capacity: At the beginning of the pilot, the main therapists were facilitating both morning and afternoon sessions. Subsequently, Hamilton Psychological Service provided two therapists for the afternoon sessions. The question of whether programme facilitators or psychologists should facilitate these sessions needs to be resolved. Using psychologists from the Hamilton Office was a drain on resources and different models of delivering the programme need to be explored.

85. Psychological staff turnover: The psychologist who began the pilot, resigned in November 2010. A psychologist who had been facilitating the afternoon therapy sessions also resigned, while another therapist had a significant period away from the programme due to injury. While losing staff was disruptive, the places were filled relatively quickly. This allowed more consistency in the group programme delivery.

86. House staff turnover: Staff turnover in the house was substantial and partly due to the appointment of inappropriate staff. This disrupted the programme and other staff and residents, and was concerning given the programme's pilot status.

Other sources of information

Staff questionnaire responses

87. A self-rating questionnaire was used to gather information from staff on the Tai Aroha programme. The questionnaire had five sub categories: cultural responsivity, house facilities and services including induction, activity and work spaces, medical and dental services and food quality, therapeutic community as method, and reintegration planning. Detailed results are reported in Appendix G.

88. Staff ratings were relatively positive across all categories. They rated:
    a) core programme components as very/extremely useful in helping programme participants develop their pro-social coping skills.
    b) therapeutic community as functioning to a very good standard
    c) cultural responsivity as indicating that Maori values were well embedded in the structure of Tai Aroha
    d) reintegration planning as useful but needing improvements
    e) the house and facilities as generally adequate although work and activity spaces were considered too small.

Resident questionnaire responses

89. A self-rating questionnaire sought Information from residents on the Tai Aroha programme. The questionnaire looked at five sub categories relevant to Tai Aroha: general reflections about the programme, reflections on the therapeutic community, relationships with other participants, programme and house staff, personal changes the participants made, and cultural experience and identity.

90. Only four men completed the questionnaire. While statistical analysis was not possible with so few responses, some patterns were identified. Respondents rated the core programme as helpful to very helpful in helping them to reduce their risk of re-offending and preparing them for their return to the community. They thought that being part of a therapeutic community was important in that residents and staff worked together towards a crime-free and more positive lifestyle. They generally had supportive and positive relationships with other participants, group therapy staff and house staff. All four respondents said that the programme had helped them develop more pro-social attitudes and

behaviours, including improving their relationship and communication skills. Their ratings also indicated that the programme met their cultural needs.

Statistical analyses of psychometric instruments administered to offenders

91. A comprehensive assessment of offenders included the use of psychometric instruments designed to assess (1) risk of recidivism (2) risk of violent recidivism (3) antisocial attitudes (4) treatment responsiveness and (5) general responsiveness. A report by A Tamatea (April 2012) outlining psychometric data results is included in Appendix H.

92. As at April 2012, 38 residents had attended the programme, with 13 completing it successfully; 20 were exited and five were currently in treatment. Seventy-four percent of the residents were Maori. This is a higher proportion than in the broader community offender population (45%). Fifty-eight percent of the residents claimed gang membership - general offender population (8%).

93. Analyses of risk indicated that RoC*RoI scores for the residents were significantly higher (M=0.73) than for the general offender population (M=0.57) and for violent offenders (M=0.64)

94. On the Violence Risk Scale (VRS), static and dynamic risk scores across a range of violence risk factors were notably higher for the residents than for a normative sample. Common dynamic risk factors for violence included violent lifestyles, criminal attitudes, peer association, management of negative emotions, substance abuse, impulsivity and recurring violent patters. Low level factors included institutional violence and mental illness.

95. Overall attitudes to violence were measured by the Criminal Attitudes to Violence Scale (CAVS). These indicated a high level of endorsement of pro-violence beliefs, similar to that of the original New Zealand violent offender development sample. Programme completers endorsed less pro-violence beliefs.

96. The Psychological Inventory of Criminal Thinking Styles (PICTS) scores showed that the residents had criminal thinking styles expected in an offender group. This included proactive and reactive criminal thinking, and cognitive and attitudinal patterns consistent with a criminal belief system. Programme residents' responses showed reduced endorsement across these domains. A Fear of Change scale suggested that the residents were willing to contemplate behaviour change and a post-treatment elevation on the scale for completers suggested the need for ongoing support after completing the programme.

