Tai Aroha Evaluation Project Report

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Dedication

This evaluation is dedicated firstly to the victims of crime who are the motivation for our efforts; secondly to the men who work sincerely to change their lifestyles and behaviour.

Executive Summary

This report outlines a multi-layered evaluation of the performance and effectiveness of the Tai Aroha Community Residential Programme run by the Department of Corrections, NZ. Several projects covered areas including the description of programme participants, completers' perceptions of the programme, programme integrity, pre- and post-programme results on psychometric measures, and recidivism outcomes.

The results of the evaluation show that:

- Tai Aroha is targeting the high-risk offenders for which it is designed. The Tai Aroha men have significant personality problems, high levels of criminal thinking, and extensive risk/need criminal profiles. In short, they are tough and tough to manage.
- The men leaving the programme identify family circumstances, peer influences and financial stressors as particular challenges for their community reintegration.
- The recommendations made by Lucy King (2012) in her earlier review of the programme have largely been achieved.
- Programme integrity has improved steadily across multiple assessments and is generally of a 'good' standard.
- There are meaningful changes on relevant psychological measures of change for programme completers.
- The programme has some positive results on recidivism for men on Home Detention but not for men on Intensive Supervision.

Recommendations include:

- That the programme draw principally from the pool of men on Home Detention sentences rather than those on Intensive Supervision. Selection of men for Tai Aroha from those on Intensive Supervision sentences should be exceptional and reflect a high degree of internal and external motivation for their attendance and participation.
- That the Treatment Readiness, Responsivity and Gain scale: Short Version be used in the pre-programme selection assessment rather than in the 'phase 1' psychometric assessment period.
- Given the degree of personality pathology identified during assessment, that programme staff continue to review how to further integrate personality-focussed interventions into the programme.
- That there are additional efforts to enhance the effectiveness of reintegration processes for programme participants, both during and following the programme, with an emphasis on further defining and focussing the Reintegration Worker roles.

Contents

1.0 Introduction

The Montgomery House Community Residential Centre commenced in 1987 and across a number of subsequent revisions evolved into an intensive, residential 10 week, 300 hour, violence prevention programmes for high risk repetitive and violent offenders. It was a structured programme run conjointly between the NZ Prisoners Aid and Rehabilitation Society (NZPARS) and the Department Of Corrections' Psychological Services, with specific modules addressing established criminogenic needs. The programme accepted offenders on community-based sentences and temporary release from prison, with the latter group being the majority of participants. The programme attended closely to the principles of Risk, Need and Responsivity, with additionally strengths in the area of addressing the cultural needs of programme participants (who were mainly high-risk Maori men). Evaluations of the programme were generally positive with small but positive effect sizes in terms of reduction of offending and seriousness of offending (Wilson, 2009).

In parallel to the development of Montgomery House the first of the prison-based treatment programmes for men with serious violent offences, Te Whare Manaakitanga (originally known as the Violence Prevention Unit), opened in 1998. Further violence-focussed High Risk Special Treatment Units (HRSTUs; distinct from Kia Marama and Te Piriti which cater for those with sexual offences against children) opened in rapid succession at Waikeria Prison in 2008 (Karaka), Spring Hill Corrections Facility in 2008 (Puna Tatari), and Christchurch Men's Prison in 2009 (Matapuna). As such, over time the largely prison-based pool for referrals for Montgomery House had begun to decline when, in 2009, NZPARS repudiated their contractual requirements for the Montgomery House programme which then went into temporary hiatus.

An earlier review (Jennings, 2008) of Montgomery House had already established the need to reposition the programme to meet a rehabilitation gap for high-risk community-based offenders on Home Detention or Intensive Supervision. Subsequently the revised programme re-opened as 'Tai Aroha', a Department-led 'rolling group' based on the 300-hour programme delivered in the HRSTUs. The rolling format allows each new participant to be accepted onto the programme effective at his sentence commencement. Typically it is expected that participants will remain on the programme for approximately 16-weeks during which time they progress through a series of programme phases with an increasing emphasis on self-responsibility for their change process and a greater emphasis on safe reintegration to their home environments to complete the remainder of their sentences. Non-completers are largely managed by a breach of sentence conditions (Home Detention) or a sentence review (Intensive Supervision).

A review of the first two years of Tai Aroha was undertaken by Lucy King in 2012. This review provides a concise but thorough description of the programme design and implementation during initial phases, and includes information about referral processes, programme content, operational procedures and process, feedback from staff and participants about the programme, and an initial analysis of psychometric testing of residents. It was recommended that the programme be accepted as 'business as usual' activity, there be continued exploration of different models of

delivery for the programme (to evolve the effectiveness of the 'rolling group' format), and there be further work around:

- The development of workbooks and handouts
- The reintegration planning model used by the programme
- Training of staff in the management offenders with severe personality disorders.

The current report provides a follow-up evaluation to that of Lucy King now that Tai Aroha has been in operation for over 4-years and there is sufficient information available to draw some conclusions about effectiveness based on observations of the programme and initial recidivism outcomes.

Similarly to the 2012 evaluation of the HRSTUs (Kilgour & Polaschek, 2012) this report is divided into three broad sections: 1) a process evaluation – describes participants attending the programmes up until; a sample of their experiences and perceptions of the programme after a varying periods following attendance; and evaluations of programme integrity, including progress on meeting King's (2012) recommendations; 2) an outcome evaluation – examines pre- to post-programme changes in psychological testing results for programme completers; and recidivism rates for programme completers and non-completers compared with matched controls; and 3) recommendations arising out of the evaluation for the future delivery of the programme.

Each sub-section within the first two sections contains the key questions that the evaluation seeks to determine, a brief description of the methods used to examine these questions, and a fuller description and discussion of the results.

2.0 Process Evaluation

2.1 Programme participants (descriptive statistics)

2.1.1 Evaluation questions

Who are the men that we are working with and do they match with those targeted by Department's principles of effective intervention and responsiveness to Maori?

How do the men who attend Tai Aroha compare on similar variables with men who attend the prison-based HRSTU programmes?

Were there any important differences between the men who completed Tai Aroha and those who did not?

2.1.2 Method

Results from this study were primarily derived from CARS and a Data Capture spread sheet designed during the implementation of Tai Aroha to collect descriptive and programme statistics on residents. During the pre-programme assessment phase the staff member responsible for each man collates demographic information and pre-programme psychometric testing results. This information is collated and transferred into an Excel spread-sheet. Further information is gathered and entered during the period of each man's attendance, including their post-programme psychometric results if they complete the programme successfully. Information gathered is summarised in Table 1.

Table 1

Data Capture spreadsheet information

Demographic Information	**Programme information and participant performance**	**Pre-programme psychometrics**	**Post Programme psychometrics**
Name	Programme start and completion dates	Millon Clinical Multiaxial Inventory – III	Millon Clinical Multiaxial Inventory – III
Date of Birth	Programme phases (1-3) completed	Paulhus Deception Scales	Paulhus Deception Scales
PRN	Completion or non-completion reason	Psychological Inventory of Criminal Thinking Styles	Psychological Inventory of Criminal Thinking Styles
Ethnicity	Number of incidents on programme	Anger Disorder Scales	Anger Disorder Scales
Primary and secondary iwi (if Maori)		Treatment Readiness, Responsivity and Gain Scale: Short Version	Treatment Readiness, Responsivity and Gain Scale: Short Version
Years in school & highest education		Criminal Attitudes to Violence Scale	Criminal Attitudes to Violence Scale
Relationship status at programme completion		Ontario Domestic Assault Risk Assessment	Ontario Domestic Assault Risk Assessment
Gang status, time in gang, and level of involvement		Literacy Skills assessment	Release Proposal Feasibility Assessment
		Violence Risk Scale	

As much as feasible efforts were made to review the collation of this data against programme records and ensure information was accurately transferred to the Data Capture spread-sheet. Where there were discrepancies observed between hard copy psychometric forms and information recorded in the spread-sheet, these were reviewed and corrected, in some cases resulting in the complete re-scoring of some psychometric measures to confirm accuracy.

2.1.3 Results and discussion

In the evaluation period – between the programme start of August 2010 and the end of January 2014 – there were 89 men who began the programme. One of these individuals has been excluded from the study given that he was judged to be actively psychotic when he began the programme and was promptly exited as unsuitable. Thus, basic demographic and programme completion details of 88 men are provided in Tables 2-4. Of these 88 individuals 80 men (50 completers and 30 non-completers) had at least 10-months following the programme in which their recidivism outcomes could be identified and had relatively full information available on their demographic make-up and pre- and post-programme psychological testing (see Section 3).

Table 2 compares men attending the programme on Home Detention (n=70) and Intensive Supervision (n=18) sentences. There were no significant differences on any personal factors between these groups. Men on Intensive Supervision (IS), however, had more unique prior sentencing dates, numbers of convictions, and violence offences. They were also significantly less likely to complete the programme, either to Phase 3 or the full programme, with only four of the 18 men on IS getting to the end of the programme. Practically, the failure rates of men on IS were so high that that without their results the programme would have exceeded completion targets in all periods measured (see also Table 5).

Table 3 compares basic descriptive information on the 88 Tai Aroha participants compared with a more recent snapshot of 219 high-risk men on an Intensive Supervision (IS) or Home Detention (HD) sentence in June 2014. Additionally, Table 4 shows a breakdown of programme completion (included fully completed and completion to Phase 3 of the programme) for the 88 individuals by ethnicity and gang membership.

Maori represent over 85% of the men who start the programme and approximately 83% of the completers and 89% of the non-completers. Although Maori complete at close to the rate that might be expected if ethnicity was unrelated to outcome, in terms of completion rates Maori do not do quite as well as Pakeha men who make up 12.5% of the sample but account for 15% of completers versus almost 8% of non-completers. It is possible that there were some Pasifika men of mixed ethnicity who primarily identified themselves as Maori and this means that this group appears to be less represented than in actuality.

Maori attend Tai Aroha at a considerably greater rate than their representation in Corrections overall (approximately 51%; Department of Corrections, 2011) and more specifically than represented in the snapshot of high-risk men on HD and IS (almost 63%).

Table 2

Demographic profile of Tai Aroha participants by sentence type of Home Detention (n=70) and Intensive Supervision (n=18)

	Home Detention (% or range)	**Intensive Supervision (% or range)**	**Significance test**
Personal Factors			
Maori/mixed Maori/other	61 (87.1%)	14 (77.8%)	ns
Pakeha/European	8 (11.4%)	3 (16.7%)	ns
Pacific Islander	1 (1.4%)	1 (5.6%)	ns
Age at programme start	28.35 (17.61 – 45.87)	*32.05 (19.71 – 48.49)*	ns
Education (years where known)	9.1 (2 – 12)	9.5 (5 – 12)	ns
In relationship at start of programme (where known)	50 (71.4%)	13 (76.5%)	ns
Gang membership	41 (58.6%)	12 (66.7%)	ns
Gang involvement on programme (facilitator rating)	27 (38.6%)	8 (44.4%)	ns
Programme Attendance			
Days on programme	94.24 (7 – 146)	57.18 (5 – 122)	.001**
Completers (full)	48 (68.6%)	4 (22.2%)	0.000**
Completer to Phase 3	49 (70.0%)	8 (44.4%)	0.043*
Criminal history factors			
Roc*RoI	0.74 (.42 – .88)	0.73 (.62 – .87)	ns
Current sentence length (yrs)	.57 (.14 – 2.5)	1.19 (1.0 – 2.5)	.000**
Age at first violence	17.7 (14.0 – 24.6)	18.9 (14.1 – 25.8)	ns
Age first sentenced	16.7 (14.1 – 23.4)	17.6 (13.6 – 25.0)	ns
History violence offending	69 (98.6%)	18 (100%)	ns
History dishonesty offending	70 (100%)	17 (94.4%)	.047*
History driving offending (non-substance related)	64 (91.4%)	16 (88.9%)	ns
History driving offending (alcohol related)	45 (64.3%)	12 (66.7%)	ns
History drug/alcohol offending	45 (64.3%)	14 (77.8%)	ns
Unique prior sentencing dates	19.3 (3 – 56)	29.8 (9 – 88)	.002*
Number of convictions	66.7 (8 – 195)	89.2 (27 – 184)	.031*
Violence convictions	8.1 (0 – 33)	11.7 (1 – 31)	.048*
Prior imprisonment sentences	24.4 (0 – 112)	30.2 (7 – 75)	ns
Longest prison sentence (yrs)	1.80 (0 – 6.4)	1.79 (.49 – 4.9)	ns

* Significant at p ≤ .05
** Significant at p ≤ .001

Table 3 also suggests that Tai Aroha participants are on average no younger than the HD/IS snapshot but their average RoC*RoI, while still in the high-risk range is significantly less. It is likely that this is, in part, because the Tai Aroha programme will accept men with RoC*RoIs of less than 0.7 following a formal assessment of risk override by psychologist. Thus, not infrequently the screening assessment has

overridden men from a moderate risk category (based on RoC*RoI) into a higher risk category based on additional clinical information about the case.

Gang members account for almost 2/3^{rds} of the sample (61.4%), with approximately half of these again coming from the Black Power (15.9%) and Mongrel Mob (17.1%) respectively. Notably, men from Crypts, or 'other' gangs are represented in completion and non-completion rates at about the level that might be expected if gang membership was unrelated to outcome but Mongrel Mob men failed at almost twice the rate that might be expected if gang membership was unrelated to outcome. In contrast to Black Power and 'non-gang' affiliated men did slightly better than their expected rates of completion.

Attempts were also made to establish a comparison between gang membership of men attending Tai Aroha and the level of gang membership among the high-risk IS/HD muster. However, it was deemed that the information on Probation-based offenders in CARS to make this comparison was too unreliable to be meaningful (Alex Skelton, personal communication, 01 July 2014). However, the rate of gang membership for programme participants is much higher than in the general *prison* population (estimated at almost 28% of sentenced prisoners at July 2014 via CARS report) where we might expect to have a higher rate of gang membership than for community-based offenders. This would suggest that the Tai Aroha sample may reflect a higher rate of gang membership than the cohort of 'typical' high-risk HD/IS offenders, although this cannot be confirmed for sure.

Table 3

Profile of Tai Aroha participants compared with high-risk men on IS/HD in June 2014

	Total muster (n = 219) % (SD)	Tai Aroha (n = 88)	T-Test (2-tailed)
Average age at conviction	30.34 *sd = 9.60*	29.10 *sd = 7.53*	ns
Average RoC*RoI	0.7772 *sd =.0541*	0.7387 *sd = .0820*	.000*
Percentage Maori	62.6	85.2	**
Percentage Pakeha	29.2	12.5	**

* significance at higher than a .0001 level
** a cross-tabulation with chi square analysis comparing cell difference by ethnicity identified significant differences in the ethic make-up between the samples

Tables 5 & 6 provide an outline of Tai Aroha completers (to at least Phase 3 of the programme) and reasons for non-completion (including those who left at Phase 3 in Table 6). The target for completion of community-based programmes is 65%, indicating that Tai Aroha has just fallen short of this goal overall but has achieved this target on four out of the seven 6-month programme periods measured. Generally the programme has tracked upwards in terms of completion rates with targets met in the all of the last four 6-month periods surveyed . Non-completion reasons are described more fully in Table 6 with the over-whelming reason for premature exit from the programme being due to misconduct or absconding (together accounting for 60% of exits). However, substance-related activities (including abuse, dependence, and selling drugs) together accounted for almost 20% of other programme exits and is a particularly difficult area for management within the community-based setting (Juanita Ryan, personal communication, July 2014). As previously observed the very

poor completion rates by men on Intensive Supervision sentences significantly impacted on the overall completion results.

Table 4

Programme completion rates (full and to Phase 3) by ethnicity and gang membership for Tai Aroha participants

Ethnicity

	Completers* (% of Cs)	Non-completers* (% of NCs)	Whole sample (% of whole sample)
Maori/Maori-Euro	43 (82.7%)	32 (88.9%)	75 (85.2%)
	(47; 82.5%)	(28; 90.3%)	
European/Pakeha	8 (15.4%)	3 (8.3%)	11 (12.5%)
	(9; 15.8%)	(2; 6.5%)	
Pacific	1 (1.9%)	1 (2.8%)	2 (2.3%)
	1 (1.8%)	1 (3.2%)	
Total	52 [57]	36 [31]	88

* If participants exited in Phase 3 are included as completers

Gang membership

	Completers* (% of Cs)	Non-completers* (% of NCs)	Whole sample (% of whole sample)
Black Power	10 (19.2%)	4 (11.1%)	14 (15.9%)
	(11; 19.3%)	(3; 9.7%)	
Mongrel Mob	6 (11.5%)	9 (25.0%)	15 (17.1%)
	6 (10.5%)	9 (29.0%)	
Crypts	4 (7.7%)	4 (11.1%)	8 (9.1%)
	(5; 8.8%)	(3; 9.7%)	
Other	9 (17.3)%)	7 (19.4%)	16 (19.3%)
	(10; 17.5%)	(6; 19.4%)	
No gang	23 (44.2%)	12 (33.3%)	35 (39.7%)
	(25; 43.9%)	(10; 32.3%)	
Total	52 [57]	36 [31]	88

* If participants exited in Phase 3 are included as completers

Table 5

Proportion of Completers (achieved at least Phase 3 status) and Non-completers by 6-month intervals

Programme period	Starters during period	Completers	Non-completers
Aug 10 – Jan 11	11	6 (54.6%)	5 (45.5%)
Feb 11 – Jul 11	13	8 (61.5%)	5 (38.5%)
Aug 11 – Jan 12	10	4 (40.0%)	6 (60.0%)
Feb 12 – Jul 12	17	12 (70.6%)	5 (29.4%)
Aug 12 – Jan 13	12	8 (66.6%)	4 (33.3%)
Feb 13 – Jul 13	12	9 (75.0%)	3 (25.0%)
Aug 13 – Jan 14	13	10 (76.9%)	3 (23.1%)
Total	**88**	**57 (64.8%)**	**31 (35.2%)**

Table 6

General and detailed reasons for exiting if non-completer for Tai Aroha participants

General reason for exit	**Specific reason for exit**
Misconduct or absconding (86.1%)	Absconded (36.1%)
	Aggressive or violent behaviour (25.0%)
	Drug use (11.1%)
	Alcohol dependency (5.6%)
	Disengaged (5.6%)
	Selling drugs (2.8%)
Ceased b/c of poor responsivity (11.1%)	Mental health or personality barriers (11.1%)
Withdrew for personal reasons (2.8%)	Disengaged (2.8%)
Total = 100%	*Total = 100.1%*

A comparison was also undertaken on results on the standard psychometric measures for those men who completed Tai Aroha and those who did not, including measures of personality, violence risk/need, criminal thinking, anger and deceptiveness. Overall there were few observable differences on these instruments. For example, on the primary measure of personality (the MCMI-III) the only statistically significant difference was for the antisocial subscale, with this higher for the *completers*.

