NSW GOVERNMENT Justice Corrective Services

Research Publication

A Process Evaluation of the Intensive Drug and Alcohol Treatment Program (IDATP)

Study One: Program Establishment, Design and Appropriateness

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Corrective Services NSW

A Process Evaluation of the Intensive Drug and Alcohol Treatment Program (IDATP) Corrective Services, New South Wales

Study One: Program Establishment, Design and Appropriateness

NSW 2021 Priority Action

Establish dedicated metropolitan drug treatment facilities focussed on treatment, rehabilitation and keeping drugs out of prisons

Foreward

The CSNSW Intensive Drug and Alcohol Treatment Program (IDATP), an initiative of the current NSW government which opened in February 2012, is the largest prison-based residential drug treatment program in the southern hemisphere.

While drug treatment had been available in NSW prisons for more than 20 years, the NSW government identified the need to strengthen drug treatment for prisoners and provide a new approach to rehabilitation.

At the time of writing, the IDATP was an intensive nine-month program, targeted at medium to high risk male prisoners with drug abuse problems and related dynamic criminogenic needs.

The program aimed to prevent relapse to drug use and reoffending. It also aimed to improve the social functioning, health and well-being and post-release prospects of participants.

Aside from its large capacity, what distinguished the IDATP's design from the existing programs was an intensive structure combined with a greater emphasis on the integration of a range of interventions and techniques.

It operated as a modified therapeutic community, which was delineated into three explicit program stages - Orientation, Treatment and Maintenance. These treatment stages were designed to bring about incremental degrees of psychological and social learning. The primary modalities were the community living units, therapeutic groups, education, employment, pharmacotherapy and aftercare.

As of July 2014, the program had been continually operational for 30 months. More than 300 male prisoners had participated in the program and the women's program – Yallul Kaliarna had recently opened.

This preliminary study endeavoured to examine program establishment, design and appropriateness. The next phase of the evaluation will examine how well the context of the program has been implemented.

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Terminology

For the purposes of this report, the terms *[substance], [alcohol and other drugs] and [drugs]* are used inter-changeably unless otherwise specified.

Acronyms & Explanatory Notes

AOD	Alcohol and Other Drugs
CBT	Cognitive Behavioural Therapy
CC	Criminal Conduct
CSI	Corrective Services Industries
CSNSW	Corrective Services New South Wales
CDTCC	Compulsory Drug Treatment Correctional Centre
DBT	Dialectical Behavioural Therapy
DCC	Dillwynia Correctional Centre
IDATP	Intensive Drug and Alcohol Treatment Program
JH&FMHN	Justice Health and Forensic Mental Health Network
JMCC	John Morony Correctional Complex
MTC	Modified Therapeutic Community
NSW	New South Wales
LOPs	Local Operating Procedures

MI	Motivational Interviewing
OIMS	Offender Information Management System
OMMPC	Outer Metropolitan Multi-Purpose Centre
OS&P	Offender Services & Programs
OST	Opioid Substitution Therapy
Pathways	An intensive curriculum guided offender program titled Criminal Conduct and Substance Abuse Treatment: Strategies for Self-Improvement and Change – Pathways to Responsible Living (SSC).
RP	Relapse Prevention
RUSH	(Real Understanding of Self-Help) - RUSH is a Dialectical Behavioural Therapy (DBT)-based program adapted for an Australian forensic population. It is delivered in a group-based setting via a co-facilitation model (a psychologist and a program facilitator).
SAPO/ SNR SAPO	Services and Programs Officer/Senior Services and Programs Officer
SMART Recovery®	A cognitive-behavioural maintenance program which follows a self-help group work format with open discussion and process. Its wide availability in community settings provides post release continuity.

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EXECUTIVE SUMMARY

Background

At the time of writing, the Intensive Drug & Alcohol Treatment Program (IDATP) was the largest offender behaviour change program in the southern hemisphere. The program was provided by Corrective Services, NSW (CSNSW) in collaboration with Justice Health & Forensic Mental Health (JH&FMH).

The establishment of a dedicated prison-based metropolitan drug treatment facility (IDATP) to house up to 300 prisoners with drug-related crimes was a 2011 election commitment of the NSW Liberal National Coalition, the former opposition party and current government in NSW. The aim of the IDATP initiative was to increase the capacity of CSNSW to provide drug treatment for offenders serving prison-based sentences and by inference break the cycle of drug-related reoffending.

Evaluation Aim

The overriding aim of the current process evaluation was to examine the effectiveness of the program in delivering a service and meeting its stated program implementation goals and objectives.