97. Residents' treatment readiness and responsivity were measured on the Treatment Readiness Responsivity and Gain Scale (short version TRRG:SV). Scores fell within a normal range for an offender group and showed that inconsistent motivation, anger and pro criminal views were characteristic treatment engagement issues for this group. Post-treatment scores indicated improved readiness for treatment across all items, improved responsiveness and perceived positive benefits from treatment.

98. The Millon Clinical Multiaxial Inventory – III (MCMI-III) screened for personality and clinical pathology that could affect treatment readiness. Residents had high scores for antisocial personality traits, substance and alcohol abuse and anxiety. Post-treatment scores showed reductions in behaviours associated with personality pathology for antisocial, sadistic and negativistic traits, all likely to impact on violent behaviour. Reductions in behaviours associated with severe personality pathology (schizotypal, paranoia and borderline) were also observed in completers.

99. Residents' impression management and social desirability style were measured by the Paulhus Deception Scale (PDS). Scores were considered typical for an offender group but there were fewer efforts at impression management than among comparative prison and non-offending populations. Completers revealed a tendency towards social conventionality.

Conclusion

100. Overall, demographic factors and risk/need variables showed that appropriate offenders attended the Tai Aroha programme. Positive indicators across all measures suggested that they benefited from attending. Post-programme support in addition to standard services was also critical in helping offenders maintain their treatment gains.

101. The high proportion of residents identified as having personality disorders suggested that therapists and house staff will need training to help identify and manage personality issues.

Recommendations

Recommendations are that the Department:

1. Notes that Psychological Services has completed the design, initial implementation and evaluation of the Tai Aroha Therapeutic Community Programme for high-risk male offenders.

2. Notes that changes made to the programme during the initial implementation phase have been incorporated into the existing programme.

3. Agrees that the programme should now be considered business as usual.

4. Approves the ongoing running of Tai Aroha as a residential programme for high-risk offenders serving community-based sentences.

5. Notes that the following recommended changes will be implemented
   - Development of workbooks and handouts
   - Further development of the reintegration planning model
   - Training developed and delivered for managing offenders with severe personality disorders.

6. Approves the continued exploration of different models of delivery for the programme.

Appendix A

Tai Aroha Project Group Members

Design Team

Lucy King, project manager, Principal Advisor, Psychological Services
Rachael Collie, programme design, private contractor
Craig Williams, programme development, private contractor
Nikki Perkins, programme reviewer, psychologist, Psychological Services

Advisory Group Members

Nikki Reynolds, Director, Psychological Services
Glen Kilgour, Principal Psychologist, Psychological Services, Hamilton
Gordon Sinclair, Manager Programmes, Policy and Practice,
Jim Van Rensburg, Principal Psychologist, Te Piriti Special Treatment Unit
Robert Paramo, Senior Psychologist, Psychological Services, Wellington
Rochelle Connell, Senior Advisor, Rehabilitation and Reintegration Services

Cultural Advisor

Te Ariki Pihama, Regional Relationships Manager, Rehabilitation and Reintegration Services, Hamilton Central Regional Office

Appendix B

Community as Method - Nine Essential Concepts

1. *Participant roles:* Individuals contribute directly to all activities of the daily functions in the therapeutic community. This includes engaging in a variety of social roles (e.g. peer, friend, coordinator, tutor). These roles provide learning opportunities and require members to be active participants in the process of changing themselves and others.

2. *Membership feedback*. A primary source of instruction and support for individual change is peer membership's observations of and authentic reactions to the individual. Providing ongoing feedback is the responsibility of all participants. Whether positive or negative, membership feedback must be constructive and expressed with responsible concern.

3. *Membership as role models*. Each participant must strive towards being a role model of the change process. In addition to their responsibility to provide feedback, members must also provide examples on how their peers can change.

4. *Relationships*. Relationships in the therapeutic community are used to foster change and personal growth in various ways. They can facilitate engagement, develop trust, encourage emotional expression (as it is safe to do so) and self learning and teach interpersonal skills. Relationships developed in treatment often become the basis for the social network needed to sustain recovery after treatment ends.

5. *Collective learning formats for guiding individual change*. The experiences needed for change and personal growth unfold through social interactions. Therapeutic activities, education and training occur in groups, meetings, seminars, job functions and recreation. The individual engages in the process of change predominantly with their peers. These formats incorporate the power of groups and teams in facilitating learning and change.