There were two notable exceptions to this observation of general similarity. Firstly, on the key measure of violence risk, the Violence Risk Scale, overall treatment *non-completers* were observed to have slightly greater dynamic risk needs at pre-treatment (in particular 'criminal peers', 'interpersonal aggression' 'emotional control',

'insight into violence', and 'violence cycle'). Secondly on a measure of treatment readiness (the Treatment Readiness, Responsivity and Gain scale-Short Version; TRRG-SV) several subscales indicated that *men who had completed* were generally more ready for treatment (on all but one of eight subscales and the overall 'readiness' index) and had less responsivity barriers to treatment on three of eight subscales ('denial', 'power and control', and 'pro-criminal views') and the overall 'responsivity' index.

Tables 7 below summarises results on key offence history variables and psychometric measures (VRS, MCMI-III, RPFA-R) used at the pre-programme stage to give an indication of the personality and risk-need profile of Tai Aroha participants. These results are shown alongside results from the prison-based HRSTU programmes (STURP and original VPU) to provide a comparison of the types of presenting problems and risk/needs between these groups of men. This is of particular interest because the control group for men in the Tai Aroha programme was selected on the basis of proximity of age, RoC*RoI, ethnicity, and (community) sentence type and length (and a comparison – see section 3 – shows that there were no significant differences in the groups based on these criteria). Thus it is possible that Sentencing Judges have sentenced some men to Tai Aroha who they would otherwise have sentenced to periods of imprisonment, given the availability of an intensive, community-based, treatment option. This raises the possibility that the Tai Aroha sample may be somewhat more difficult to manage than men in their control group. This is a difficult hypothesis to test given that other variables (such as measures of personality and treatment needs) are available on the Tai Aroha group but not on the control group men. A non-conclusive but indicative way to examine this is to compare the Tai Aroha men with the programme attendees at the HRSTUs, who might be expected to be have more serious personality profiles and a greater prevalence of treatment needs than men on community-based sentences. Table 7, therefore compares the Tai Aroha men with HRSTU samples based on their demographic, offending and psychological testing profiles. VRS scores are calculated out of possible total of 60 for dynamic needs (20 items) and a static total of 18 (6 items).

Table 7

Key demographic and psychological profile comparisons between Tai Aroha attendees and men attending the prison-based HRSTU programmes (STURP and VPU)

	Tai Aroha				***STURP***				***VPU***				***F(p)***	***Welch's F(p)***
	N	*M*		*SD*	*N*	*M*		*SD*	*N*	*M*		*SD*		
Age at programme entry***	81	28.6a	a	7.7	245	34.4a	b	10.1	92	32.9a	b	9.7	10.8(<.001)^	14.4(<.001)
Years of schooling	76	9.1		1.9	232	9.5		1.4	88	9.3		1.5	1.9(.306)	
Days in programme ***	80	98.7	a	61	236	204.1	b	71	89	207.2	b	73.7	87.8(<.001)^	106.2(<.001)
Length of time in primary gang (years)	33	8.8		7.2	83	12.4		8.1	24	10.4		10	2.4(.096)	
Number of convictions	81	72.3		40.7	244	67.7		62	92	58.8		44.7	1.4(.245)	
Longest prison sentence (days)***	78	662.2	a	498.5	208	1923.3	b	1497.6	83	1899.8	b	1762.3	24.0(<.001)^	68.0(<.001)
Age at first offence***	81	16.2	a	1.9	244	17.7	b	2.7	92	17.5	b	2	11.8(<.001)	
Age at first violent offence***	80	17.9	a	2.7	235	17.8	b	4.7	88	19.4	b	3.9	6.1(.003)^	10.4(<.001)
Number of violence convictions***	81	8.8	a	7	243	7.3		5.6	91	5.9	b	4.5	5.9(.003)^	6.1(.003)

RoC score closest to programme entry***	81	0.979	a	0.016	245	0.95	b	0.085	92	0.946	b	0.097	4.8(.009)^	17.4(<.001)
RoI score closest to programme entry	81	0.755		0.076	245	0.744		0.137	92	0.739		0.15	.32(.724)^	.59(.554)
RocRoI score closest to programme entry	81	0.74		0.081	245	0.707		0.162	92	0.709		0.17	1.5(.232)^	3.1(.043)
Pre programme VRS total score	81	58		11	192	56.2		8.3	62	56.4		8	1.2(.300)	
Pre programme VRS static score***	81	13.9	a	2.7	192	12.8	b	2.6	62	13.1		3	4.9(.008)	
Pre programme VRS dynamic score	81	44		9.2	192	43.3		7.2	62	43.4		6.6	.27(.767)	
Disclosure***	72	73.5	a	16.2	233	63.7	b	18.0	86	66.6	b	18.1	8.5(<.001)	
Desirability	72	63.5		17.6	233	67.7		16.4	86	68.0		16.4	1.8(.165)	
Debasement	72	55.3		21.4	233	49.9		19.2	86	50.9		20.4	2.0(.132)	
Schizoid	72	63.1		18.3	233	60.2		22.3	86	61.3		18.9	.53(.588)^	.61(.544)
Avoidant	72	59.5		23.9	233	52.0		28.0	86	56.5		26.1	2.5(.082)^	2.8(.067)
Depressive	72	63.2		26.4	233	59.0		26.9	86	60.4		27.0	.67(.510)	
Dependent	72	62.6		22.6	233	51.3		58.5	86	52.7		25.6	1.6(.212)	
Histrionic	72	45.0		17.6	233	44.4		15.0	86	44.6		15.7	.04(.958)^	.04(.964)
Narcissistic	72	62.3		17.8	233	59.1		15.8	86	59.7		19.2	.97(.382)	
Antisocial***	72	84.6	a	12.8	233	74.2	b	15.0	86	76.2	b	14.6	14.2(<.001)	
Sadistic ***	72	67.0	a	14.0	233	58.4	b	17.4	86	59.9	b	17.3	7.2(<.001)	
Compulsive	72	41.9		15.6	233	45.2		13.1	86	44.7		15.1	1.5(.215)	
Negativistic ***	72	64.0	a	24.8	233	53.8	b	27.0	86	55.9		28.5	4.0(.020)^	4.5(.013)
Self Defeating***	72	63.8	a	22.4	233	55.3	b	27.3	86	58.9		26.9	2.9(.056)^	3.5(.032)
Schizotypal***	72	61.8	a	23.0	233	50.9	b	27.0	86	54.9		26.7	4.8(.008)^	5.6(.004)
Borderline***	72	64.5	a	17.7	233	53.2	b	22.1	86	56.4	b	21.9	7.8(<.001)^	9.9(<.001)
Paranoid***	72	67.3	a	19.7	233	57.6	b	24.8	86	59.0	b	22.8	4.7(.009)^	6.0(.003)
Anxiety***	72	67.5	a	28.9	233	54.8	b	33.7	86	59.1		32.6	4.2(.026)^	4.9(.009)
Somatoform	72	42.0		25.7	233	37.1		27.3	86	36.2		27.3	1.2(.315)	
Bipolar Manic	72	67.2	a	17.1	233	53.5	b	19.9	86	57.8	b	18.1	14.4(<.001)^	16.3(<.001)
Dysthymia	72	53.6		26.3	233	48.5		27.6	86	49.2		26.9	.97(.382)	1.0(.366)
Alcohol***	72	84.0	a	18.1	233	70.6	b	17.8	86	74.8	b	16.6	16.1(<.001)	
Drug Dependence***	72	82.2	a	16.5	233	72.2	b	16.6	86	72.5	b	17.2	10.3(<.001)	
PTSD	72	52.9		26.5	233	44.4		28.0	86	47.5		26.2	2.7(.069)^	
Thought Disorder***	72	55.5	a	21.5	233	43.0	b	25.8	86	47.0		25.7	6.9(<.001)^	8.3(<.001)
Major Depression***	72	43.8	a	30.1	233	34.7	b	26.5	86	36.4		26.8	3.1(.048)	
Delusional***	72	58.6	a	21.1	233	49.7	b	26.4	86	48.7	b	24.8	4.0(.019)^	5.2(.007)
RPFA Total	43	12.3		3.8	163	11.8		5.4	55	11.1		5.9	.64(.528)^	.73(.528)

Note: Ns may vary given availability of valid profiles or available information on some measures.
***identifies variables that yielded significant differences between groups.
+ different superscripts indicate statistically significant differences between pairs of means. No superscript indicates mean did not significantly differ from others.
^ indicates that the assumption of homogeneity has been violated (significant Levene's statistic). In these cases, Welch's *F* has been included.

Summarising the above results there are a number of similarities between the men attending Tai Aroha and the prison-based STUs, including years in school, time spent in gangs, and prior convictions. Results on the RoC*RoI and VRS generally

suggest that men attending Tai Aroha are similar in their risk/need profiles to men attending the programmes in the HRSTUs (although the RoC scores and static VRS scores of the Tai Aroha men are somewhat higher). In essence these results indicate a high level of identified treatment needs for programme attendees across both the prison and community settings. For those men who have completed their respective programmes they also have similar reintegrative needs (i.e., RPFA results).

Unsurprisingly the length of the longest prison sentence for HRSTU men is greater than Tai Aroha men but, in contrast, Tai Aroha men have significantly more convictions for violence, and are younger at first conviction and first violence conviction. The Tai Aroha men have significantly more personality pathology than men attending the STUs. In particular they have higher scores on all three of the severe personality scales (paranoid, borderline, and schizotypal), and on a number of the other personality (antisocial, sadistic, avoidance, negativistic, self-defeating) and clinical scales (anxiety, substance use, PTSD, thought disorder, depression). It may be that because men beginning Tai Aroha are mainly coming straight from community-based settings and have had little or no recent period in a relatively stable custodial environment, these results reflect a greater degree of chaos and dysfunction occurring in their lives prior to treatment.

In summary to this point, the men attending Tai Aroha are those that the programme is designed to target. They are men assessed as high-risk for further versatile and violent offending. Maori men participate at greater levels than they are typically represented among the IS/HD high risk group and it is likely that gang members also participate more frequently as well. The Tai Aroha men have significant treatment needs, similar to those found among men attending the HRSTU. However, their personality profiles suggest that they are more disturbed and dysfunctional than men beginning the HRSTUs.

Considering the differences between those who did and did not complete the programme, non-completers tended to be under less restrictive sentences (i.e., Intensive Supervision rather than Home Detention) and were less treatment 'ready' during the early stages of the programme.

In conclusion, the Tai Aroha men have significant personality problems, high levels of criminal thinking, and extensive risk/need criminal profiles. In short, they are tough and tough to manage.

2.2 Follow-up interviews with programme participants

2.2.1 Evaluation questions

What are some of the challenges faced by men who have been out of the Tai Aroha programme for some time? How might the programme be improved further in light of these challenges.

2.2.2 Method

Full survey results for this section are available in a separate document completed by Psychology Trainee, Amanda Pinny (2014). A summary of results, the majority of which are directed transposed from Amanda's report (with full acknowledgement) is provided below.

A semi-structured interview (see Appendix A) was developed which covered many of the common areas identified in the literature as related to reintegrative needs for offenders. This measure was peer reviewed by an external expert (Professor Devon Polaschek) and minor revisions made as a consequence.

A total of 84 former Tai Aroha residents were identified as potentially able to take part in the current research and were selected based on having taken part in the treatment programme, irrespective of whether they completed treatment successfully or not. However, results for these men are included together given that the sample size for each group would be independently relatively small. Initially the goal was to survey 20 or more ex-residents who had attended the programme at least six-months earlier. Extensive efforts were made to locate and contact the men who could contribute to the study. Of those who were able to be found and contacted, 17 consented to take part in the present study. Of those 16 were included in the analysis, with Participant 14 being unavailable to complete the interview process. Eleven participants completed the treatment programme successfully, with the remainder being exited prior to completion (see Table 8 for participant details). A comparison between the participant sample and the total participant pool indicated that the two groups are not too dissimilar to one another in terms of age, ethnicity, RoC*RoI, gang membership and time in treatment (Pinny, 2014). Informed consent was obtained at the time of the interview and recorded on the interview transcript. Most contributed by way of phone interview given their geographical distribution and availability. Typically interviews took between one and 1 ½ hours.

Given the exploratory nature of the survey, a descriptive approach was used to analyse results. The interpretative phenomenological analysis (IPA), is a four stage process designed to extract thematic responses from semi-structured interviews (Smith and Osborn, 2003). This involves (i) reading interview transcripts several times, (ii) noting first impressions on each transcript, (iii) developing a cluster of themes from transcript notes, and (iv) condensing themes to allow tabulation and the examination of similarities and differences across results. This analysis focuses on areas in which a minimum of two to three men express similar views; however attention is also paid to infrequent but highly divergent views.

Table 8

Details of men participating in Tai Aroha follow-up survey

Age	<=20	21-25	26-30	31-35	>36
	2	3	4	2	5
Ethnicity	Maori	Pakeha	Pacific Peoples		
	16	1	0		
RoC*RoI	<0.7	0.7-0.79	0.8-0.89	0.9-1.00	
	5	9	2	0	
Gang	Mongrel Mob	Black Power	Crypts	Other gang	Nil
	3	3	2	3	5
Completion Status	Completer	Non-Completer			
	10	6			

Note: Age, RoC*RoI & gang membership are calculated at date of programme entry

The current findings should be interpreted with consideration of three key methodological limitations. Firstly, interviews relied primarily on hand-written recording so some information may have been missed in terms of the recording of the specific content responses. Given that transcripts were then analysed and the data interpreted by a different person, it is possible some information may have been lost because what is deemed important by one person may not be considered important by another (Smith, Flowers & Larkin, 2009). Secondly, the interviewer had varying degrees of prior contact with the participants, ranging from no prior contact to having completed pre and/or post-treatment psychometrics with some participants. One possibility is that there may have been a higher level of disclosure from those with previous contact with the interviewer, as a consequence of increased rapport. Finally, it should be noted that in the current study there was the potential for self-selecting sample bias. It is possible that the individuals that chose to be part of the study had a higher level of engagement with Tai Aroha and more positive experiences with their reintegration.

2.2.3 Results and discussion

Overall the participant interviews revealed the importance of social context in the transition from treatment to the community. This includes the importance of relationships, social roles and self-concept, and managing finances. Superordinate themes and emergent themes are listed in Table 9.

Table 9

Themes from interpretative phenomenological analysis of follow-up interviews from 16 Tai Aroha participants

Superordinate Themes	Emergent Themes
Importance of Relationships	Intimate/partner relationships
	Family relationships
	Social network – friends and associates
	System relationships.
Social Roles and Self-concept	Family roles
	Gaining employment
	Meaningful activities
Managing Finances	Living within your means

Each of these themes is briefly summarised, with one typical quote included and with reference to relevant literature. For a more comprehensive list of supporting quotes for each of the superordinate and emergent themes see Pinny (2014).

Theme 1: Importance of Relationships

Intimate/Partner Relationships

The partner relationship appears to have a significant impact on many participants in terms of their plans and goals for life, and their ability to cope with and manage stress. Five of the men in the current sample reported on this theme, with the relationship appearing to help in shaping their identity, their sense of belonging in the world, and the social roles they adopt in their life.

> "My plans went out the window when my relationship went. I'm in this 'out of it' space and I can't think outside the box." (Participant 15).

Similarly, in a piece of qualitative research comparing parole successes to parole failures in the United States, Bucklen and Zajac (2009) reported that having a quality marriage or intimate relationship served as a protective factor in reducing re-offending. Further, it was found that those with a high level of satisfaction in their marriage described having a sense of stability and support (Bucklen and Zajac, 2009).

Family Relationships

For three men, resolving conflict without aggression or violence within their familial relationships following treatment appeared to be challenging.

> "Yep. Disagreement with my old man about disciplining my three year old. I just ended up having an argument. My old thoughts were I'll punch you in the head but I switched to alternative thoughts, look at how I turned out, I've got to finish my sentence here, and so I just talked about it." (Participant 12).

These men described family relationships that have suffered some damage over the years, and a process of reconciliation and restoration of these relationships during the process of treatment and reintegration. In a longitudinal study of men following release from prison, Visher, Bakken & Gunter (2013) identify family contact as being important and linked to the successful completion of a parole sentence. They suggest that reintegration should involve regular contact with family members where possible, whether this be in person, by phone or through letters. As an example, a number of the men identified the reintegration meeting at Tai Aroha as being an important part of this process, with the offender getting the opportunity to communicate their desire for change and their plans for the future. This appears to hold particular weight when there is some endorsement by family members or significant others of the progress made thus far, as reported by four of the participants.

> "The look on my family's faces when they see my progress, buzz them out. Their reaction is what got me." (Participant 17).

Qualitative research by Maruna, LeBel, Mitchell & Naples (2004) supports this, with participants in their study reporting that many offenders will often doubt their own reintegrative success until those around them acknowledge they have observed it also (Maruna et al., 2004). This is consistent with the idea of labelling and de-labelling, which has been implicated in the acquisition of, and desistance from, crime (Maruna et al., 2004).

<u>Social Network – Friends and Associates</u>

Four men identified very clear boundaries in terms of the people they would associate with and in cutting ties with old associates. In addition to this, these individuals and three others made reference to the value of new pro-social friendships and the impact this has had on consolidating their treatment gains. Generally men are reporting that they are making new friends through work (both paid and volunteer), sport, or church groups.

> "Better mates than I had before I went to Tai Aroha, I guess. They've gone a long way to keeping me out of trouble. They sort of weren't into things a lot of the people I was associating with were into when I was in and out of jail. They all had jobs and weren't into crime; so pretty much they were a role model to me; so I just learnt off them how to be a better person." (Participant 2).

Seven men reported difficulty contemplating putting an end to their antisocial associations, perceiving that there was some physical safety (or backing) necessary in the world which these associations could provide. For others, these were valued relationships which had a sense of loyalty and belonging attached to them, particularly where these associations were to a gang.

> "Just the family thing, brotherhood, didn't have much of that when I was growing up. Got to have someone to give all your loyalty to. Honour, not much of that around. They're always going to be there when no-one else is." (Participant 4).