6. *Culture and language*. The therapeutic community is a culture of change. Celebrations, traditions, rituals and ceremony are used to enhance community cohesiveness and reinforce individual progress. The concepts, beliefs, values, norms and philosophy that guide treatment, change and right living are expressed in the unique language of the therapeutic community. Learning in this 'language' reflects assimilation into the culture of the therapeutic community and the gradual process of identity change.

7. *Structure and systems.* The organisation of work, job functions, chores and prescribed procedures maintains the daily operations of the community. The activities strengthen self-help practices and are vehicles for teaching self-development. Learning and growth occur not only through specific skills training but also in adhering to the orderliness of procedures and systems, accepting and

respecting supervision, and behaving as a responsible member of the community upon whom others depend.

8. *Open communication.* The public nature of shared experiences in the community is used for therapeutic purposes for the individual and others. The private inner life of the individual is important to the change process, not only for the individual but for other members. Decisions about when and how private issues are publicly shared are always at the discretion of the individual participant. Especially sensitive private issues (child abuse, sexual preference, healthy status) may be shared first with a therapist who preserves confidentiality but may, as appropriate, encourage some disclosure in the group (provided it is safe for the participant to do so). However private issues relevant to the cardinal and house rules of the community (e.g., current drug use, stealing, lending money, criminality, violence etc) must be publicly shared to sustain the safety, credibility and health of the community.

9. *Community and individual balance.* The purpose of the community is to serve the individual, but the relationship between the individual and the community is reciprocal. The needs of the community and of the individual must be balanced to sustain the member's positive perceptions of the community as authentic and credible. This requires that the community has a capacity for self criticism through continued self examination of the behaviour and attitudes of staff as well as residents. The membership itself, staff and residents, has the responsibility to confront, affirm and correct the community.

Appendix C

Tai Aroha Communication Plan June 2011

Date listed	Stakeholder	Importance to the project	Current status of the relationship	Objective for this relationship	Actions to achieve the objective	Who	Review date
17 June 2011	Probation officers (Ham, Rot, Manukau)	Key player. Critical to the identification and referral of clients and liaison with the Courts at a local level.	Poata Watene (PW) with the support of the probation liaison officers is currently completing a road show about Tai Aroha to drum up interest and referrals for the programme. The response to this has been very positive. We have largely established a productive and positive relationship with probation	Maintain enthusiasm and positive regard for the programme and generate sufficient referrals for programme maintenance and integrity.	Continue developing strong and positive relationships with probation liaison officers achieve a high level of referrals for the programme	PW, Juanita Ryan (JR), Nigel Leaver (NL) PW, NL, JR	17 September 2011 Weekly
17th June 2011	Judges	Key Player Programme will require Judges to support via appropriate sentencing options.	JR has met with Judge Connell who has indicated enthusiasm for the philosophy of the programme and suggested that the Judges are invited to the whare. A verbal offer was made for them to attend the whare for lunch on 8th July 2011. This will be followed up by a written invitation.	Reliably inform Judges about the status of the programme so they can make relevant sentencing decisions when recommended.	Send out formal written invitation to the whare (to be done on 17 June 2011) Meet with Judges to show them around the whare and share the programme philosophy with them.	JR JR, PW, NL, psych team, whare staff,	15.06.11 11.07.11

17 June 2011	Hamilton Mayor	Moderate May provide a calming voice if the media direct their attention to the programme.	Tai Aroha is known to the previous Mayor as the programme was discussed with him at the outset of the pilot by PW, Glen Kilgour (GK) and Heather Mackie (HM), however, the Mayoralty has shifted hands and it is uncertain how much the current Mayor knows about the programme.	To inform the current Mayor about the programme and engage her support for the programme.	Develop some key messages Arrange a briefing meeting with the Mayor (her office to be contacted by 8th July 2011)	JR & PW with assistance from Rebecca Powell (RP; Comms)	5 August 2011
17 June 2011	Local MPs	Moderate May be politically motivated to contribute to discussions. Thus, some key messages and an invite to the re-launch may help to engage them in a positive manner.	Tai Aroha is largely known to the MPS, two National MPs (including Tim Macindoe) have visited the whare on advice from neighbours and been informed about the programme. Tim's response to this information seemed positive. However, the MPs are probably largely not emotionally or politically invested in the programme. It is, however, an election year so the programme may feature more saliently on their agendas once brought to their attention.	To engage their interest in a supportive manner.	Develop some key messages Arrange a briefing meeting (their offices to be contacted by 8th July 2011)	JR & PW with assistance from RP.	August 2011

22 June 2011	Pita Sharples	Moderate/High Given his interest in the Corrections field and similar programme the Minister has potential to be a strong advocate.	The initial intent was to ensure that the minister was made aware of Tai Aroha. We need to clarify whether this happened.	Invite the associate minister to visit Tai Aroha. This might be particularly relevant given his current focus on The Whare Oranga Ake and that there may be ways that Tai Aroha staff/management this imitative.	Develop some key messages Provide briefing via Comms unit and in mid July invite the Associate Minister to visit Tai Aroha early August	JR, PW, and Te Ariki Pihama (TP) with assistance from RP.	11July 2011
22 June 2011	1. Tainui Iwi 2. Anaru Tamehana 3. Ngati Wairere 4. Ngati Mahanga	High 1. Tainui have expressed support for the programme. They also own the land which they are leasing to the Dept with the lease expiring 27 February 2012. The department is however, currently in negotiations to obtain a new lease. 2. Anaru as the Tumuaki has considerable influence on a tribal and political level	1. The Department is currently in negotiations to obtain a new lease with Tainui. Negotiations are proceeding well 2. Anaru is on the Tai Aroha advisory committee which meets bimonthly and this helps to ensure that relevant iwi representatives are well informed of the programme 3.4. – Ngati Mahanga are taking an active role with respect to consultation particularly around tikanga within the whare. We need to work to become more actively involved with	Keep informed and maintain support for project. To continue to engage and negotiate with a particular focus on extending the lease.	To continue to provide regular updates via Anaru's involvement on the advisory committee Invite Tainui representatives to graduation ceremonies Participate in the poukai with the intention to promote the programme.	PW, TP, GK and JR	30 September 2011

		and also has a past involvement with Monty house 3/4. Ngati Wairere and Ngati Mahanga as Mana Whenua of Hamilton play a key role in the support of the new whare embracing effectiveness with Maori and providing consultation/advice as needed	Ngati Wairere.				
22 June 2011	Te Runanga o Kirikiriroa	Low – but a good potential ally.	They have some good reintegrative related programmes and a gym – we are currently accessing the gym and feedback from residents is that they are being well supported with their fitness goals.	Explore opportunities for further co-operation.	To continue utilizing gym Explore other potential ways we could work together (e.g., quitting smoking programme, nutrition and health programme) effectively	PW, Tutapu Pere (TuP), Graham Driver (GD)	31 August 2011
22 June 2011	Media	Could vary depending on whether they pick up on and target the programme as newsworthy. May be more likely given it is an election year.	Not currently active although the Waikato Times has run stories on the programme (positive and neutral in past years)	Media report positively about Corrections' efforts to treat community-based offenders	Develop key messages and identify lead in the relationship (probably Nikki Reynolds - NR). Decide on media strategy (e.g., contact directly or wait for contact and respond)	Comms advice/ JR, PW/Alison Thom/Katrina Casey	Early July Early July

22 June 2011	Neighbours & Community	Key player	In the past neighbours have been generally supportive although small numbers were openly hostile. Justin Vodane is the neighbourhood spokesperson who PW and staff regularly catch up with. Staff have been responsive to feedback from neighbours about minor issues/concerns and this seems to have contributed to being able to maintaining positive relationships.	Maintain support from neighbours and clear lines of communication particularly with Justin Vodane so we can address any concerns/ mis-information promptly if they arise.	Develop key messages with regard to the possibility or remaining at Anglesea Street. The lead in this relationship is PW. Discuss the above option with Justin in the first instance and seek his feedback and guidance on how to approach this with other neighbours. Hold another open-day for neighbours.	Coms advice, PW, GK, TP, NR, JR	End of July Invite neighbours to an open day to be held mid August. Invite will go out end of July
22 June 2011	Police	Key player	Generally supportive and responsive to prior non-compliance.	Have clear communication lines and mutual procedural understanding in the event of resident absconding/being exited.	Identify Police rep to discuss and review procedures and key contacts. Discuss how we can work more effectively with men we are concerned are presenting with escalated risk within the whare.	NL, PW	Late July Mid July
22 June 2011	Prison Services	Interested party	Previously been a key player in the service that found the majority of offenders for the programme. There were some initial expectations that we would accept prison referrals. This appears to be becoming less of an issue.	Established lines of communication via AMCs – ensure eligibility criteria are shared with and clear to prison	Brief PPs at PP planning about raising at AMCs PPs to agenda and discuss at monthly AMCs	Juanita Jessica Borg (JB) who attends on JR's behalf	November 2011 July 2011