Membership to a gang is considered to significantly increase risk of re-offending upon release to the community. Gang associations influence this risk and contribute to the maintenance of antisocial attitudes and behaviour in a number of ways, including limiting exposure and investment in relationships with pro-social others, and

obstructing the development of a reformed identity as a pro-social member of society (Thornberry et al., 2003; as cited by Braga, Piehl & Hureau, 2009).

System Relationships

Three men gave the impression that the initiation of system-based relationships with Work and Income NZ (WINZ) and Community Probation during treatment was something Tai Aroha is doing well. The majority of the men reported having contact with their Probation Officer and WINZ representatives prior to their release back into the community. Despite this early contact men were still consistently viewing their relationship with the Probation Officers as compliance-based, rather than supportive, with eleven of the men expressing this view. The participants in the sample generally reported having amicable relationships with their Probation Officers, based on an understanding that they needed to complete their sentence.

> "It's nothing to me coz it doesn't matter how many times I change my PO it's not like I'm trying to make friends to them, no loss to me, not like we're building relationships the whole time they're my PO." (Participant 13).

Theme 2: Social Roles and Self-concept

A number of men commented on the usefulness of family roles, employment or meaningful activities, particularly those which have an element of responsibility attached to them in assisting their transition back into the community. One commonly identified benefits of these roles was to keep active throughout the day and week, leaving less time and energy for antisocial behaviour.

Family Roles

Six men in the current study spoke about the importance of their families and their desire to be a good father or grandfather, and a positive role-model for their children and families. These men also commented on the commitment required to fulfil this role, and the need to be involved on a day-to-day basis, which effectively uses much of their available free time.

> "It's way up there [participant's motivation to adhere to release plans], I just want a whole new future now. I just want to succeed, try to get a job, be able to have money to buy my kids presents, birthdays, go to school functions, parent meetings, those sort of things I haven't really done before. I just want to be the best Dad there is." (Participant 3)

This is consistent with desistance literature which has indicated that taking on family roles promotes the formation of a pro-social identity (Hairston, 2002; as cited by Visher, Bakken & Gunter, 2013). In a longitudinal study of offenders following re-entry into the community it was found that successful completion of parole was more likely for fathers that were actively involved in the lives of their children upon release (Visher, Bakken & Gunter, 2013).

Gaining Employment

For the men that have managed to gain employment this is reported to have been a positive experience, providing access to pro-social networks of people and reinforcing treatment success through acknowledgement and acceptance by pro-social others. Six men reported difficulty in gaining employment, and perceived barriers in terms of their own motivation, skill base, and expected rejection based on their history of offending.

> "I understand it is hard to get employment, we have criminal records and they do police checks and people don't like criminals working for them." (Participant 1).

Previous research into reintegration has identified employment as a factor contributing to successful reintegration. In their qualitative review of reintegration for a group of child sex offenders in New Zealand, Russell, Seymour and Lambie (2013) found that offenders viewed employment as important to their reintegration. In interviews offenders expressed a desire to have the means to support themselves financially and also acknowledged the role of employment in increasing their life satisfaction and self-esteem (Russell, Seymour & Lambie, 2013).

Meaningful Activities

Many of the men shared the view that the structured activities and daily routine provided at Tai Aroha was beneficial to their overall treatment. Three men commented that they simply continued on with parts of this routine once they were released back into the community. One participant who had not managed to implement such structure in his life in the community reported the desire to do so.

> "Tai Aroha had things to do every day. When I got home it was boring coz everyone had things to do. I found it quite boring so that's why I joined that Habitat so I didn't fall back into my old ways." (Participant 1).

While many men in the current study explicitly mention the benefit of keeping busy, it is possible that engagement in community activities holds further benefits in terms of facilitating the development of a pro-social identity, which allows the former offender to see themselves as separated from the 'offender' label (Burnett & Maruna, 2006). It appears that this can occur through the acquisition of social roles and participation in activities in the wider community whereby the former offender has the opportunity to behave pro-socially and have this recognised by others. In effect this assists the de-labelling process, the reformation of self-concept, as well as reducing feelings of isolation from the pro-social community (Maruna et al., 2004; Burnett & Maruna, 2006).

Theme 3: Managing Finances

Living within your means

Ten men in the current sample reported that they were struggling financially and that this was causing distress in their lives and relationships. It is repeatedly identified by them as one of the factors most likely to cause them to commit an offence in the future. A number of men commented that while Tai Aroha provided budgeting support during the programme, the relevance of this was not apparent to them until they were faced with managing their finances in the community. Many of the men reported outstanding fines and debts, largely as a consequence of their previous offending lifestyle and irresponsibility with finances. There was a sense that some of them found these obligations overwhelming and difficult to manage. For the men that were coping well, they largely reported good support from family members which enabled them to meet their financial obligations, either through financial assistance or through the provision of food or other items.

> "The plan went out the door. Finances at the time. I was tight at the time so the only other option was to grow. Grow and smoke it" (Participant 6).

In their study comparing parole successes to parole violators, Bucklen and Zajac (2009) reported a high level of difficulty in managing finances among parole violators. Those that were violating parole tended to find budgeting and prioritizing their spending as significant challenges (Bucklen & Zajac, 2009).

Overall, the above study explored the experiences of high risk violent offenders in their transition from the Tai Aroha treatment programme to the community. Key factors impacting on the experience of reintegration for this group of men were relationships with intimate partners, family, friends and system representatives, the social roles adopted and their ability to manage their finances. Results highlighted the reciprocal nature of the reintegration process as the individual interacts with their community environment; and the overlap between treatment and reintegration. The experience of reintegration for these particular men appears to be mediated by their continuing motivation to establish a non-offending lifestyle and pro-social identity, the progress made in treatment regarding both criminogenic and non-criminogenic needs, and the quality and availability of a pro-social support network. In particular, the study highlighted the importance of relationships in an offender's experience of reintegration, and the endorsement of significant others in their change journey. In the current study information was not available regarding the capacity of the family or significant others to provide reintegration support. It may be useful to investigate this in future research in terms of how capacity and motivation to provide support impacts on reintegration outcomes.

The current research indicates that an individual's ability to navigate relationships and make sensible life decisions is mediated by psychological factors such as underlying beliefs, relationship and communication skills, as well as motivation to change. In terms of motivation to change, it is possible that those individuals with greater motivation to change engage more actively in the reintegration process and therefore, have better reintegration outcomes (Graffam, Shrinkfield, Lavelle & McPherson, 2004). The link between the ability to manage important relationships and reintegration outcomes points to the overlap between reintegration and treatment. It is possible that those individuals which struggle to manage themselves in their personal relationships also have greater difficulty in managing themselves in their various treatment, reintegration and system relationships. This may impact on working alliance and ultimately treatment, reintegration and recidivism outcomes. There is some indication in the above study of a link between the ability to manage finances and attitudes towards employment, welfare and money. For some men it appeared that irrespective of their income they were unable to manage their money. This in part may have been due to difficulties with budgeting, however, some of the views expressed indicated an underlying attitude of entitlement and difficulty in delaying short-term rewards with respect to finances. This may be useful to explore in future research and consider the implications for both treatment and reintegration practice.

In conclusion, the current research is supportive of the idea that reintegration is an individual process which occurs over time, and is influenced by the social context in which it occurs. Therefore, on-going treatment needs and responsivity factors need to be taken into account when determining the nature and level of reintegration support required by an individual. Further research is required to ascertain the relationship between the reintegration experience and successful reintegration outcomes.

2.3 Audit, compliance and integrity monitoring

2.3.1 Evaluation questions

What is the level of programme integrity as measured against programme design and the principles associated with the "Community of Change"?

How has the programme progressed in terms of addressing Lucy King's recommendations following her formative evaluation in 2012.

2.3.2 Method

Integrity Monitoring (IM) of the HRSTUs (including Tai Aroha) is part of a the strategy of Psychological Services to maintain high integrity in these programmes.

Given the developing acknowledgement of programme integrity as a critical factor in programme impact, Andrews and Dowden (2005) outline what they identify as key indicators of integrity. Those relevant to the implementation of programmes include:

(1) ***Specific model***: a model or theory of criminal behaviour is specific in regard to desired practice.
(2) ***Selection of workers***: workers selected possess general interpersonal influence skills such as enthusiasm, caring, interest, and understanding.
(3) ***Trained workers***: workers are trained in the delivery of the programme.
(4) ***Clinical supervision of workers***: workers receive clinical supervision from a person who has been trained in the delivery of the programme.
(5) ***Training manuals***: desired practice is specified through printed and/or taped manuals.
(6) ***Monitoring of service process and/or intermediate gain***: structured procedures assess service and/or intermediate gains.
(7) ***Adequate dosage***. The length and content of the programme is matched to the risk and needs of the participants.

Where not already addressed by the existing structure of the HRSTUs, the current IM framework attempts to sample these domains alongside compliance with therapeutic community principles (see below). To achieve this a two-step model of monitoring covers the following:

1. **Audit/Compliance (A/C).** A/C measures are completed by a programme manager (i.e., Principal Psychologists or Programme Manager of Tai Aroha) from another STU. A/C measures are used to identify the presence or absence of activities, environment, behaviour, policies and procedures that support the goals and processes of a therapeutic community and more general programme integrity. Although not designed to cover IM in depth, A/C measures are considered necessary (but not sufficient) to support the effective running of the programme.

   Evidence is gathered from a variety of sources including observation of the physical environment, discussion with senior staff (and occasionally programme participants), and review of programme documentation (e.g., IOMS, referral lists, case files, procedures manuals, completed programme documentation and forms). Comments include particular strengths or recommendations to remedy an identified issue. Domains covered by A/C include: (i) the physical venue; (ii) resident selection, management and programme documentation; (iii) participant

induction; (iv) the therapeutic community; (v) supervision of programme staff; and (vi) the interface with other services; and (vii) integration of cultural values, concepts and processes (see Appendix B & D for A/C documents).

2. **Therapeutic Community Integrity Monitoring (TCIM).** In contrast to Audit/Compliance, which focuses on the presence or absence of items being surveyed, TCIM aims to investigate the ***quality*** of these domains (Appendix C and D). TCIM is divided into two sections, the first gathering behavioural evidence related to the integration of bicultural concepts and the occurrence of nine TC principles (i.e., member roles; membership feedback; members as role models; relationships; collective learning formats; milieu and language; structures and systems; open communication; and, community and individual balance; DeLeon, 2000). Sources of evidence include written materials, observation of activities and therapy groups, and, in some instances, participation in activities. Monitors also interview a selected number of staff and programme residents to gather information about their experiences of the TC as a whole and for specific information related to the nine principles.

   In the second section of TCIM specific criteria directly related to the delivery of group psychotherapy are examined. Areas include: (i) pre-programme assessment; (ii) adherence to programme manual; (iii) adherence to treatment style; (iv) group psychotherapy skills; (v) responsivity skills; (vi) therapeutic quality – facilitator skills; (vii) therapeutic quality – process used; (viii) adherence to theoretical principles; (ix) facilitator therapy interfering behaviours; and, (x) facilitator skills for overcoming participant therapy interfering behaviours. Evidence for these domains is gathered by direct observation of sessions or DVD recordings of sessions. Staff and residents are also interviewed where appropriate. A/C results (conducted in the month prior to TCIM) are provided to the monitor in order to assist with the preparation for audit.

Rating scales were developed to summarise AC and TCIM results and provide comparisons within and between STUs over time (see Appendix E). These scales were used to moderate Tai Aroha's Integrity Monitoring results (both AC and TCIM) independently by the current author and one of the two senior staff completing the TCIM for the 2014 period. On comparing these results, the reliability between ratings was initially 91.2%. Agreement was reached on all items following discussion. Where ratings were discrepant, a conservative approach was taken (i.e., assuming the poorer score).

2.3.3 Results and discussion

Since IM (as described above) began in the HRSTUs, Tai Aroha has been audited on three separate occasions; in 2011, 2012, and 2014. The ratings for Tai Aroha across these three time periods are shown in Table 10.

Summarising results, IM processes identify consistency of 'good' practice across the time periods in the programme delivery at Tai Aroha. Monitors have been consistently impressed with the quality of programme delivery and the dedication of staff and residents to the principles and practice standards of the programme.

Table 10

Tai Aroha Integrity Monitoring results for 2011, 2012, and 2014

Date of A/C	May-11	Mar-12	Apr-14
A/C monitor	Paul Whitehead	Jim Van Rensburg	Edward Green
Dates of TCIM	Jun-11	Apr-12	Apr-14
TCIM monitor	Andrew Frost	Andrew Frost	Crista McDaniel
Audit Compliance			
Cultural values, concepts, and processes	Good	Good	Good
Physical venue	Good	Good	Good
Resident selection, management, and prog documentation	Limited	Good	Good
Participant induction	Good	Good	Good
Member roles	Adequate	Good	Good
Membership feedback	Adequate	Good	Good
Membership as role models	Adequate	Good	Good
Relationships	Good	Good	Good
Collective learning formats	Adequate	Good	Good
Milieu and language	Good	Good	Good
Structure and systems	Adequate	Good	Good
Open communication	Adequate	Good	Good
Community and individual balance	Adequate	Good	Good
Supervision of prog staff	Adequate	Good	Good
Interface with PS and CPS	Good	Good	Good
Therapeutic Community Integrity Monitoring			
Member roles	Good	Good	Good
Membership feedback	Good	Good	Good
Membership as role models	Good	Good	Good
Relationships	Good	Good	Good
Collective learning formats	Good	Adequate	Good
Milieu and language	Good	Good	Good
Structure and systems	Good	Good	Good
Open communication	Good	Good	Good
Community and individual balance	Good	Good	Good
Cultural values, concepts, and processes	Good	Good	Good
Pre prog assessment	Good	Good	Good
Adherence to manual	Good	Good	Good
Adherence to treatment style	Good	Good	Good
Group psychotherapy skills	Adequate	Good	Good
Responsivity skills	Good	Good	Good
Therapeutic quality	Good	Good	Good
Theoretical principles adhered to	Good	Good	Good
Facilitator Therapy Interfering Behaviours	Good	Good	Good
Participant Therapy Interfering Behaviours	Good	Good	Good
Overall Quality	**Good**	**Good**	**Good**

Between the 2012 and 2014 monitoring periods further work has been undertaken to address the recommendations made by Lucy King in her 2012 formative evaluation. Addressing each of these areas in order:

Developments of workbooks and hand-outs

Improvements to the programme materials have primarily occurred in the two key therapeutic modules of the programme: the 'Core' group; and, 'Skills' group.

The Skills group session occurs two times per week and focuses on developing key interpersonal behaviours to support pro-social behaviour change. Programme staff have worked to develop practical documentation and resources for participants including:

- A 'skills passport' where participants are accredited for demonstrating identified pro-social skills at various opportunities during the programme. The expectation is that all skills will be evidences and 'stamped' to show mastery of each skill before programme completion. This has helped to improve relevance and engagement with skills practice for the men.
- A 'skills manual' is the companion document to the 'passport'. This is a handout for residents covering the key skills including emotional regulation, interpersonal effectiveness, mindfulness skills and distress tolerance.

The Core module covers a range of themes and activities targeting participants' offence-related needs. As noted at the end of Section 1 of this report, the Tai Aroha men have significant personality problems, high levels of criminal thinking, and extensive risk/need criminal profiles. This dynamic often presents within the treatment environment as regular interpersonal crises; reflecting such issues as substance abuse, family conflict, conflict with other residents, impulsive hedonistic behaviour, resistance or disruption to the therapeutic community, and other therapy interfering behaviours. These behaviours regularly make it difficult to achieve scheduled goals or objectives set for the 'treatment room'. Treatment team members can become conflicted between addressing what is 'on top' for the residents or the imperative to meet planned treatment objectives.

The main development in this area has to superimpose a treatment hierarchy designed to manage the various challenges brought to group by the men in a way that more effectively manages group process, blocks to change and engagement. This model, drawn from Dialectical Behaviour Therapy (DBT; Linehan, 1993) and, assuming a degree of significant personality disturbance among group participants, creates a shared structure (for facilitators and participants alike) for addressing therapeutic challenges with first and subsequent priorities respectively given to: violence ideation; therapy interfering behaviour; quality of life interfering factors; addressing core beliefs; mindfulness/skills/treatment goals; and trauma effects (which participants are encouraged to address post-programme). The implementation of this DBT model, is designed to 'ground' everyone in what the key issues are and what needs to be prioritised, with a particular focus on using the skills that the men have been developing in the programme. Use of this model should also contribute to a decrease in violence behaviour/ideation and increased retention of residents on the programme but is currently in the bedding down stage with the team working to put the theory into practice. However the fundamentals of the model are well understood but staff and current residents and there is a high degree of ownership of the model.

The above developments are subject to regular and iterative review by staff with moderation by senior staff in the Psychologists' office to avoid programme drift.

Further development on the reintegration planning model

There have been limited further developments in this area given this is part of a broader project within Psychological Services on the focus for and activities of the Reintegration Coordinators across the STUs. However, in preparation for this project the Tai Aroha programme manager has instituted a weekly reporting template for the Reintegration Coordinator to report on activities and issues for the group members. Additionally Psychological Services staff have developed a 'first 100 days' poster which focusses discussion and planning for residents around managing the highest risk period following their treatment completion.

Training developed and delivered for staff managing offenders with severe personality disorders

Training has been developed and delivered by the local Principal Psychologist on the above-mentioned DBT treatment hierarchy. This training has been well received and it is planned for it to be able on a regular basis for those involved in the treatment team. Similarly, an in-depth training on John Livesley's (2012) model for treating personality disorders has also been available to staff at the National Training Event and when further required. Staff have also undertaken intermittent training in the areas on motivational approaches, CBT, managing personal processes in group therapy, and managing trauma effects.

Continued exploration of different models of delivery of the programme

This recommendation was primarily concerned with the staff resourcing requirements of the programme, particularly around the co-facilitation model resulting in two psychologists being required to run the modules. A number of options to reduce the cost and impact of co-facilitation have been trialled since King's 2012 review. In the main co-facilitation has been achieved by combining a lead psychologist with a second (less costly) provider such as BTM provider, psychologist intern, or junior staff member. Costs have also been offset in other areas of the programme to free up resources, such as the use of psychometricians – who are significantly less expensive than staff psychologists – to complete time-consuming pre- and post-psychometric testing and exit interviews of programme participants. This has produced significant savings, allowing staff psychologists to be redeployed into the more complex responsibilities of treatment delivery.