			There is the possibility of ROC offenders being eligible for Tai Aroha	staff. Memo to request ROC offenders to be drafted.		JR	
22 June 2011	Judges/Court Liaison team	High	Have had preliminary contact with Judges and meetings with Court Liaison team.	To have the Judges support for the programme. To have the Court Liaison team actively and regularly identifying referrals for the programme	Judges and CLT have been invited to an open day in July – yet to hear back from them confirming their attendance.	Juanita Ryan, PW, NL	25 July 2011

Appendix D
Psychometric Instruments for Tai Aroha Assessment

Scale	Pre-test	Post-test	As needed
Violence Risk Scale (VRS)	√		
Millon Clinical Multiaxial Inventory-III (MCMI-III)	√	√	
Paulhus Deception Scale (PDS)	√	√	
Psychological Inventory of Criminal Thinking Styles (PICTS)	√	√	
Treatment Readiness, Responsivity, and Gain Scale: Short Version (TRRG:SV)	√	√	
Anger Disorder Scales (ADS)	√	√	
Criminal Attitudes to Violence Scale (CAVS)	√	√	
Kaplan Baycrest Neurocognitive Assessment (KBNA)			√
WIAT – 3 subscales. Word Reading, Comp, pseudowork Decoding	√		
Wecshler Abbreviated Scales of Intelligence (WASI)			√
Note** Exit Interview (STU version) Release Proposal and Feasibility Assessment –Revised (RPFA-R)		√	

Appendix E

Time	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
7.00 am – 8.00 am	Wake-up; personal hygiene; meal preparation; breakfast; clean-up/duties					Wake-up; personal hygiene; meal preparation; breakfast; clean-up/duties Departure on day/weekend leave as approved	
9.00 am	Kotahitanga (clearing the air; de-brief; re-orientation)				<u>External agency</u>: Addictions themed psycho- education Community based counselling		
9.00 am – 10.00 am	Core module	Core module	Core module 'Giving back': community based volunteer work	Core module	<u>External agency seminars</u>: Life skills; community services Engagement with community based agencies	Adventure- based day: note: activities may require the support of external/ specialist agencies	House clean; weekly meal planning/budget review; supermarket shopping
10.30 am	Tea Break	Tea Break	Tea Break	Tea Break	Tea break		
11.00 am – 12.00 pm	Core module	Core module	Core module	Core module	Self-directed goal planning; homework reintegrative planning;		
12.00 pm	Meal preparation; lunch; clean-up				Meal preparation; lunch; clean-up		Meal preparation; lunch; clean-up
1.00 pm	Resident seminars	Skills module	Case management/ <u>PO visits and assessment</u>	Skills module	Resident seminars		Family visits/contact
2.00 pm	Self-directed goal planning; homework; reintegrative planning; <u>PO visits</u>				Self-directed goal planning; homework; reintegrative planning; <u>PO visits</u>		
3.00 pm – 4.00 pm	Gym	<u>External agency</u>: Education based training i.e. computer studies; work place skills Community based education/work training	Gym	Structured hobby (<u>note</u>: may require the support of external agencies) Community based hobby/interest group	Gym		
5.00 pm	House meetings					House meetings	
6.00 pm	Meal preparation; dinner; clean-up				Meal preparation; dinner; clean-up	Meal preparation; dinner; clean-up	
6.30 pm	Homework; Departure on overnight leave as approved					Free time	Self-directed preparation for upcoming week: homework; module review
7.00 pm – 8.00 pm	Culture/ Spiritual (Maori & Non-Maori)	Self-directed reintegrative (inc career) planning; homework	Culture	Shopping excursion	Culture		
9.00 pm – 10.00 pm	Free time					Pre-approved 'DVD night' (or alternative indoor activities)	Free time
11.00 pm	Lights out						

Key: Staffing

- 2 people
- 3 people
- 4 people

Key: Residents

Black lettering: all residents unless otherwise stipulated (note: preapproved exemptions from activities may be granted on a case-by-case basis).

Blue lettering: 'Phase 3' residents only

Note: Consideration may be required for individual residents' cultural or religious needs throughout the week. For example, residents of Muslim faith prayer requirements; residents of Christian faith attendance at church. In addition, time may be allocated for facilitated whanau liaison as required (i.e. 1.30-3.30pm on Friday).