2.4 Section summary

Overall the Tai Aroha programme is targeting men who are high-risk with versatile and violent offending, and with complex offence-related needs. Maori men and gang members are likely accessing the programme at a higher rate their presence in the broader high-risk Home Detention and Intensive Supervision populations. Assessment of programme starters suggest that participants have significant treatment needs and interpersonal disturbance as assessed on measures of personality disorder, offence-related needs, and other relevant psychometrics. These needs appear to be of equal or greater level than their STU compatriots. At first glance this may appear surprising given that it might be expected that men on community-based sentences would be less dysfunctional than those men who have committed offences resulting in imprisonment. However, more likely, these men are drawn from the same overall population of high risk offenders and differences may, in reality, reflect that the Tai Aroha men are often sentenced directly from dysfunctional and chaotic community-based lifestyles compared with STU participants who have a period of time in prison during which their behaviour is more likely to become settled and stable.

There were few significant differences on psychometric measures between men who completed the programme and those who did not, with a notable exception that completers tended to have higher scores on a measure of treatment readiness and responsivity (TRRG:SV). However, men on Intensive Supervision sentences have a far poorer completion rate than those on Home Detention. Although retention and completion rates have generally improved over time, these rates could have been far higher if 14 of the 18 men on Intensive Supervision in the sample had not dropped out. Despite this, attrition rates are still favourable compared with observations of attrition rates within programmes targeting similar offenders overseas (Olver, Stockdale & Wormith, 2011).

In interviews with programme attendees after some time following ‘release’, they tend to recall their time on the programme favourably and perceive the programme to have met many of their reintegrative needs. However, many still struggle to maintain changes in their lives and behaviour following treatment, particularly with managing antisocial peers, family relationships and financial stressors.

Programme integrity appears to have improved based on independent and objective measures across three different measurement periods and integrity was overall identified as ‘good’ (i.e., the highest defined rating) at the last review in 2014. There are ongoing efforts by the therapy and supervisory staff of the programme to make improvements in the programme and many of the developments recommended by King (2012) have been pursued, although there is still much work to be done in the area of reintegration.

3.0 Outcome Evaluation

3.1 Pre- and post-testing results of participants on selected psychometrics

3.1.1 Evaluation questions

Has the programme influenced key indicators of change in the men who have participated and are any observed changes in the anticipated direction?

3.1.2 Method

Prior to analysis, psychometric data were checked for accuracy and reliability of entry into the Data Capture spreadsheet as described in Section 2.1 (above).

Psychometric measures chosen for pre-post analysis include the following:

The ***Millon Clinical Multiaxial Inventory – III*** (MCMI) is a 175 item inventory derived from personality theory (Millon, Millon, Davis & Grossman, 2009). This measure identifies significant personality traits and other broader psychopathology in clinical populations. Research both in New Zealand and overseas has observed a higher rate of significant personality dysfunction with high risk offenders (Burns, et.al., 2011; Wilson, 2004) and so it is expected that MCMI results for participants would:

- Reflect significant patterns of personality pathology at pre-programme assessment. This issue has been covered in Section 2.1 (above).
- Reflect a reduction in some personality traits across treatment, particularly those traits likely targeted either directly or indirectly in the treatment environment (e.g., antisocial, narcissism, passive-aggressive, paranoid).

The ***Paulhus Deception Scales*** (PDS) is a 40-item instrument used to identify individuals who distort their responses either through self-deception, impression management, or a combination of these methods (Paulhus, 1998). If treatment was effective in improving participants' insight into their offending and increasing their self-responsibility, then changes in pre- and post-testing on this measure would result in decreases in self-deception and impression management on the PDS subscales.

The ***Anger Disorder Scales*** (ADS) is a 74-item self-report measure designed to assess clinically dysfunctional anger in adults and help practitioners to design individualised treatment plans (DiGiuseppe & Tafrate, 2004). For participants with high levels of dysfunctional anger at pre-treatment it could be expected that there would be post-treatment reductions on this measure.

The ***Psychological Inventory of Criminal Thinking Scales*** (PICTS) is an 80-item self-report measure that assessed eight thinking styles considered to support and maintain criminal lifestyles (Walters, 2006). Reductions in criminal thinking would be anticipated for men successfully completing the programme.

The ***Criminal Attitudes towards Violence Scales*** (CAVS) is a 20-item self-report measure designed to assess criminal attitudes to violence (Polaschek, Collie, &

Walkey, 2004). Men successfully completing Tai Aroha would be expected to endorse less beliefs supportive of violence following treatment.
The ***Treatment Readiness, Responsivity and Gain scale: Short Version*** (TRRG:SV) is a 24-item measure completed by clinicians to systematically assess an offender's readiness and responsivity to treatment and to subsequently measure the degree to which gains have been made (Serin, Kennedy & Mailloux, 2005). Only the first two sub-scales ('readiness', and 'responsivity') are completed at both pre- and post-treatment time periods and, thus, the changes in these sub-scales are reported on below.

Changes in pre- and post-treatment results were analysed for the above measures using paired t-tests (and ANOVAs where relevant) and are presented below. In all cases the 0.001 level of statistical significance was used to reflect a higher level of confidence in the results if one was observed.

Other measures were either completed at pre- or post-programme phase only (e.g., the Violence Risk Scale and the Release Proposal Feasibility Assessment) or had been introduced part-way through the programme and so there are yet insufficient test administrations to meaningfully describe.

3.1.3 Results and discussion

During the evaluation period there were 52 men who successfully completed the programme and in most instances both pre- and post-treatment psychometric results were available for comparison.

The Millon Clinical Multiaxial Inventory – III (MCMI)

Changes from pre- to post-treatment MCMI-III scores for Tai Aroha graduates are shown in Table 11 and Figure 1. These results show statistically significant improvements across all scores excepting the 'narcissistic', 'antisocial', 'sadistic' and 'drug-dependence' sub-scales. Overall 'disclosure' and 'debasement' scales have dropped, with a concomitant increase in 'desirability'. This suggests that men are more cautious about impression management following treatment and/or their self-report reflects a self-perception of change. All other personality and clinical sub-scales on the MCMI-III *reduced* significantly, excepting a significant *increase* in the 'compulsive' scale. For a sample of impulsive/ aggressive men, an increase in 'compulsive' behaviour is probably a good result; suggesting a tendency for increased self-control. Notably there are significant drops on the severe disorder scales of 'borderline', 'schizotypal' and 'paranoid'.

Table 11

Pre- and post-programme MCMI-III score comparisons (repeated measures t-tests) for programme graduates (N=52)

	Pre-programme		**Post-programme**		
Scale	Mean	SD	Mean	*SD*	*t (p)*
X Disclosure +	77.8	16.0	62.7	18.4	5.4
Y Desirability +	62.6	18.6	72.2	11.4	-4.3
Z Debasement +	59.3	17.0	38.0	22.3	6.6
1 Schizoid +	61.4	16.1	50.8	21.8	3.6
2A Avoidant +	58.7	21.1	43.8	28.9	3.7

2B Depressive +	62.8	25.9	45.4	27.6	4.8
3 Dependent +	62.9	22.0	48.6	26.7	4.4
4 Histrionic +	43.5	18.5	55.7	14.0	- 6.0
5 Narcissistic	64.6	18.7	70.4	17.5	-2.5
6A Antisocial	86.4	12.1	81.0	11.5	2.6
6B Sadistic	69.2	12.5	66.1	12.1	1.4
7 Compulsive +	39.0	16.6	51.9	16.5	- 4.6
8A Negativistic +	65.8	21.0	46.2	26.4	4.5
8B Masochistic +	66.1	18.4	50.0	27.2	4.1
S Schizotypal +	***64.2***	***22.2***	***46.9***	***28.1***	***4.5***
C Borderline +	***66.9***	***16.0***	***54.0***	***20.0***	***4.0***
P Paranoid +	***70.3***	***16.3***	***57.9***	***20.5***	***5.0***
A Anxiety +	71.7	28.9	50.9	33.8	4.3
H Somatoform +	44.1	25.0	25.7	*25.6*	4.6
N Bipolar/Manic	69.8	14.0	62.4	20.3	2.9
D Dysthymia +	57.6	21.9	35.6	25.1	5.5
B Alcohol +	85.3	14.3	77.8	12.8	3.6
T Drug Dependence	84.8	15.4	84.6	14.3	.12
R PTSD +	55.4	24.9	37.4	27.7	5.1
SS Thought Disorder +	59.0	19.0	42.6	25.8	4.5
CC Major Depression +	46.3	31.0	26.5	24.9	4.7
PP Delusional Disorder +	61.9	19.1	45.5	27.4	4.2

+ differences are significant at $p<.001$. Negative t values indicate score increase rather than decrease.

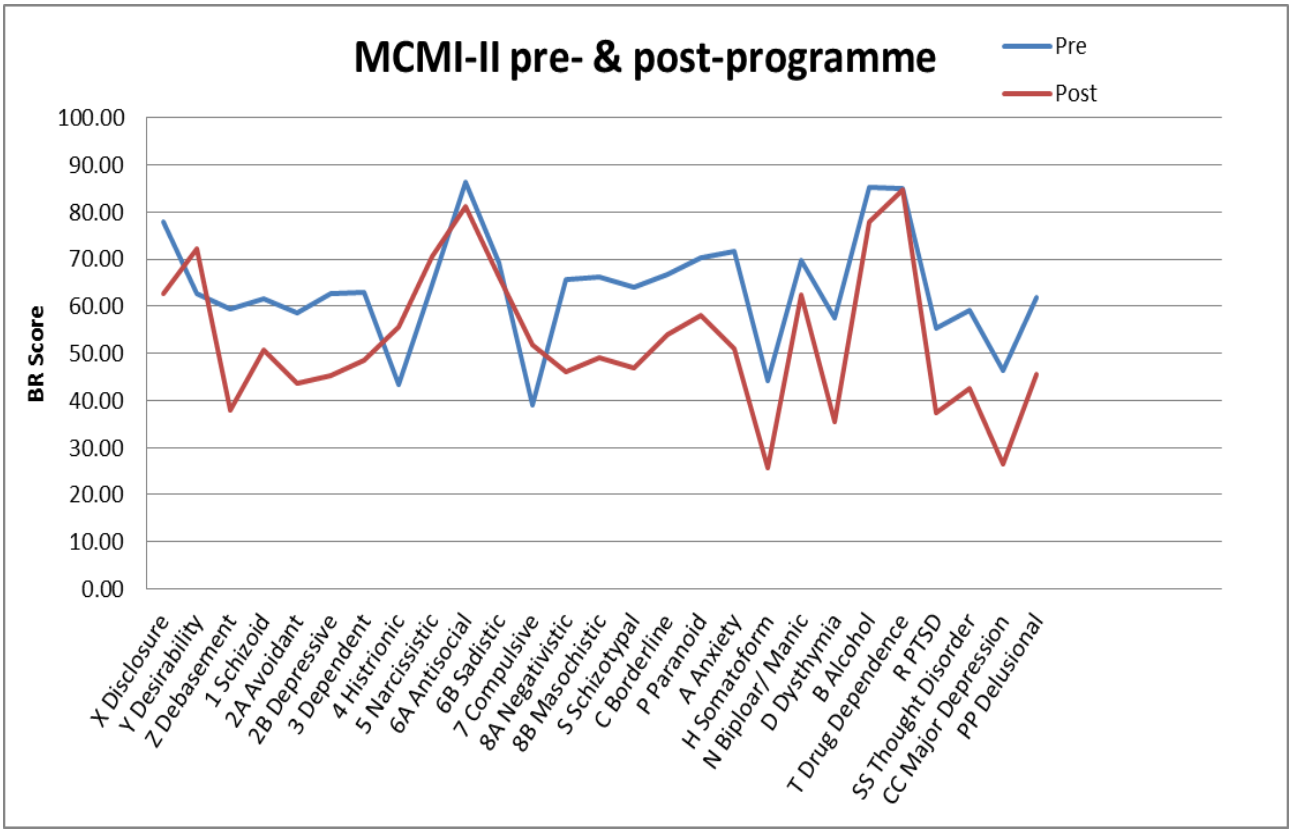

Figure 1. Pre- and post-programme MCMI-III score comparisons

The Paulhus Deception Scales (PDS)

At both pre- and post-testing, the group-based scores where generally in the 'average' or 'slightly above average' range for scales on the PDS. Additionally, were no statistically significant differences observed between pre- and post-scores on the PDS for programme completers. This suggests no strong group-based trend for participants to increase or decrease efforts to manage impressions or socially desirable responding on this measure. This result brings some confidence to assuming acceptable levels of disclosure among programme completers undertaking the psychometric testing while on the programme.

The Anger Disorder Scales (ADS)

Changes in mean scores on the ADS suggested both statistically meaningful change in many of the indices of anger measured by this scale (Table 12).

Table 12

Pre- and post-programme ADS score comparisons (repeated measures t-tests) for programme graduates (N=49)

	Pre-programme		**Post-programme**		
Scale	Mean	SD	Mean	*SD*	*t (p)*[+]
A Scope of anger provocations +	2.84	0.79	2.30	0.88	3.9
B Hurt/Social rejection +	3.16	0.84	2.57	0.80	4.7
C Physiological Arousal	1.87	0.91	1.78	0.72	0.9

D Duration of Anger Problems	3.12	1.48	2.74	1.48	2.0
E Episode length	1.92	0.72	1.59	0.56	3.0
F Suspiciousness +	2.62	0.87	1.96	0.68	5.5
G Resentment +	2.35	0.96	1.73	0.72	5.3
H Rumination +	2.52	1.04	2.02	0.97	3.4
I Impulsivity	2.04	1.12	1.73	0.82	2.2
J Revenge +	2.26	1.12	1.68	0.80	3.4
K Tension reduction	3.30	1.07	3.25	1.18	0.3
L Coercion	1.94	0.70	1.63	0.48	2.7
M Brooding +	2.86	0.90	2.23	0.61	4.6
N Verbal expression	2.07	0.91	1.63	0.65	3.2
O Physical aggression	1.63	0.89	1.22	0.33	3.2
P Relational aggression	1.25	0.42	1.34	0.66	-1.1
Q Passive aggression +	2.23	0.93	1.65	0.69	4.1
R Indirect aggression	2.05	1.00	1.83	0.86	1.4
S Positive impression +	19.84	4.92	16.71	4.39	4.4
T Reactivity/Expression +	16.41	5.42	13.81	4.27	3.8
U Anger-In +	16.21	3.50	13.31	2.75	6.5
V Vengeance +	9.42	3.22	7.72	2.14	4.2
W ADS TOTAL Score +	42.03	11.01	34.84	7.95	5.13

+ differences are significant at $p<.001$. Negative t values indicate score increase rather than decrease.

Only one scale increased, against expectations, that of 'relational aggression' but this was not statistically significant. ADS scores were converted into percentile ranks for the purposes of display in Figure 2. This figure highlights that all of the combined 'higher order scales' had significant changes in the expected direction – including the Total Score – and several of the 'statistically significant' differences across the measure reflected meaningful clinical changes of percentile reductions of 20 points or more.

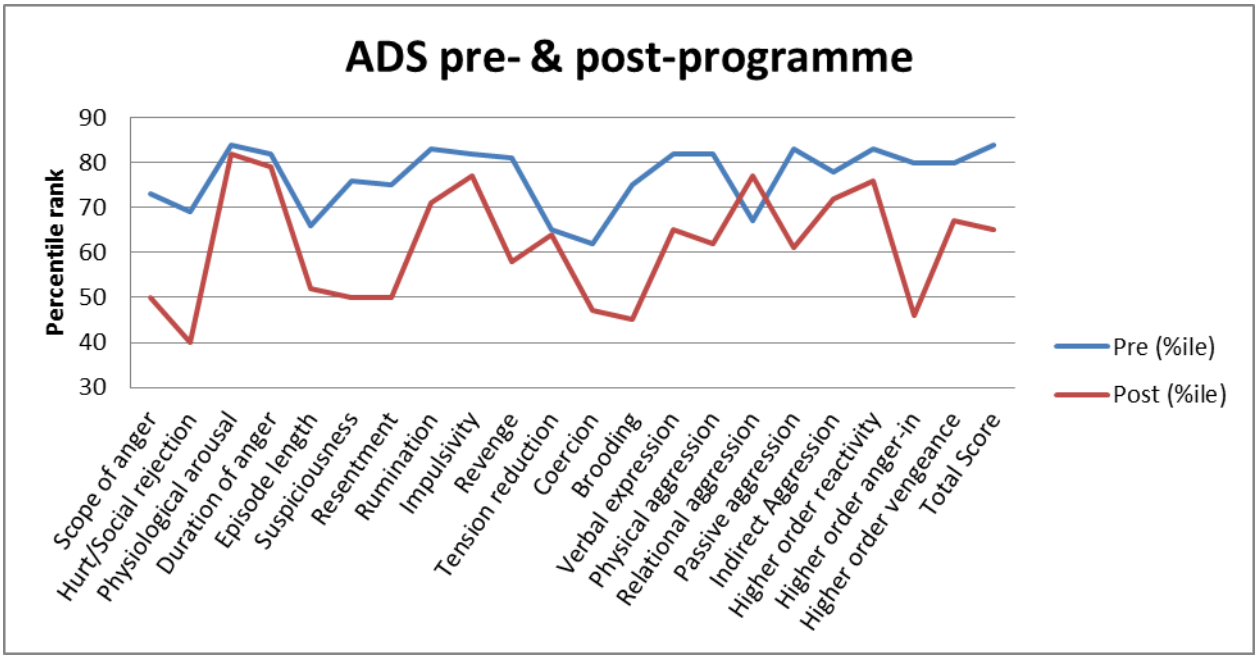

Figure 2. Pre- and post-programme ADS score comparisons

The Psychological Inventory of Criminal Thinking Scales (PICTS)

Pre- and post-programme results on the PICTS also supported observations in improvements in criminal thinking across a number of sub-scales (see Table 13 and Figure 3). Most scales moved in the expected direction with those showing statistical significance including reductions in criminal thinking and problem avoidance.

Table 13

Pre- and post-programme PICTS score comparisons (repeated measures t-tests) for programme graduates (N=48)

	Pre-programme		**Post-programme**		
Scale	Mean	SD	Mean	*SD*	*t (p)*[+]
Confusion-Revised +	64.3	13.4	55.3	11.1	4.8
Defensiveness-Revised +	36.5	9.1	41.5	8.0	-3.6
Mollification	59.7	11.8	54.7	9.7	2.9
Cut off	64.3	11.5	59.2	9.2	2.8
Entitlement	61.9	13.0	60.0	10.6	1.1
Power orientation	58.0	14.2	54.7	12.1	1.6
Sentimentality	56.1	11.7	52.6	12.5	1.9
Super optimism	60.7	13.5	59.3	11.6	0.7
Cognitive indolence +	61.5	10.4	54.7	9.2	4.5
Discontinuity +	62.4	11.5	55.9	9.6	4.3
Current criminal thinking +	62.9	11.8	54.4	10.1	5.0
Historical criminal thinking	64.0	12.1	64.0	11.6	-0.1
Problem avoidance +	62.6	10.6	54.8	9.0	5.0

Interpersonal hostility	60.5	17.9	53.8	10.8	2.8
Self-assertion	63.4	12.4	62.9	10.7	0.4
Denial of harm	53.0	10.0	49.3	9.3	2.5
Pro-criminal thinking	64.2	13.0	62.8	11.2	0.9
Reactive criminal thinking +	64.0	11.5	56.4	9.3	4.4
Fear of change	61.5	14.3	58.0	11.9	1.9

+ differences are significant at *p*<.001. Negative t values indicate score increase rather than decrease.

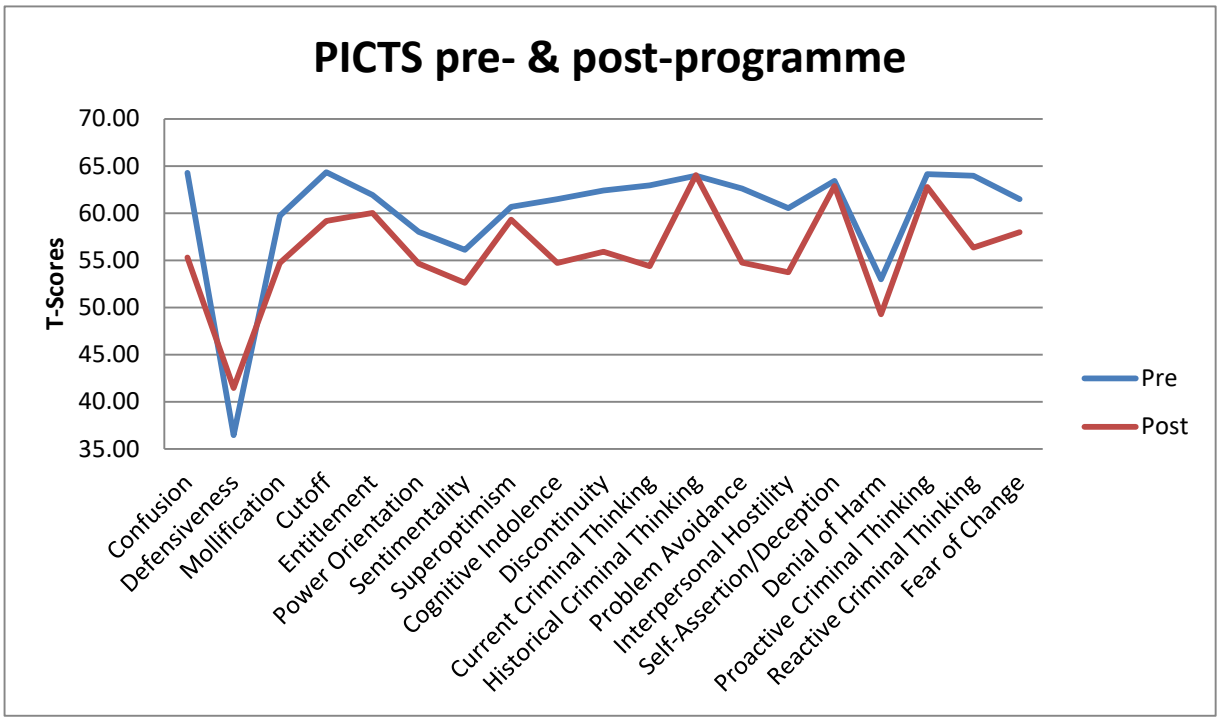

Figure 3. Pre- and post-programme PICTS score comparisons

The Criminal Attitudes towards Violence Scales (CAVS)

There was a significantly lower score at treatment completion (mean score = 37) compared to the pre-programme assessment (mean score 51) reflecting self-reported reductions in approval of violence for men finishing the programme.

The Treatment Readiness, Responsivity and Gain scale: Short Version (TRRG:SV)

On the TRRG:SV (see Table 14 and Figure 4) the overall 'Readiness Scale' and several sub-scales showed improvement across treatment including problem recognition, and each of treatment benefits, goals and behaviours. Similarly for the 'Responsivity Scale' all sub-scales trended in the right direction with significant reductions in procrastination, intimidation, power and control, rigidity, victim stance,

and pro-criminal views. Combined with the observation that completers had higher scores on the TRRG:SV than non-completers at the pre-programme it is notable that this measure continued to show further improvements with treatment engagement across the programme for treatment completers.

Table 14

Pre- and post-programme TRRG:SV score comparisons (repeated measures t-tests) for programme graduates (N=51)

	Pre-programme		**Post-programme**		
Scale	Mean	SD	Mean	*SD*	*t (p)*[+]
Problem recognition +	2.18	0.68	2.60	0.60	-3.7
Benefits of treatment +	2.10	0.58	2.51	0.68	-3.9
Treatment interest	2.18	0.79	2.39	0.78	-1.7
Treatment distress	2.18	0.62	2.51	0.58	-3.1
Treatment goals +	2.02	0.62	2.57	0.58	-4.9
Treatment behaviours +	2.02	0.74	2.43	0.67	-3.9
Motivational/Consistency	2.02	0.71	2.35	0.66	-3.0
Treatment support	1.92	0.69	2.16	0.70	-2.4
READINESS TOTAL +	16.61	2.62	19.53	3.25	-7.6
Callousness	2.22	0.54	2.31	0.68	-0.9
Denial	2.31	0.47	2.61	0.64	-3.1
Procrastination +	1.82	0.82	2.35	0.69	-3.7
Intimidation +	1.08	0.85	1.80	0.66	-5.5
Power and control +	1.94	0.73	2.45	0.76	-3.8
Rigidity +	1.71	0.73	2.55	0.64	-6.8
Victim stance +	1.84	0.54	2.43	0.73	-5.2
Pro-criminal views +	1.88	0.65	2.39	0.72	-4.3
RESPONSIVITY TOTAL +	14.80	2.36	18.90	3.95	-7.1

+ differences are significant at $p<.001$. Negative t values indicate score increase rather than decrease.

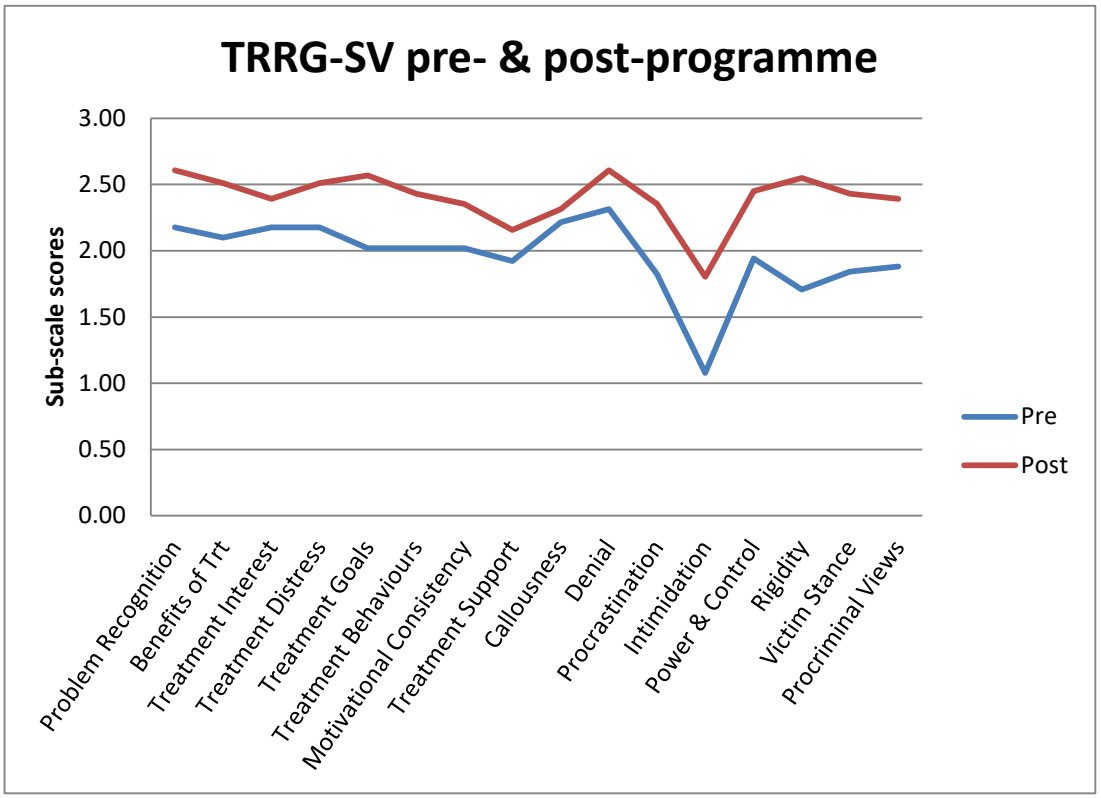

Figure 4. Pre- and post-programme TRRG-SV sub-scale score comparisons

Summarising the results from the pre- and post-psychometric assessments, there are generally consistent changes in the pre- to post-treatment scores for Tai Aroha programme graduates. These changes are generally in the direction expected and reflect reductions in personality disturbance (MCMI-III), the functional expression and control of anger (ADS), and criminal thinking (PICTS, CAVS), and improvements in the ratings by therapists of treatment orientation and responsivity (TRRG-SV). At least, as they depart the programme, Tai Aroha men who have successfully completed treatment 'look' – on standardised clinical measures relevant to their rehabilitation – as if they have made statistically and clinically relevant changes in their thinking and behaviour.

3.2 Recidivism evaluation

3.2.1 Evaluation questions

What effect has the programme had on the reoffending of participants once released into the community?

3.2.2 Method

Of the 88 men identified during the evaluation period 80 men (50 completers and 30 non-completers) had at least 10-months following the programme in which their recidivism outcomes could be identified. This group of men is referred to below as the Treatment Group (TG). Because some of this Treatment Group had been overridden into a higher risk group based on a full psychological assessment, these individuals were assumed to have a minimum RoC*RoI of 0.70 for the purposes of matching with suitable controls. A CARS report was drawn down for men on Home Detention and Intensive Supervision from which a Control Group (CG) could be identified. This included a sample of 12609 individuals. This group was rationalised further based on offence type (no sex offenders; at least one prior violent offence); RoC*RoI (0.68 and above); and similar age and ethnicity to the treatment sample. Further reductions in this sample were made by identifying and removing individuals who had participated in some other significant psychological intervention beyond an initial assessment

Potential matches were then identified by attempting to match each treatment group member to all control subjects within 0.02 RoC*RoI (either side of score); within two years (either side) of age at sentencing; the same ethnicity; gang membership; and sentence type and length. Matching was done 'blind' to recidivism outcome. Attempts were made to identify three matched controls for each treatment individual, although this was not successful in 25 cases. When more than three potential matches were identified, three individuals were randomly selected from each pool. Overall 206 Control Group matches were obtained. A subsequent comparative statistical analysis of the treatment and control groups revealed no significant differences between RoC*RoI, age, sentence type and length, ethnicity, and gang status. This lent confidence to the matching process.

Following sample selection, criminal histories were gathered for all men in the study. Databases were developed to identify a range of reoffending outcomes including:

- Time (days) to first offence, first violent offence and first re-imprisonment.
- Time (days) to first non-breach offence and first non-breach re-imprisonment.
- Number of new offences and length of longest imprisonment sentence (as measures of pattern change).

Information was obtained from individual reviews of criminal conviction histories. Analyses provide a comparison of speed to offending (by type and seriousness). Separate comparisons of time to offending with and without breach offending were undertaken to enable comparisons between criminal and administrative offending. A comparison of outcomes for men on Home Detention and Intensive Supervision was also completed, as was a comparison between treatment completers and non-completers.

3.2.3 Results and discussion

Overall the Control Group (CG) had significantly longer at large (average = 1230 days) than the Treatment Group (TG; average 924 days). Given this survival curves were primarily used as the comparison between reoffending for the two groups because this type of analysis controls for periods at large.

Survival analysis comparisons between the TG and CG observed no statistically significant differences for any re-offence category (i.e., first offence, first non-breach offending, first violence, first imprisonment, first non-breach imprisonment).

Given the prior observation of the high drop-out rate of men on Intensive Supervision a further comparison was undertaken comparing these men with men on Home Detention. Figures 5-6 shows survival curves for these sub-groups of treated men compared with the overall survival curves for the CG for any re-offence and any non-breach offence, respectively. There were significant differences between each sub-group for each of these re-offence type, with treated men on Home Detention (TGHD) likely to do better than the Control Group who, in turn, did better than Treated Men on Intensive Supervision (TGIS). Similarly men who completed treatment did significantly better than non-completers for non-breach offending. There were no statistically significant differences on other comparisons (first violence, first imprisonment, first non-breach imprisonment) for these three groups.

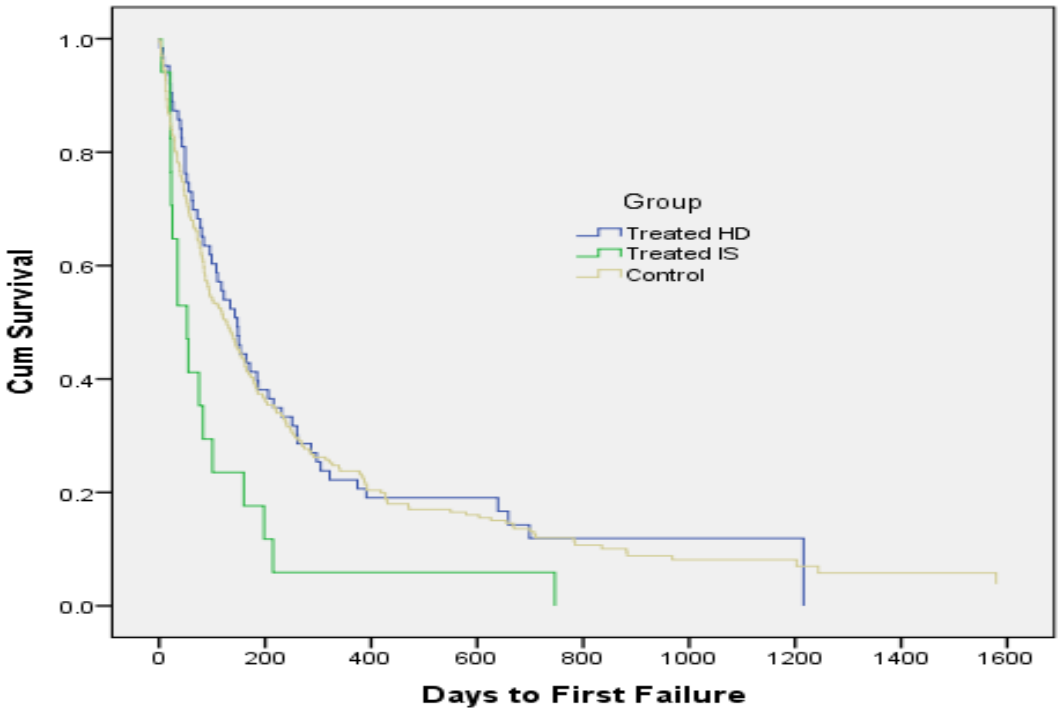

Figure 5. Survival results for Treated HD, Treated IS, and Control Group men (any failure)

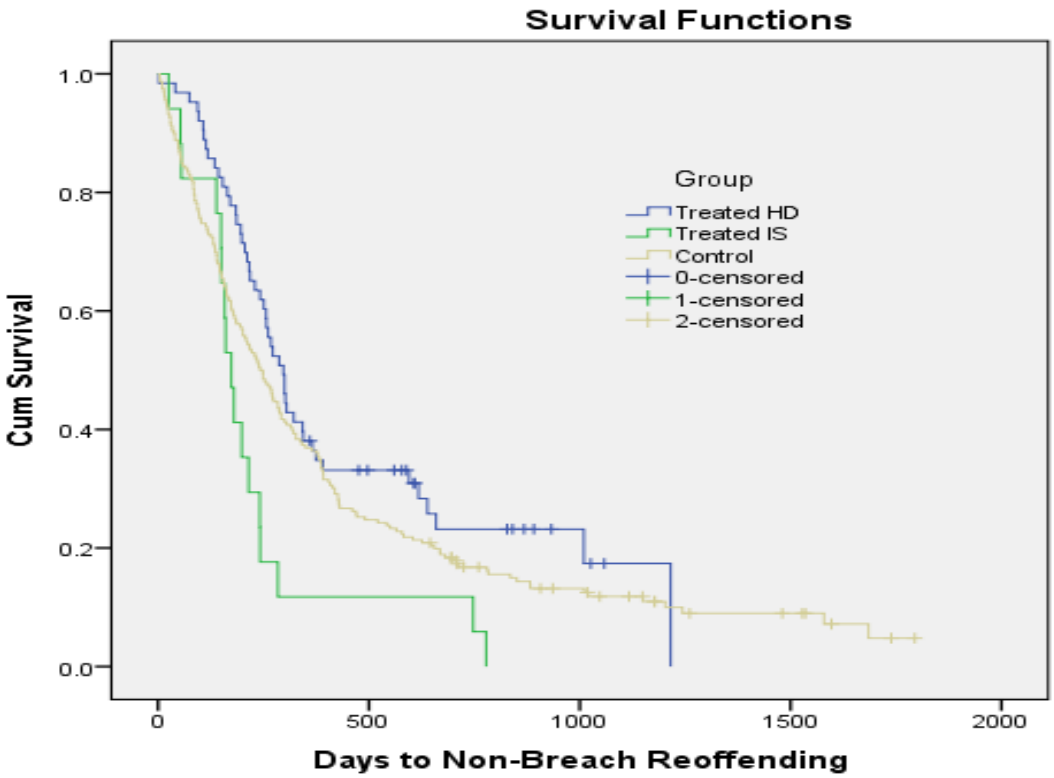

Figure 6. Survival results for Treated HD, Treated IS, and Control Group men (non-breach failure)

Additionally men who had completed treatment (TC) were compared with treatment non-completers (TNC). Significant differences were observed between each group for any reoffending with TCs doing better than the CG who again, in turn, did better than TNCs (see Figure 7).