Appendix F
Staff Induction Plan

Induction activity	Presenter	By which stage	How
Show and explain unit facilities	Programme manager and/or designated participant (in final phase of treatment programme)	Within 24 hours of arrival	Accompany new entrant through unit and show various facilities
Explain unit routines, rules (e.g. room standards, cleaning, visits, mail etc), tasks (cleaning, laundry etc) and opportunities (cultural activities, educational programmes, constructive recreation etc.	Programme manager and/or designated participant (in final phase of treatment)	Within 48 hours of arrival.	Explain and provide handout which lists the various routines and activities of Tai Aroha. Handout will indicate the days and approximate times on which the activities occur.
Introduce unit culture – e.g. aspects of Therapeutic Community, tikanga Māori focus of programme and Tai Aroha generally	Programme manager and/or designated participants, Cultural consultant if available, Therapy staff	Within 7 days of arrival	Explain individually/ at first Case Management/Beginners Group or in all of the above
If a Therapeutic Community has not been established yet, the rules of conduct in the residence should be explained	Programme manager and/or therapy staff	Within 7 days of arrival	Explain individually or as part of Beginners Group if there is one
Introduce new participant to staff members and other participants	Programme manager or other appropriate representative	Within 7 days of arrival	At first appropriate gathering

Introduce to assessment and therapy	Beginners Group therapist / other participants	Within 14 days of arrival	In Beginners Group or the group undergoing assessment
Formal welcome	All available staff and participants	As soon as formal function / mihi whakatau has been arranged	Formal function
Complete treatment consent forms	Therapist	Before any formal assessment or treatment has taken place.	Formal explanation and give sufficient time to read and sign forms.

Appendix G

Information was sought from staff and residents on their views of Tai Aroha programme on a self rating questionnaire. The questionnaire looked at five sub categories relevant to Tai Aroha: Cultural responsivity (Tai Aroha as responsive to Maori and other cultures), house facilities and services (including induction, activity and work spaces, medical and dental services and food quality), therapeutic community as method (relating to the degree the house was functioning as a therapeutic community) and reintegration planning (including appropriate leaves).

The staff rated the items on five point Likert type rating scales (The higher the score, the more positive the rating; 1 = strongly disagree/ not useful; and 5 = strongly agree/ extremely useful).

Twelve staff members (four psychologists and eight house staff) responded to the questionnaire.

The graph in Figure 1 shows the mean responses for each of the five subcategories relating to Tai Aroha. Staff ratings were relatively positive across all of the categories. The highest ratings were obtained for core programme (m= 4.24), therapeutic community (m= 3.90) and cultural responsivity (m=3.79). Reintegration (m = 3.52) and house facilities and services (m= 3.21) obtained the lowest ratings.

Core programme components were rated as being between very useful and extremely useful in helping programme participants to develop their pro social coping skills. Staff commented that they had observed positive changes in many of the residents as they learned skills to cope with high-risk situations.

Of note only eight of 12 members (five house staff and two psychologists) responded to this section. One reason for this lower response rate may have been staff perceptions that they did not know enough about the core programme content and expected outcomes to comment.

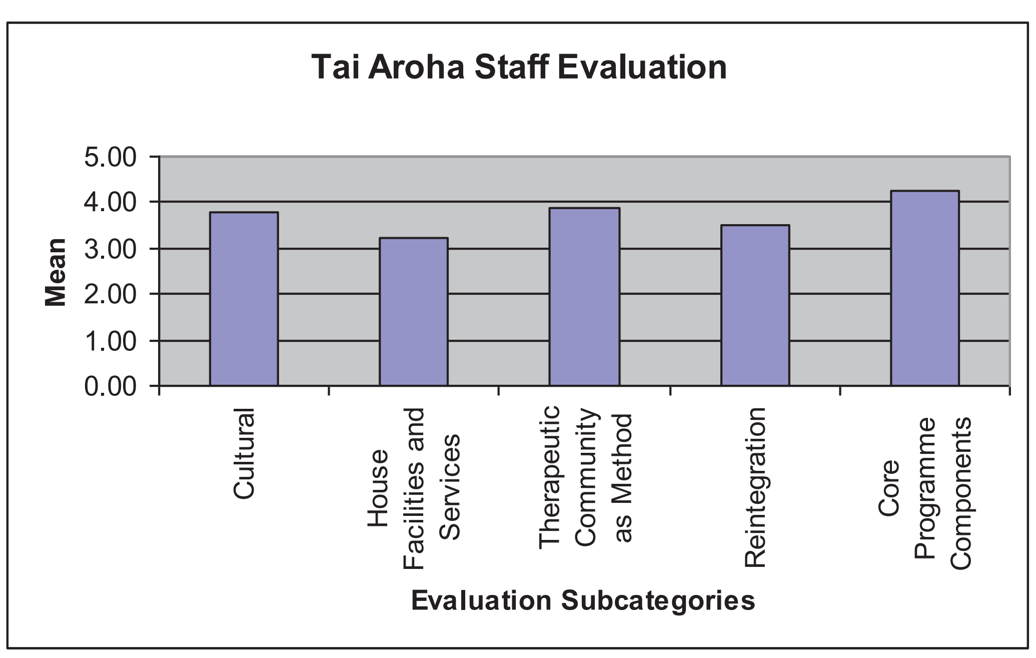

Figure 1 Mean responses for five categories relating to Tai Aroha.

Overall, therapeutic community as method was rated as functioning to a very good standard. This included structured week schedules, feedback as a two-way process between staff and residents, opportunities for pro-social role modelling, holding regular house meetings, an operational privileges and sanctions system, and excellent learning opportunities for residents across a range therapeutic community contexts.

Comments included that:

- the therapeutic community rules and standards had not been consistently adhered to/enforced by staff and residents
- at times there were communication difficulties between house staff and other staff and residents; and staff were not always proficient at providing appropriate feedback to residents
- while residents stepped up to being good role models, house staff had not always done so
- therapy staff had been involved in enforcing rules relating to dress when on outings. Feedback was given at a house meeting. This forum was inappropriate as therapy staff then left the house, leaving the house staff with resident 'fall out'
- the quality of house meetings varied from good to poor
- participants' presentations also varied in quality but were 'often highlights for the day'.
- not all relevant house staff helped participants prepare their presentations (as they should do)
- residents did not have access to a library facility so they relied on staff to provide information relevant to their topics.

Staff ratings on cultural responsivity items indicated that Maori values are embedded in the structure of Tai Aroha, and that Maori cultural practices occur as part of daily activities. Other cultures were acknowledged to a lesser degree.

Some staff members felt that practices did not always reflect Maori values (e.g. individualistic attitudes and behaviours instead of working together as whanau). Others thought that other cultures could be acknowledged more consistently. One person noted that some pakeha residents thought that they didn't fit in, while others enjoyed the cultural element.

Reintegration planning was rated as useful but needing improvement.

House facilities and services were rated as generally adequate; but work and activity spaces were generally considered to be too small.

Appendix H

Tai Aroha:

A further brief update on offender variables, risk and need measures, and responsiveness for treatment

April 2012

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EXECUTIVE SUMMARY

This brief report summarises the psychometric data relating to the residents of Tai Aroha, a recently established community residential programme for violent offenders, and is submitted to inform the broader evaluation of this programme to be conducted by Psychological Services National Office. The outcomes to date are as follows:

- Since inception, 38 residents have participated in the programme, 13 have successfully graduated, and five are still in treatment. The remaining 20 were exited voluntarily or at the discretion of staff.

- The residents' demographic characteristics revealed a higher proportion of Maori (74%) – a target population – than is represented in the broader community offender population (45%).

- Consistent with the programme mandate, most residents were serving short community-based sentences (*M* = 1.9y, *SD* = 1.5).

- A much higher proportion of residents claimed gang membership than is reflected in the general offender population (i.e., 58% vs 8%).

- The psychometric battery was compiled to assess (1) risk of recidivism, (2) risk of violent recidivism, (3) antisocial attitudes, (4) treatment responsiveness, and (5) general responsiveness.

Risk Assessment

- RoC*RoI scores for the residents were significantly higher (*M* = 0.73) than those for the general offender population (*M* = 0.57) as well as for violent offenders (*M* = 0.64).

- Identified static and dynamic risk scores across a range of violence risk variables on the Violence Risk Scale (VRS) were notably higher for the residents than the normative sample (*N* = 918 Canadian violent prisoners) on this measure (*M*(Total) = 53.8, *SD* = 8.6 cf. *M* = 41.9, *SD* = 16.4).
- Common identified dynamic risks for violence – and subsequent treatment goals – as rated on the VRS included violent lifestyles, criminal attitudes,

peer associations, management of negative emotions, substance abuse, impulsivity, and recurrent violence patterns. Commonly low level factors included institutional violence and mental illness.

Needs Assessment

- As a group, the residents revealed elevations on the Anger Disorders Scale (ADS) subscales with regard to *reactive* anger and *vengeance*-consonant attitudes, but not to a pathological degree.