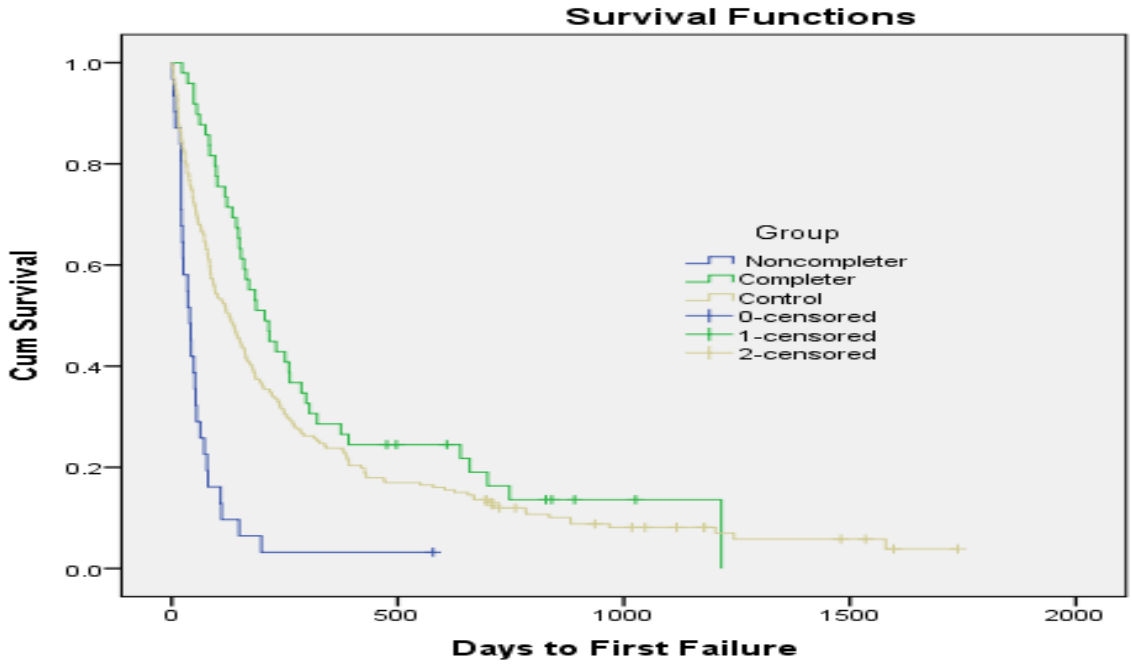

Figure 7. Survival results for Treatment Completers, Treatment Non-completers and Control Group men (any failure)

Finally, we examined re-offending for men during the early phase of the programme (first 18 months) versus those men who began during the next 18 months. This comparison was undertaken to test the observation that new programmes often take some time to 'bed-down' and refinements based on early experience of running a new programme have the potential to improve outcomes. Results suggested that men in the more recent programme period did better on recidivism outcomes than those men who attended at the early stages. Although not all results were statistically significant, most trended in the right direction and a significant and positive result was shown for any-reoffending (see Figure 8). This suggests that the programme, appears to be 'improving' over time. Although the specific mechanisms of improvement are not entirely clear, these could be reflected in a number of factors including improved integrity (see Section 2.3, Table 10), greater programme retention (see Section 2.1, Table 5), improvements to programme content (see end of Section 2.3), reductions in IS participants (see Figure 6 just above) or any combination of these factors.

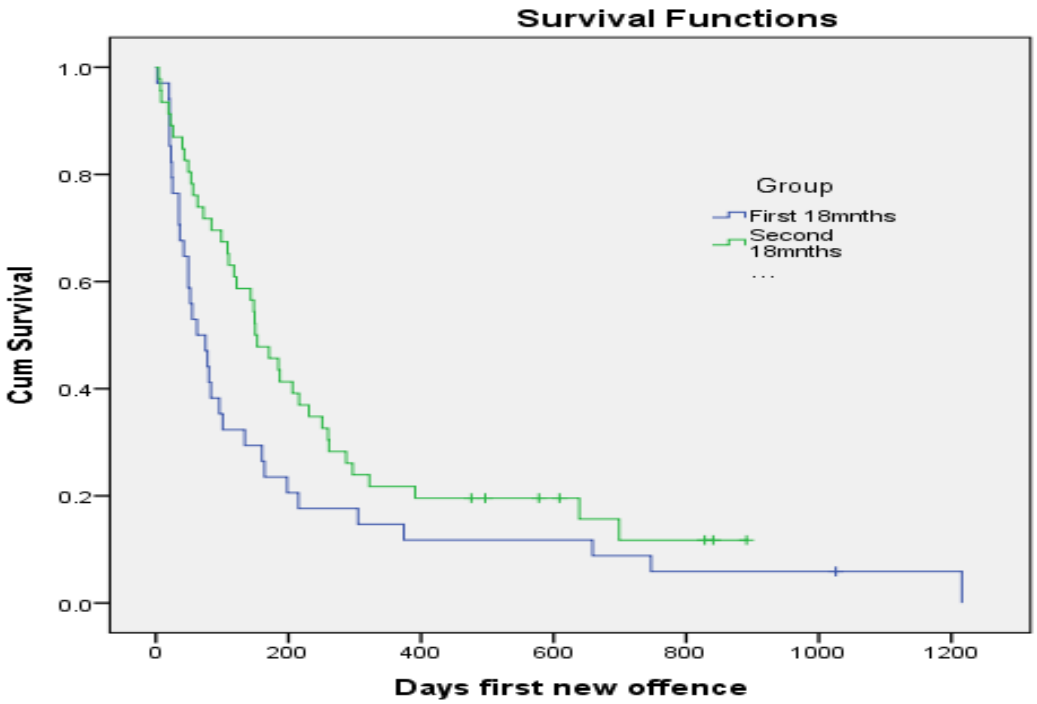

Figure 8. Survival results for Treatment Participants (Completers and Non-completers) by programme period (any failure)

Of note in each case is the high base-rate of offending for all groups, emphasizing earlier observations that these sub-groups of offenders have a high degree of criminal inclination and behaviour.

Survival analyses are limited in that they give an indication of speed to first offending but don't give an indication of pattern change over time in terms of further offending behaviour beyond that first offence. Two further comparisons (length of longest imprisonment; and number of new offences) were undertaken to provide an indication of potential pattern changes between the TG and CG. Comparison of the longest imprisonment for those in the TG and CGs who had been re-imprisoned showed no significant difference. Although the men in the TG had significantly less re-offences overall (7.2) than the CG (9.4), the CG had a longer follow-up period. This difference may then be accounted for, in part, by more opportunity to offend

amongst the CG.

Finally we provide a brief description of the type of offence that resulted in re-imprisonment (Table 15) as an indication of the pattern of further reoffending for both Tai Aroha participants and Control men. Overall Tai Aroha participants have a greater rate of re-imprisonment for compliance-based offending (i.e., breach of conditions) – a difference of over 12 percentage points – with the reasons for other re-imprisonment being similar across the samples. Largely this difference is accounted for by the automatic review of sentences undertaken by programme participants who did not complete the programme, with 24 of the 29 Tai Aroha participants first re-imprisoned for sentence non-compliance being programme non-completers. Thus, of Tai Aroha participants returned to prison for non-compliance (on their first re-imprisonment) almost 83% were programme non-completers. This suggests that Probation is delivering a clear and significant consequence for programme non-participation and that, with gradually improving completion rates, re-imprisonment rates for programme attendees may also reduce.

Table 15

Offence Category (most serious) for first re-imprisonment of Tai Aroha and Control participants

Offence Category	**Percentage re-imprisoned for this offence**	
	Tai Aroha Participants (n=80)	**Control Participants (N=206)**
No-reimprisonment	32.50	38.35
Breach of sentence	36.25	23.79
Dishonesy	12.50	12.62
Violence	12.50	14.08
Driving	2.50	7.28
Contravenes Protection Order	1.25	1.94
Other	2.50	0.49
Drugs	0	1.46
Sex	0	0
Total	***100%***	***100%***

3.4 Section summary

The outcome component of this evaluation examined changes on psychometric measures for programme completers, and changes in reoffending following treatment for completers and non-completers.

An examination of psychometric results shows consistent and robust changes in the pre- to post-treatment psychometric scores for Tai Aroha graduates. These are generally in the directions expected and reflect reductions in personality disturbance, and criminal attitudes and anger.

These results do not consistently translate into robust observations of reductions in reoffending following treatment. In summary and overall, the programme appears to be having a limited positive effect on recidivism with some sub-groups of high-risk men (TGHD and TCs) but a detrimental effect with those on Intensive Supervision. In reality the outcomes for those men on IS are so ineffective they cancel out any positive impact that the programme has on offending rates overall. Thus, while the programme appears to be doing no-harm in terms of overall offending rates, removing men on IS sentences (which is already being attended to by programme staff) and working to contain and retain those men who do attend the programme are likely to serve to further improve overall programme outcomes. In addition the programme appears to be having an improved impact on recidivism rates over time, possibly reflecting better selection, retention, integrity and technology.

4.0 Conclusions and Recommendations

This evaluation examined the Tai Aroha programme by describing programme participants, reviewing available observations of programme integrity, and looking at various outcome measures of performance, including the experiences of participants, psychometric results and recidivism outcomes.

Overall the programme is targeting men who are high-risk with versatile and violent offending, and have complex offence-related needs. In other words, the programme has been effective in selecting men for whom the programme has been designed. Maori men and gang members are likely accessing the programme at a higher rate than in their representation in the broader high-risk Home Detention and Intensive Supervision populations. Assessments of programme starters suggest that participants have significant treatment needs and interpersonal disturbance as assessed on measures of personality disorder, offence-related needs, and other relevant psychometrics. These needs appear to be at an equal or greater level of need than their STU compatriots, perhaps reflecting that the men are often sentenced directly from dysfunctional and chaotic community-based lifestyles compared with STU participants who have a period of time in prison during which their behaviour is more likely to become settled and stable. In short, Tai Aroha participants are tough and tough to manage. There are few significant differences on psychometric measures between men who complete the programme and those who do not with a notable exception that completers tend to have higher pre-programme scores on a measure of treatment readiness and responsivity (TRRG:SV). However, men on Intensive Supervision sentences have a far poorer completion rate than those on Home Detention. Measures of programme integrity appear to be satisfactory and have improved across three successive administrations, perhaps contributing in part to improved recidivism outcomes for men in the second 18-month period of the evaluation compared with the first 18-months. Contributions to the improvement in outcomes over time may include better selection and retention strategies, updates to the programme manuals and materials following King's 2012 review, and ongoing efforts to improve integrity. The programme attendees perceive the programme to have met many of their reintegrative needs, but they have struggled following attendance, particularly with managing antisocial peers, family relationships and financial stressors. In terms of outcome, results on psychometric measures from pre- to post-treatment suggest changes in the right direction (e.g., decreased personality pathology, less experience of anger, and a decrease in criminal thinking styles). Although the programme appears to be having a positive impact on reoffending rates with men on Home Detention this has been fully offset by the lack of impact on those men on Intensive Supervision, with the high programme drop-out and reoffending rates of this latter group nullifying an overall treatment effect.

The evaluation also identifies a number of opportunities for ongoing improvements in the programme. Recommendations arising out of the evaluation include:

1. Given the extremely poor outcomes for men on Intensive Supervision, the Tai Aroha programme could not be said to be working for these men. It is recommended that the programme draw principally from the pool of men on Home Detention sentences who appear to be benefiting more directly from this residential treatment option. Selection of men for Tai Aroha on Intensive

Supervision sentences should be exceptional and reflect a high degree of internal and external motivation for their attendance and participation.

2. It is recommended that the Treatment Readiness, Responsivity and Gain scale: Short Version (TRRG:SV) be used in the pre-programme selection assessment rather than in the 'phase 1' psychometric assessment period. The TRRG:SV appears to have some ability to predict programme engagement and success and the information available from this measure would be valuable to the Case Management Team when making decisions about programme entry rather than being left to after the participant has already started.

3. Given the degree of personality pathology identified during assessment, efforts to integrate treatment strategies to address personality – both as a treatment need and responsivity barrier – are commendable (e.g., the DBT hierarchy). It is recommended that programme staff continue to review how to further integrate personality-focussed interventions into the programme (e.g., considering developments within the High Risk Personality Programme – Revised, ongoing staff development initiatives in this area).

4. Although there are some positive recidivism outcomes for Home Detention participants – particularly as the programme has matured and, in particular, for programme graduates – these results are still limited and ex-residents report ongoing struggles in their desistance pathways. The greatest opportunity in this area is in the focussed use of the reintegrative resources provided by the programme (i.e., Reintegrative Worker positions; time spent in the later part of the programme on reintegrative activities). Several recommendations may assist improve outcomes with a focussed use of these resources, including:

    - Providing sessions on effective budgeting for Phase 3 participants.

    - Increasing the regularity of 'Supporters' Day' sessions to help Phase 3 residents build their pro-social support networks prior to programme completion.

    - Developing and maintaining the programmes relationship with other external providers of reintegrative need (e.g., Whanau Ora, religious organisations, employment and education providers).

    - Reintegration Workers would benefit from some training and guidance on the most effective utilisation of their time. Informal examination of their weekly reporting suggests many of their day-to-day activities are focussed on the broad but non-offence-focussed needs of the Tai Aroha participants (e.g., booking appointments, health visits, etc). This issue is complicated for essentially para-professional staff without (necessarily) a strong background or understanding of criminal justice psychology. With this in mind it is worth considering some temporary additional support to these roles – perhaps in the form of a Level 7 Psychologist's project – to:

        i. Undertake a literature review of the most relevant reintegrative tasks for men on community-residential programmes.
        ii. Develop a model for designing and prioritising individual reintegrative intervention plan.
        iii. Designing a suitable training package for staff moving into these positions.

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6.0 Appendices

Appendix A: Tai Aroha Evaluation: Post-release Survey

Information sheet for men taking part in the Survey

Thank you for taking part in this survey. The reason for the survey is to find out more about the needs of Tai Aroha participants as they completed or exited from the programme and returned to their communities. We are interested in what went well for you, what didn't go so well, and what Tai Aroha could have done better to support your transition. This is your opportunity to help us improve our support to programme participants in the future.

If you agree to take part today, we will take you through a series of questions covering several different areas. Depending on how much you have to say, this interview will take about 1 hour. If you need a break during the interview, just ask. We will be writing down your answers on paper, but not recording them in any other way.

This survey is being led by Corrections Department registered psychologist, Glen Kilgour (Principal Advisor Special Treatment Unit Development) and Research Assistant, Ann Tapara. If you do choose to take part, any information you provide is confidential to the survey. No information that you provide will specifically identify you to anyone from the Department of Corrections. Results will be reported only as themes and patterns. Your involvement will have no effect on how you are treated by the Department. It is the same if you decline to take part with this decision having no impact, good or bad, on your management.

If there is a particular issue or need for you that comes up in our discussion that we think Tai Aroha might be able to support you with, I will ask you if you would like me to pass this to the Tai Aroha Programme Manager to follow-up. Other than this you may consider your responses to remain confidential – unless there are any serious or imminent safety issues that come up. If this is the case then I will talk with the senior researcher (Glen Kilgour – who is a registered psychologist) who will decide on the most appropriate course of action.
If you agree to take part, and then change your mind later, you can tell us, and you will not have to continue the survey. If you *do* change your mind, we will ask you if you are still OK about us keeping the information you have provided up to that point. If you request we do so, we will destroy any information you have provided and this will not be used. All notes we take on your answers will be secured in a locked filing cabinet. The notes will not have your name on them, only an identifying number. Your consent form, which does contain your name, will be kept separately.

Finally, if after taking part in the session today, you have any other questions or concerns about the survey, you are welcome to contact, Glen Kilgour using the contact details listed below.

Glen Kilgour
Principal Advisor
Department of Corrections
P O Box 19 003, Hamilton
07 858 1615

I _____(*print name clearly*), hereby consent on the basis set out above to participate in the interview process as part of the Tai Aroha evaluation.

Signature: _____ Date:_____

Interviewer signature:_____ Date:_____

Do you have any questions before we begin?

1.0 Accommodation
- 1.1 Who are you living with at the moment?
  - 1.1.1 Is this the same place you planned to live when you were at Tai Aroha?
  - 1.1.2 Are there any problems or challenges living there? What are they?
- 1.2 How many places have you lived since leaving Tai Aroha?
  - 1.2.1 Were there any difficulties with your accommodation after you left Tai Aroha?
  - 1.2.2 How could Tai Aroha have supported you better in this area?
- 1.3 How happy are you with your current (or if imprisoned, last previous) accommodation (1-6)

2.0 Employment/Training
- 2.1 Are you currently in employment or training?
  - 2.1.1 What sort of work are you doing? (sector, part/full time, casual/permanent)
  - 2.1.2 Is this the work you planned to do while you were at Tai Aroha?
    - 2.1.2.1 If not, why not?
- 2.2 If not, what have been the barriers to gaining employment or training opportunities? (What stopped you?)
- 2.3 If not, are you currently seeking employment/training? How?
- 2.4 How happy are you with your employment/training situation?
- 2.5 How could the programme at Tai Aroha have supported you better in this area?

3.0 Leisure
- 3.1 (If not working) What do you usually spend your time doing?
- 3.2 (If working) What do you usually do in your spare time?
- 3.3 How much time do you spend on leisure activities in a typical week?
- 3.4 Have you joined any groups?
- 3.5 Are there any ways that you are giving back to the community?

4.0 Finances
- 4.1 How are you managing financially at present?
  - 4.1.1 If badly: do you have any plans for managing better financially?
- 4.2 How many debts/fines do you have outstanding?
  - 4.2.1 How are you managing these?
- 4.3 What is your main source of income?
- 4.4 Have you been in contact with WINZ and how did that go?
- 4.5 Rate how happy you are with your finances at the moment (1-5)
- 4.6 Is there anything you needed to do or learn at Tai Aroha, but did not, that would help in this regard?

5.0 Prosocial support
- 5.1 Who are your current personal support people?
- 5.2 How often per week have you been in contact with them (on average) since leaving Tai Aroha?
- 5.3 Have you had any difficulties or challenges with your support people, for example with them bossing you around, or getting into arguments with them?
- 5.4 Are there any other downsides of being around them, for example if they use drugs, or need too much help from you?
- 5.5 Did you have a reintegration meeting with them before you left Tai Aroha?
  - 5.5.1 If yes, how did this go?
  - 5.5.2 If not, why not? Would you have liked to have had a reintegration meeting?
- 5.6 What sorts of support have they been able to give you? (Financial, emotional, practical, transport)
- 5.7 Have you been able to rely on help from your support people to work through problems?
  - 5.7.1 Can you give me an example?