- The residents' overall attitudes to violence (as measured by the Criminal Attitudes to Violence Scale (CAVS) was similar to that of the original New Zealand violent offender development sample, and reveals a high level of endorsement of pro-violence beliefs. Programme graduates revealed less endorsement of pro-violence beliefs.

- The Psychological Inventory of Criminal Thinking Styles (PICTS) scores revealed typicality amongst the residents in relation to criminal thinking styles expected of an offender group. For instance:

    - The mean *T*-scores on the *composite* scales indicated that the residents generally tended to express thoughts of a planned criminal nature reflecting goal-directed behavioural styles (Proactive) as well as indications of hostility and impetuosity (Reactive). Graduates revealed overall reductions in their endorsement of crime as a functional behavioural style.

    - The residents' mean scores on the *thinking styles* scales largely fell within the average range (i.e., *T*-score < 60), indicating that the residents exhibited largely typical responses and attitudes in relation to 'average' offenders on areas such as blame externalisation (mollification), entitlement beliefs, control-seeking (power orientation), empathy not typically used to justify criminal acts (sentimentality), overconfidence and poor planning (superoptimism), and poor critical reasoning skills and taking 'short cuts' (cognitive indolence). However, impulsive response to stress in a reactive fashion (cutoff), and distractibility from structured tasks and goals (discontinuity) were particularly characteristic thinking styles of the residents. Overall programme residents responses reflected reduced endorsement across these domains.

    - No notable elevations were revealed with regard to the *factor* scales, suggesting that committing offences to avoid problems (problem avoidance), extreme hostility (interpersonal hostility), rationalisation (self-assertion/deception) or minimization (denial of harm) as rapid responses to justifying criminal behaviour. The residents' mean *T*-scores on the *content* scales indicates identification with a criminal belief system – past and present – with graduates indicating a shift in these areas.

   - The current criminal thinking scale is considered to be the most relevant PICTS item regarding change on criminal attitudes and beliefs. The Fear of change scale indicates that the residents are largely conducive to contemplating behaviour change revealing a post-treatment elevation on this scale for graduates suggesting the need for ongoing support after programme completion.

Responsivity Measures

- The resident's treatment readiness and responsivity scores (as measured on the Treatment Readiness Responsivity and Gain Scale (Short Version) (TRRG:SV) were within the normal range for an offender group, and reflect that inconsistent motivation, anger, and procriminal views are characteristic treatment engagement issues for this group. At post-treatment, graduates indicated improved readiness for treatment across all items as well as improved responsiveness and perceived positive benefits from treatment.

- The Millon Clinical Multiaxial Inventory-III (MCMI-III) was administered to screen for personality and clinical pathology that may impact on treatment responsiveness. Overall, notable elevations of antisocial personality traits were revealed as well as substance and alcohol abuse and anxiety. Some positive changes on critical subscales were noted by existing graduates so far. Post-treatment scores indicate a reduction in personality pathology, especially personality styles that are likely to impact on violent behaviour such as antisocial, sadistic and negativistic scales. Furthermore, reductions on severe personality pathology (i.e., schizotypy, paranoia and borderline) were also observed with graduates responses on this measure.

- The residents' impression management and social desirability style, as measured by the Paulhus Deception Scale (PDS) were considered typical for an offender group, but revealed less efforts at impression management than both a prison and non-offending populations. Graduates revealed a tendency toward 'social conventionality' as reflected in mid-range scores on this measure.

Future Directions

- The programme appears to have targeted the appropriate offenders as per the demographic features and risk and need variables.

- Whilst largely positive indicators across all measures suggest benefits of the treatment programme, the need to consider post-programme support in addition to standard services is recommended as the next critical step in an effort to incorporate risk, treatment change, and protective factors to inform the impact of the programme on recidivism and desistance.

- The high proportion of personality disordered residents suggests a training need for therapists and internal staff to learn strategies to identify pathological issues related to personality and how to manage these issues effectively.

- In addition, the elevated ‘Fear of Change’ scores on the PICTS suggests the need for post-programme support for graduates.

- While it is cautioned that Tai Aroha’s short life to-date as well as the small number of residents, it is too early to fully establish the effectiveness of Tai Aroha as a rehabilitative intervention programme. However, future analyses that elicit information about the residents’ process of change would benefit decision-making regarding (1) programme content, (2) sequencing of content and other therapeutic tasks, (3) the importance of turning points and other desistance-related phenomena, and (4) the role of working alliances.

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