5.8 Are you happy with your current level of personal support? (1-6)
5.9 Is there any way that Tai Aroha could have helped you gain additional support before you left the programme?
5.10 Have you been in contact with any of the other residents since you left? Can you tell me a bit about that?

Now we've talked a bit about the people who you are close to who support you, I'd like to ask about community support, that is, organisations that you might be working with to support you in the community.

6.0 Community support
- 6.1 What community support do you have in place at the moment?
  - 6.1.1 How have you been supported by these organisations?
  - 6.1.2 Were these supports part of the release plan you wrote at Tai Aroha?
  - 6.1.3 Are there any community supports that you would have like to have arranged but were not able to?
- 6.2 Have you had any contact with the staff (including therapists) from Tai Aroha since you left?
  - 6.2.1 Who, and how often?
  - 6.2.2 If not, would you have liked to have maintained contact? Why?

7.0 Antisocial associates
- 7.1 Who are you spending most of your spare time with?
  - 7.1.1 Are they mostly 'straight' or into crime/violence/substance abuse?
- 7.2 Have you made any new friends since leaving Tai Aroha? How did you meet them?
- 7.3 If client was gang affiliated: are you still involved with the gang?
  - 7.3.1 If left: How did you manage to leave the gang?
  - 7.3.2 When did you make the decision to do so?
- 7.4 Have you faced any pressure from old associates to return to your old lifestyle?
  - 7.4.1 How did you deal with that?
- 7.5 If associating with antisocial peers: what are some of the benefits of associating with them?

8.0 Probation
- 8.1 How many probation officers have you had since leaving Tai Aroha?
  - 8.1.1 (*if more than one change*) How did you find working with different people?
- 8.2 When did you first meet your current probation officer?
- 8.3 How is your relationship with your probation officer?
- 8.4 Do you see probation as a positive support or just more hoops to jump through?
  - 8.4.1 What sort of support has your probation officer given you?
  - 8.4.2 What problems have you had with your probation officer?
  - 8.4.3 Do you feel that it is safe to be honest with them or do you feel that you have to hide some things from them?
- 8.5 What would improve this relationship?

(Trying, with 7.1, to tap transition from TA to community)

9.0 Post release treatment
- 9.1 Were you required to undertake any other programmes after Tai Aroha, or to see a psychologist? What?
- 9.2 If yes, did you manage to complete these requirements?
  - 9.2.1 If not, what were the barriers to you doing this?
- 9.3 If no, would you have liked to have continued to see a psychologist? Or to have completed additional programmes?
  - 9.3.1 What?

10.0 Stress and coping (inc. use of safety plan, HRSs)
- 10.1 What were the hardest things about returning to the community?

10.1.1 How could the programme at Tai Aroha have helped with this issue?

10.2 How are you managing the ups and downs of life at the moment?

10.2.1 Were these skills/tools you learned at Tai Aroha?

10.2.2 What do you think might help you to cope better?

10.3 Have you been in any high risk situations since you left Tai Aroha?

10.3.1 Can you give me an example? How did you handle that?

10.4 Have you used your safety plan since leaving Tai Aroha? Tell me a bit about that.

10.5 Have you had any contact with previous victims of your offending since leaving Tai Aroha?

10.5.1 How did that happen?

10.5.2 How did you manage this?

11.0 Substance use

11.1 Since leaving Tai Aroha, how often have you drunk alcohol per week, on average?

11.1.1 If no use: Are you intentionally avoiding it? Are you finding it difficult to stay away from alcohol? How are you doing this?

11.2 How often have you used drugs since leaving Tai Aroha? What sort of drugs?

11.2.1 If dugs use: Is this a problem for you? If yes, what are you trying to do about it?

11.2.2 If no use: Are you intentionally avoiding drug use? Are you finding this difficult? How are you doing this?

11.3 When you left Tai Aroha, what were your plans for drug and alcohol use?

11.3.1 What has helped you stick to your plan?

11.3.2 What were the barriers to you sticking to your plan?

12.0 Personal identity (inc. motivation)

12.1 How much did you see yourself as a violent person before coming to Tai Aroha? (1-6)

12.2 How much did you see yourself as a violent person during the programme at Tai Aroha? (1-6)

12.3 How much do you see yourself as a violent person now? (1-6)

12.4 How much do you see yourself at the moment as someone who is just trying to be an ordinary, straight member of the community or as someone who is still a bit of a criminal? (1-6)

12.4.1 How easy or hard has it been so far to avoid engaging in criminal activity? (1-6)

12.4.2 What types of crime have you found it hard to stay away from?

12.4.3 Are there any crimes that you aren't worried about staying away from? [Prompt as necessary]

12.4.4 What do you think are the biggest obstacles to staying away from crime?

12.4.5 Is there support that would help you to stay away from crime that you need? (although if they come up with a need, there's an obligation there to try help point them to that if it's reasonable and I'm asking for their time for Correction's needs)

12.5 How would you describe your motivation to stick to the release plans you made while at Tai Aroha?

12.6 How relevant is the release plan that you created at Tai Aroha to you now?

(can compare view of self and change to exit interview; did new self concept persist beyond the programme?

Appendix B: Audit and Compliance Measures for Therapeutic Community Components of Special Treatment Units

This document is the companion measure to the "Integrity Monitoring" document entitled "Therapeutic Community Integrity Monitoring Template". Integrity Monitoring is to be completed by an individual who is independent from the STU environments. In contrast, Audit and Compliance measures are designed to be completed by Principal (or Senior) Psychologists, and the Programme Manager of Tai Aroha, within the STU of a sister-unit. Audit and Compliance measures are intended to identify the presence or absence of activities, environment, behaviour, policies and procedures that would support the goals and processes of a therapeutic community. Although, not designed to cover Integrity Monitoring in depth, these Audit and Compliance measures are considered necessary (but not sufficient) to support the effective running of the programme.

Evidence is gathered from a variety of sources including observation of the physical environment, discussion with senior staff including cultural advisors and supervisors (and occasionally residents), and review of programme documentation (e.g., IOMS, referral lists, case files, procedures manuals, completed programme documentation and forms). Comments should include particular strengths or recommendations to remedy an identified issue.
This template forms the primary evidence for the Executive Summary. It needs to be completed and returned to the Integrity Monitoring project leader along with the Executive Summary once the Monitoring is complete. It should also be made available to the Independent Integrity Monitor before they conduct their site visit.

Section 1: Integration of Cultural values, concepts and processes		
Indicators	**Present Yes/No**	**Comments**
Does the unit's operations manual incorporate and integrate Maori concepts values and processes? Has it been checked off against the Departments 'Effectiveness with Maori Offenders Guide?		
Does the therapeutic programme manual incorporate and integrate Maori therapeutic models concepts and practices? Has it been checked off against the Departments 'Effectiveness with Maori Offenders Guide?		
Do Whanau hui and reintegration hui incorporate the values of Whanaungatanga, Manaakitanga and Aroha?		
Does the unit celebrate any specific cultural events such as Matariki, Maori and Pacific Language weeks?		

Is there evidence of the regular use of Te Reo?		
Does the physical environment include examples of cultural art work, Maori posters and written whakatauki?		
Are there art, kapa haka, Te Reo classes available to all community members?		
Are any community members engaged with prison Kai Whakamana, Kaumatua, Bi-Cultural Therapy Model (BTM) or any other Maori Service Provider?		
Is there a cultural protocol to welcome visitors and new members to the unit		
Are community meetings opened, closed and conducted in a culturally appropriate way?		
Maori cultural supervision is available to all staff?		
Staff attend and engage in cultural supervision at the agreed frequency		
Is there an agreed process to address and resolve any cultural issues within the therapeutic community, related to incorrect/distorted cultural beliefs held by community members?		

Section 2: Physical Venue		
Indicators	**Present Yes/No**	**Comments**
The room is big enough, has adequate lighting, climate control, soundproofing and seating for all participants		

Learning resources e.g. whiteboards and flipcharts, are available		
Recording devices are present, working, have sufficient recording time per session (three hours), and staff know how to operate equipment		
All sessions are being recorded, are of adequate quality (sound, vision, media) and are being made available to supervisors		

Section 3: Resident Selection, Management and Programme Documentation		
Indicators	**Present Yes/No**	**Comments**
Selection records reflect consideration of and adherence to business rules		
There is clear documentation of any rationale for override when selection of offender is outside normal business rules		
Screening assessments completed and documented on file/IOMS for all offenders		
Reason for rejection of any applicant is specified		
Any relevant responsivity barriers identified and management strategies recommended in screening assessments		
Pre-programme assessments completed and documented for all participants and within agreed timeframes		
All relevant psychometrics, demographics and offending information is entered into the relevant research database within one week of the completion of the		

assessment phase (or within one week of all data being collected)		
Post-programme assessments are completed and documented for all participants, and are consistent with Psychological Services policy		
All completing participants have documented reintegration plans in place		
All completing participants have been active in the production of their reintegration plan		
In the reintegration plan, appropriate support groups and/or agencies have been identified, informed and enlisted to provide reintegrative support		
Whanau/support group hui have been completed for all participants prior to programme completion or at the time of release		
Post-programme assessment have been provided within a timely fashion to the Custodial staff or Probation Officer in sufficient time to allow informed management of the case		
There is a system to record absences		
All absences are explained		
There is a system to keep participants who have been absent for a session up to date with programme content		
There is a documented rationale for all participant exits		
Exited participants have exit reports on file/IOMS that include recommended follow-up within two weeks of exit		
All reports are completed to the standard specified in the Psychological Services' manual		
Session notes are completed for all		

sessions		
There is a record of module completion on the participant's file		
Section 4: Participant Induction		
Indicators	**Present Yes/No**	**Comments**
Relevant staff are allocated to the induction of participants and their responsibilities in the induction process are clearly defined		
All those involved with induction know their role in the induction process		
Programme participants are inducted according to established procedures and within allocated timeframe		
An established checklist is used to track the completion of induction for every participant		
Exit interviews are completed with all participants who have completed the programme		
Section 5: The Therapeutic Community		
Section 5.1 Member roles		
Indicators	**Present Yes/No**	**Comments**
The roles of staff and participants are clearly defined and support the principles of the TC (see Operations Manual and TC document)		
There is evidence in induction that staff and participant roles are clearly		

understood		
There is a system in place to monitor roles and behaviour of participants		
Section 5.2 Membership feedback		
Indicators	**Present Yes/No**	**Comments**
There are regular forums for participant feedback		
There is a culture of feedback that is known and accepted by participants and staff		
The feedback principle is supported by a variety of methods (e.g., handouts, posters, role modelling by staff, programme manual content)		
There are records of feedback given to and received from participants		
Section 5.3 Membership as role models		
Indicators	**Present Yes/No**	**Comments**
There are regular opportunities for participants to act as role models for others (e.g., during the morning meeting, afternoon meeting, other community meetings, seminars, informally throughout the day)		
There is a culture of role modelling prosocial behaviour that is known, accepted and put into action by staff and participants		
The 'members as role models' principle is supported by a variety of methods (e.g., handouts, posters, role modelling by staff, programme manual content)		
Section 5.4 Relationships		
Indicators	**Present**	**Comments**

	Yes/No	
All of the participants contribute to the social network of the community		
Participants are encouraged to engage fully in all TC related activities		
There is evidence that participants are encouraged to take responsibility for their learning and behaviour		

Section 5.5 Collective learning formats		
Indicators	**Present Yes/No**	**Comments**
All TC meetings occur according to a regular and agreed schedule		
Group therapy occurs according to the agreed schedule		
There are systems in place for continuing group therapy in the event of therapist absence or leave		
Collective learning formats cater for a wide variety of criminogenic needs (e.g., educational, adjunct therapy, substance abuse)		

Section 5.6 Milieu and Language		
Indicators	**Present Yes/No**	**Comments**
Community rituals are used to mark special occasions (e.g., entry to community, commencement of treatment, graduations, movement through programme phases, special visitors to the programme, etc)		

Records reflect that prosocial language is encouraged and antisocial language is actively managed and dissuaded		
Section 5.7 Structure and systems		
Indicators	**Present Yes/No**	**Comments**
There is a daily and weekly structure in place that supports and maintains the TC		
There is a widely understood set of cardinal rules in place and a system in place for reviewing and negotiating these as required		
Rule breaking is addressed through the appropriate processes as per operations manuals		
Case Management occurs consistent with documented procedures of the programme (timely, task focussed, clearly defined outcomes)		
There are documented processes to reward progress and prosocial behaviour and these include reference to choosing from an appropriate hierarchy of possible consequences for prosocial behaviour There is documented evidence of staff actively managing incidents and misconduct consistent with the use of prosocial skills and values		
Incident reports are completed on time and in accordance with Psychological Services' policy on Incident Reporting		

Section 5.8 Open Communication		
Indicators	**Present Yes/No**	**Comments**
There is evidence from records that staff and participants are encouraged to be open and honest		
There are avenues for open communication in the pyramid structure from top to bottom and bottom to top		
Section 5.9 Community and individual balance		
Indicators	**Present Yes/No**	**Comments**
The structured daily/weekly routine supports the therapeutic (rehabilitative/ reintegrative) aspects of the programme and is consistent with TC principles		
There are learning forums in place that cater to collective and individual learning opportunities for participants		
There is a pre-programme assessment for each participant that identifies their particular learning goals		
Participants have the opportunity for greater independence and autonomy from the group as they progress through the programme There is evidence of increasing tailored reintegrative activities for individual participants as the progress through the programme		

Section 6: Supervision of Programme Staff		
Indicators	**Present**	**Comments**

	Yes/No	
All therapeutic staff have an assigned clinical supervisor		
Supervisors have the appropriate level of skills, training and experience to supervise intensive group therapy programmes with high risk offenders		
All staff have supervision contracts in place		
House staff have had the training offered for working within the therapeutic community		
Supervisors have attended supervision training		
Programme facilitators are credentialed or actively in the process of pursuing credentialing and/or Supervision to Registration scheme		
All therapeutic staff have an assigned cultural supervisor		
Cultural supervisor has attended supervision training for cultural supervisors		

Psychologists are receiving supervision consistent with the Psychological Services' supervision policy		
Programme facilitators are receiving clinical supervision at least weekly		
All therapeutic staff are receiving cultural supervision at least monthly		
Sessions are being reviewed at least fortnightly by supervisor (i.e., direct observation, video or audio recording)		

There is a clear record of supervision notes and outcomes		
The supervisor and supervisee regularly set clear goals for each week for practice improvement where appropriate		
Any supervision reports are completed by supervisors within accepted timeframes		
Programme documentation, such as final reports, are reviewed by supervisors		
Changes to recommended session content have been discussed with supervisor before being delivered and records of the changes are being kept		
Supervisors meet with Principal Psychologists (STUs) or Programme Manager (Tai Aroha) to discuss general supervision issues at least quarterly		
Non-therapy staff have administrative or practice supervision, consistent with programme policy and procedures		

Section 7: Interface with Prison Services (prison-based STUs) or Community Probation Services (Tai Aroha)		
Indicators	**Present Yes/No**	**Comments** (please add any further relevant comments on the relationships between therapy staff and custodial/house staff which may impact on the effective operation of the therapeutic community)
Therapy staff contribute to the selection of prison or probation staff involved in the STU		
Therapy staff have a role in the induction of prison or probation staff involved in the STU		
There are multiple effective lines of communication between the therapy staff and other key services (prison and/or probation)		

There are agreed and effective strategies for resolving issues with other services		
Representatives from other key services (either prison or probation) are actively involved in Case Management		
There is recognition within the broader system (either prison or probation) that the Therapeutic Community has differing or specialised needs compared to other non-therapeutic environments		

Additional observations and recommendations for change
Monitors Name: **Monitors Signature:** **Date:**

Appendix C: Integrity Monitoring Template for Special Treatment Units

Monitoring Process

The process of monitoring the integrity of a therapeutic community involves gathering evidence related to the occurrence of ten principles which underpin a therapeutic community. Evidence is gathered from a variety of sources including written material, observation of activities and therapy groups and in some instances, participation in activities. Monitors will also interview a selected number of staff and residents to gather information about their experiences of the TC as a whole and for specific information related to a number of the ten principles.

Therapy groups are monitored as part of the overall monitoring but have specific criteria that are directly related to the delivery of group psychotherapy. Evidence for this can be gathered in two ways. First, in vivo observation of a session and second, observation of DVD recordings of sessions. This template has a separate section for recording the evidence associated with the group therapy sessions.

Note: Monitors will need to give examples in the comments and process section for all principles.

Terminology

Staff: This includes Therapy Staff (TS) whose primary role is to facilitate the therapeutic programmes, Custodial Staff (CS) if the TC is Prison Based and Community Supervisory Staff (CSS) if the TC is in the community. For the purposes of integrity in a TC, staff also includes the Principal Psychologist, the Principal Corrections Officer if prison based, and the Programme Manager if community based. All these groupings will need to be sampled when assessing any of the nine principles.

Residents: This term is consistent with the 'spirit' of a therapeutic community and is the term used in this template. It refers to those who are receiving treatment in the TC and is a generic term used to describe 'offenders', 'participants', and 'prisoners' in a TC.

This template forms the primary evidence for the Executive Summary. It needs to be completed and returned to the Integrity Monitoring project leader along with the Executive Summary once the Monitoring is complete.

Monitoring Template

Principle	Behavioural indicators	Process	Comments
1. Integration of cultural concepts Description Each community member has an applied understanding of and is encouraged to explore and engage in cultural values, concepts and practices.	▪ Core Maori social values are developed and maintained within the therapeutic community and the therapy groups e.g. ᔓ Whanaungatanga ᔓ Manaakitanga ᔓ Aroha ᔓ Does the unit's operations manual incorporate and integrate Maori concepts values and processes? If yes, to what level is this done ᔓ Does the therapeutic programme manual incorporate and integrate Maori therapeutic models concepts and practices? If yes, to what level is this done ▪ Maori processes and protocols are effectively managed within	This section focuses on the quality of the integration of Maori cultural practices concepts and values within the STU. It is also concerned with the quality of the community members' experience of the integration of these practices concepts and values in the STU. It is closely related to the Cultural Integration section of the STU Audit and Compliance monitoring template and should be completed in the context of those findings. The integration of cultural concepts is fundamental to the operation of the STU and applies to the therapeutic community principles and also the therapy groups that are delivered within it. The monitor will need to collect evidence about the community members' experience of the use of these concepts within the STU and the therapy programme. Many of the cultural behavioural indicators should be observed	

Principle	Behavioural indicators	Process	Comments
	the therapeutic community and the therapy groups - Mihi - Pepeha - Whakatauki - Waiata - Mihi Whakamutunga ▪ Maori principles/values/ethics are linked with the philosophy of the therapeutic community and are translated into everyday practice within the therapeutic community and the therapy groups. - Nga tapa wha model - Tikanga - Kawa - Waananga - Mana - Tapu - Noa - Tika - Pono - Awhi - Tautoko	across the domains of all the principles and group therapy processes. To do this monitors will need to: ▪ Read the operations manual and therapeutic programme manual ▪ Read case notes and minutes of meetings ▪ Observe the physical environment of the unit ▪ Observe sessions from the therapeutic group, in vivo and recorded ▪ Attend a community meeting if possible ▪ Sit in on morning and afternoon meetings ▪ Observe seminars ▪ Interview members (Cultural supervisors, staff and residents about their experiences) Example questions are - How have you experienced the principle of Manaakitanga	

Principle	Behavioural indicators	Process	Comments
		recently in the unit? ᔓ Describe an example of cultural tension and how it was addressed ᔓ How is whakatauki used to promote pro social values and learning ᔓ Can you reflect on whether you experience Maori culture as being respected in the Unit and why/why not ᔓ Describe how your use of cultural practices is supported by the unit e.g. Te Reo classes? Courses on cultural values and concepts? These questions are examples, there will be many more that the monitor can ask that begin to gauge not just the presence or absence of these concepts and	

Principle	Behavioural indicators	Process	Comments
		values in day to day practice but also the quality of their use	

2. Member Roles (Member includes both staff and residents) Description **What** contact do staff have with residents and each other **How** do they involve themselves with residents and each other	▪ Does contact occur in a respectful manner? How? ▪ Is the use of pro social language evident and frequent? ▪ Is the language of the TC used e.g. pull ups? ▪ What evidence is there that learning opportunities are given and result in attitudinal and behavioural change? (monitor will need to get examples of this from both staff and residents) ▪ Are members able to demonstrate flexibility in roles e.g. lead meetings, be a cleaner etc ▪ What evidence is there that staff function as 'rational authorities'? E.g. provide residents with reasons and projected consequences	To do this monitors will need to: ▪ Read case notes and minutes of meetings ▪ Sit in on morning and afternoon meetings ▪ Observe seminars ▪ Interview members (staff and residents) ▪ Be familiar with the values in the Operations Manual and Residents' Handbook	

	related to decisions. ▪ Are staff able to state the STU values and explain how they use them in their work? ▪ Are senior residents orienting and instructing new residents (through 'buddying up', seminars) ▪ Are senior residents presenting seminars on TC e.g. on how it works, how to live in it, the values of the TC and the expectations of all members. Are they also presenting on other informative topics? ▪ Do the presentations appear prepared and authentic to the person presenting – that is does it sound like their work as opposed to a standard off the shelf presentation maybe prepared by a previous resident?		(please add any further relevant comments on the relationships between therapy staff and custodial/house staff which may impact on the effective operation of the therapeutic community)

3. Membership feedback Description This can be structured and	▪ Are members able to give examples of giving feedback using the DEAR model? ▪ What evidence is there that feedback is being given and received constructively and in	Monitors will need to observe ▪ Community meetings ▪ The day to day interactions of members ▪ Therapy groups ▪ File notes for the more	

formal and occur in community meetings, staff offices and therapy groups. It can also be unstructured and informal occurring in the corridors and the 'day to day' interactions of the members. It encompasses resident to resident feedback, staff to resident feedback, resident to staff feedback and staff to staff feedback. A process for communicating 'up and down' the TC structure	the context of the TC spirit? ▪ Is the frequency of feedback from peers greater than the frequency of feedback from staff? ▪ How is feedback been given by staff? Do they use the DEAR model? ▪ Is there evidence of a balance between positive and negative feedback?	formal feedback ▪ Look to see if there are posters on the wall about this or other prompts around the residence/unit	

4. Membership as role models Description Role Modelling by all	▪ What evidence is there of role modelling of pro social attitudes and behaviour, respectfulness and the change process? ▪ Are areas of change in others	Monitors will need to ▪ Observe meetings, day to day interactions and therapy groups ▪ Interview residents and staff about their	

members should include ▪ Pro social behaviour ▪ Pro social attitudes ▪ Respect for others ▪ The provision and receipt of feedback ▪ Modelling the change process The identification of areas for change in others and provision of feedback on how to go about the change	being identified including feedback on how to go about that change? ▪ What examples can staff members provide of their use of role modelling? ▪ What examples can senior residents give of their use of role modelling? ▪ What examples can residents give of things that have been role modelled for them by others? ▪ Can they identify how the role modelling by others has helped them change?	experience of role modelling.	
5. Relationships Description Relationships between all members of the TC are used constructively to	▪ If there is evidence of 'splitting' is there a means/process/structure to resolve it? ▪ What evidence is there of staff using their relationships with residents to encourage and support pro social changes? ▪ What evidence is there that	Monitors will need to ▪ Read case notes and meeting minutes ▪ Observe meetings and therapy groups ▪ Interview members ▪ Do any "incident reports" detail how this was resolved within the	

foster growth, trust and encourage emotional risk taking. They are used in a constructive way to facilitate positive pro social change and develop the TC network	residents are encouraging and supporting each other in pro social changes? ▪ What evidence is there that engagement in the TC is characterised by the occurrence of pro social and supportive conversations between peers, and between staff and peers? ▪ How are attempts being made by members to include those who are quiet or isolated in the community? ▪ Are attempts being made to engage and/or draw resistant residents or sub cultures back into the TC through the use of relationships and relationship skills? ▪ How is this achieved?	community, or was it treated as a disciplinary matter outside the community process	
6. Collective learning formats Description Learning in groups is encouraged. This can take a variety of	▪ Are morning, house, general and resident seminars happening? If Yes ▪ Are they being operated in the manner described on p34 of the Tai Aroha operations manual? ▪ In the meetings are staff and	Monitors will need to ▪ Sit in and observe meetings ▪ Read meeting minutes ▪ Be familiar with p34 of the Tai Aroha operations manual. ▪ How are the various	

forms including, daily meetings, therapy groups, seminars, adventure learning, recreational activities	residents taking on the appropriate roles for the meeting? ▪ Is the communication in the meetings consistent with the 'TC spirit' e.g. respectful, encouraging, shows the giving and receiving of positive and negative feedback, role modelling is demonstrated? ▪ Is the level of resident involvement in the learning formats greater than staff involvement?	roles allocated and changed when necessary?	

7. Milieu and language Description This principle is concerned with the use of rituals and traditions to strengthen the cohesiveness of the community. It is also concerned with the appropriateness of	▪ What celebrations are occurring e.g. birthdays, movement through treatment phases, birth of child etc ▪ When celebrations occur are they conducted in the 'TC spirit' ▪ How do the celebrations facilitate the ongoing cohesiveness of the community? ▪ Are all members using the language of the community e.g. verbal pull ups, pro social language, non misogynist etc	Monitors will need to ▪ Read case notes and minutes of meetings ▪ Interview members both staff and resident ▪ Listen to the language used. ▪ Do residents and staff avoid swearing/ profanity	

the language used and its use to develop community cohesiveness, through the use of language 'unique' to the community.	which is a reflection of assimilation into the therapeutic and community culture?		

8. Structures and systems Description These are vehicles for change and include ▪ Procedures for the day to day running of the TC ▪ Job functions ▪ Chores ▪ The use of privileges and sanctions to keep the TC safe Residents receiving more privileges as they work through the treatment phases.	▪ Do all residents have job functions in the community? E.g. is there a roster and process for the allocation of job functions? ▪ Are the job functions being conducted responsibly? E.g. the clothes are clean after being laundered, tasks are achieved on time and of an acceptable standard? ▪ As residents move through the four (4) phases of the programme are they receiving the related privileges? ▪ If sanctions are given are these, documented. ▪ Are sanction appropriate and match the transgression ▪ Are the reasons for the decision present? ▪ Are the conclusions	Monitors will need to ▪ Read case notes ▪ Read incident forms ▪ Interview staff, residents and house manager. ▪ Observe the rhythm of the TC over two or three days	

These are not entitlements but are earned and are based on self modification	appropriate? ▪ Is there evidence of a TC discussion regarding the sanction? ▪ Are the sanctions in line with the TC principles? ▪ What examples are there of this? ▪ What involvement has the case management team had in the sanction process?		
9. Open communication Description The level of communication between members is as open as possible. Some very private issues may be discussed on a one to one basis prior to being discussed in a group setting. Private issues related to breaches of cardinal rules e.g. alcohol/drug use, however, would	▪ Is there evidence of open and immediate authentic communication? E.g. clear and immediate communication about both pro social behaviour and transgressions. ▪ If yes, please give examples. ▪ Do staff have a clear vision/expectation about the disclosure of confidential information? ▪ Do the residents and staff have clear expectations about the boundaries of personal disclosure, including the issue of disclosure of information related to breaches of cardinal	Monitors will need to ▪ Observe meetings, therapy groups and day to day interactions. ▪ Read case notes	

be discussed in a group format.	rules? ▪ House rules are discussed openly e.g. current drug use, offending?		

10. Community and individual balance Description There is a balance between the needs of the individual and the needs of the community. The community is viewed by the individual as being credible	▪ Is there an opportunity for members to have input into the structures, rules, sanctions etc of the TC, e.g. community meetings are held specifically to discuss issues related to the functioning of the TC? If Yes ▪ Are issues being identified? ▪ Are the issues being resolved? ▪ If resolved, are the resolutions being implemented or is there a plan for implementation?	Monitors will need to ▪ Observe meetings ▪ Read minutes of meetings ▪ Read case notes	

Group Processes
Therapeutic Integrity: Treatment as conceptualised is treatment as delivered

Factor	Indicators	Present Y/N	Comments
Pre programme assessment	Is there evidence of treatment planning		
	Does the treatment plan reflect the pre programme interview data and the pre programme psychometric results?		
	Does the treatment plan and formulation reflect how the person will interact with the programme content, the group process and other group members?		
Adherence to programme manual	Are the goals of the session made clear at the beginning of the session?		
	By the end of the session have the goals been achieved?		
	Sessions and exercises are run according to the manual		
	Any changes to the recommended session content have been discussed with supervisor prior to delivery.		
	Therapy Staff (TS) do not supplement with extra/ irrelevant exercises that drift from the		

Factor	Indicators	Present Y/N	Comments
	purpose of the session.		
	TS do not encourage or initiate discussions that lead away from the purpose of the session.		
Adherence to treatment style	TS use questioning to guide participant discovery through the use of Socratic questions: **as follows:**		
	Use of open questions to elicit information (informational questions)		
	Use of questions to probe further or more deeply (i.e., questions to analyse and evaluate interpret etc)		
	Use of questions to help synthesise all of the information into conclusions about what is going on for person		
	Use frequent summarising across the questioning with final summary/ conclusion		
	Vary the style and tone of questions to engage offenders and the group		
	Know when to stop and move on (do not ask endless open questions that don't take the		

Factor	Indicators	Present Y/N	Comments
	participant to an end without a purpose)		
	TS effectively challenge offence supporting attitudes. For example: They link the challenge to the particular learning on the programme and use Socratic enquiry to develop discrepancy between current behaviour and future goals. **Examples** of questions used to do this are as follows : What is a fact? What is an opinion? Which is it? What is the evidence for? What is the evidence against? What does that mean? What are the advantages of thinking like this? The disadvantages? What does your relevant other think? What are the consequences of continuing to think in this way? To self, others, whanau etc? How helpful or useful is it to think in this way? How will this thinking benefit the New Me? What alternative ways of thinking and behaving have you come up with?		

Factor	Indicators	Present Y/N	Comments
	TS refer to ground rules and do not repeatedly challenge but model appropriate pro-social attitudes and behaviours.		
	TS listen, reflect and summarise well		
	TS allow enough time for reflection and use appropriate body language (eye contact, smiles, nods etc).		
	TS use motivational techniques. e.g. They elicit pro-social change talk, encourage offenders to use their own examples, encourage positive parts of self, encourage practice and validation of skills taught in sessions, are not reliant upon the manual and a 'delivery' style with little engagement with offenders.		
	TS use appropriate and genuine praise and reinforcement.		
	TS are warm and genuine – attempt to understand the feelings of individuals and the group		
	TS are non defensive within group		

Factor	Indicators	Present Y/N	Comments
	setting		
Group psychotherapy skills	TS adapt pace to the level of the group		
	TS model respectful and effective co-facilitation relationship whereby issues in the group are processed in a seamless manner		
	TS convey an impression that they and the group are working collaboratively		
	TS present as calm, transparent and respectful		
	TS encourage working in the 'here and now' with the programme content		
	TS encourage participation and reflection but roll with resistance. For example: Do not get hooked into arguing, confronting, blaming, judging. Encourage analysis of the process versus the content of the message Encourage a problem solving approach to dealing with resistance Encourage group/individual ownership of change process		

Factor	Indicators	Present Y/N	Comments
	TS are emotionally responsive		
	There is evidence of good interpersonal boundaries		
	TS work well with quieter and domineering group members e.g. know when to ‘move” the discussion on and when to draw out participation of the quieter members as necessary.		
	TS use appropriate reflection and summary tone and body language etc to signal what needs to be happening		
	TS deal with conflict in the here and now and encourage both ownership and movement within the group		
	TS do not demonstrate either submissive or aggressive interpersonal styles when challenged		
	TS understand the stages of development within the group and demonstrate responsivity within these parameters		
Responsivity	TS sensitive and responsive to		

Factor	Indicators	Present Y/N	Comments
Skills	individual stages of change		
	TS's language is pitched to the level of the group		
	TS are sensitive and responsive to cultural issues and material is given cultural relevance by eliciting examples from the group		
	TS attempts to understand the background of individuals within the group by eliciting examples of how the material could be relevant to them		
	TS use a variety of mediums to encourage reflection and learning		
	TS pace and style are adapted to the groups development		
	TS sensitivity is used with group members who are encountering difficulties		
	TS take time out to check and reflect upon learning before moving on		
	TS take time to attempt to pair offenders with different levels of literacy needs		
	TS avoid a didactic approach to facilitation		

Factor	Indicators	Present Y/N	Comments
	Room layout, visual representations and seating arrangements are suitable for safe and effective group work		
Therapeutic Quality: Facilitator characteristics	TS exhibit characteristics of successful therapists as below:		
	Interpersonal warmth		
	Expresses empathy		
	Engaging style		
	Enthusiasm for the content		
	Communicates belief in individual's ability to change		
	Gender issues managed in group		
Therapeutic Quality: Process used	Who talks to who? Is there interaction between group members, or only through the TS		
	Here and now focus		
	Stages of group growth used		
	Group members participate		
	Cognitive distortions area challenged in group by facilitators		
	Cognitive distortions are challenged by group members		
Theoretical principles adhered to (CBT, RP,	ABCD used when appropriate across all sessions		
	Problem solving approach		
	Homework exercises set		

Factor	Indicators	Present Y/N	Comments
Tapa wha and Good lives)	Homework exercises reviewed		
	Cultural components facilitated		
	Mindfulness practice in each session		
	Is the practice observed aligned with theoretical principles of the programme		
Facilitator therapy-interfering behaviours	**Examples include the following:** TS change the rules with the client (e.g., are not consistent when giving feedback about behaviours) TS are late for group or other appointments TS appear or dress unprofessionally (e.g., short skirts, jeans and T-shirt) TS allow interruptions during sessions TS are inattentive during sessions TS forget important information (name, relevant history etc) TS repeat selves, often forget what they have said TS avoid eye contact TS treats clients as inferior to facilitators		
Facilitator	**Examples include the following**		

Factor	Indicators	Present Y/N	Comments
skills for overcoming participant therapy-interfering behaviours	TS define and describe therapy interfering behaviour/s accurately: such as: Non attention, non collaboration,non compliance pushing limits; refusing to engage in the work; demanding solutions to problems that the facilitator cannot solve; asking for excessive time		
	TS undertake a behavioural analysis of the behaviour/s (i.e., use an ABCD format or an offence map format)		
	TS adopt a problem solving plan (SOLVE) in order to reduce the therapy interfering behaviour and this includes: - motivational issues, - reducing problem emotions, - changing thinking, developing alternative behaviours		

Additional observations and recommendations for change
Monitors Name: **Monitors Signature:** **Date:**

Appendix D: Format for Executive Summary STU Audit-Compliance and Integrity Monitoring

Programme Name:
Date of Report:
Report Writer:

Sources of Information:

Section 1: Integration of Cultural components

Section 2: Physical Venue

Section 3: Resident Selection, Management and Programme Documentation

Section 4: Participant Induction

Section 5: The Therapeutic Community

Section 6: Supervision of Programme Staff

Section 7: Interface with Prison Services or Community Probation Services

Section 8: Integration of Cultural Components

Section 9: Conclusions and Recommendations

Please note: The completed executive summary needs to be returned to the STU monitoring project leader together with the completed monitoring template.

Appendix E: Measurement scale and criteria for determining quality category for individual integrity factors and overall programme integrity

For individual factors

Good = majority of sub factors present
Adequate = at least half of sub factors present
Limited = less than half of sub factors present
Poor = very few or no sub factors present

For overall programme integrity

Good = most factors are good but may have some adequate. The majority of therapeutic integrity factors are good

- Therapeutic Integrity factors
    - Co Facilitation
    - Adherence to programme manual
    - Adherence to treatment style
    - Group psychotherapy skills
    - Responsivity skills
    - Therapeutic Quality
        - Theoretical principles adhered to
        - Facilitator therapy interfering behaviours
        - Participant therapy interfering behaviours - facilitators deal with this effectively?

Adequate = most factors are adequate. May have some good and also some limited, but to be considered adequate these would need to be present in roughly equal numbers. The majority of therapeutic integrity factors are adequate (if some are limited then there must also be some that are good, for this to be considered adequate)

Limited = most factors are limited with some good and adequate. Some factors could be poor but these would need to be few in number and balanced by the presence of at least some adequate or good factors. The majority of therapeutic integrity factors would need to be limited; if there were some poor then these would need to be balanced with the presence of some good.

Poor = most factors are poor and limited, with very few adequate or good factors present. The majority of therapeutic integrity factors would be limited or poor.