The scope of this first report includes documentation of program planning, establishment and design. The report clarifies program goals, elements and the theory that links to these elements. It assesses whether the program's design fits the evidence-base and standards for correctional programs. Finally, the report assesses quality assurance and governance structures, program uptake and provides an overall appraisal of program quality.

Findings

Planning and Establishment

The IDATP became a significant business priority for CSNSW in September, 2011 when the NSW Government identified the establishment of a metropolitan drug treatment facility as a NSW 2021 (NSW ten-year strategic plan) Priority Action. Given this imperative, the planning and implementation of the IDATP was subject to tight establishment time-frames. The program's projected capacity was 250 beds for male prisoners and 50 beds for female prisoners under a staged implementation plan.

The first stage of the IDATP opened in John Morony Correctional Centre (JMCC) in early 2012 with an initial 62 beds for male prisoners. The second stage was completed in 2013, providing a further 62 beds.

The planned expansion of the program was postponed in 2014 due to an unanticipated spike in the overall NSW prison population and system-wide operational capacity pressures. As a result, the IDATP's implementation plan was revised and a decision made to relocate the program to the Outer Metropolitan Multi-Purpose Correctional Centre (OMMPCC), a minimum security centre within the same complex. Under this plan, the new centre was to be dedicated to the IDATP program. Due to infrastructure works, from mid-2014 to early 2015, the program was to be temporarily delineated between the two correctional centres – JMCC and OMMPC. This division of the program across two centres was beyond the immediate control of program management.

At the time of writing, 93 male participants were enrolled in the IDATP. Program management reported that a low population state was being maintained during the transition phase to the new site. Yallul

Kaliarna, the adjunct women's program opened on schedule in mid-2104 with an initial 22 beds in the Dillwynia Correctional Centre (DCC).

Program Design
According to design documents the IDATP aimed to:

- Provide a multi-dimensional, therapeutic program to address the rehabilitation needs of offenders with substance abuse/addiction issues and at considerable risk of reoffending;
- Prevent recidivism;
- Prevent relapse to alcohol and other drug use and dependence, and
- Improve social functioning, health and well-being and post-release prospects.

In brief, the IDATP was an intensive nine-month program, targeted at medium to high risk male prisoners with substance abuse problems and related dynamic criminogenic needs. It provided more than 200 hours of behaviour-based interventions designed to address those needs targeted by the program. Each participant had an individualised treatment plan and reintegration plan comprising of standardised & tailored elements. The program allowed for temporary regression to a Program Review Unit (PRU) which involved more intensive behaviour management. Adjunct Opioid Substitution Therapy was also available to participants.

The IDATP operated as a modified therapeutic community (MTC) which meant program participants were physically separated from the mainstream prison population. This setting provided the context for multi-modal interventions across three explicit program stages - Orientation, Treatment and Maintenance. These treatment stages were designed to bring about incremental degrees of psychological and social learning.

The primary modalities were community living/learning units, therapeutic groups, education, employment and health services. The main treatment strategies were motivational enhancement, cognitive behavioural therapy, psycho-education and relapse prevention. Cognitive restructuring and skills building were the primary cognitive behavioural techniques employed. Importantly, the core program *Pathways*, targeted criminal thinking and attitudes and relapse prevention planning for both drug use and criminal behaviour.

The IDATP incorporated core MTC elements, such as fostering a community living/learning environment and a focus on social responsibility, program stages, community meetings, peer mentors and a hierarchy of privileges. The program used peer influence mediated through group processes to help participants assimilate social norms and develop social skills. Social rehabilitation was facilitated by structured daily activities. Treatment group membership was aligned with the living unit location (community units) to foster a sense of community.

In sum, the IDATP adopted what has been described in the literature as the most promising approach for treating drug-related offenders; an integration of modified therapeutic community and cognitive behavioural approaches.

The current report endeavoured to derive a program logic model and theory of change framework to conceptualise the program in its entirety. This derived model revealed a highly complex, holistic program with the intended program outcomes linked to many sequential elements. The complexity of the program was justified given the complex, interrelated needs of offenders with drug-related problems.

The IDATP had a structured approach, grounded in a coherent theory. The conceptual framework was deemed to be based on sound principles and evidence. The impetus for the program was well-grounded

given the large number of drug-involved offenders and the significant social burden that ensues. According to the IDATP model, once living unit capacity is realised, the program community provides the context that is favourable to positive behaviour change and this is supported by an amalgam of principles and treatment approaches endorsed in the correctional and drug treatment effectiveness literatures. In short, risk, need and responsivity (RNR) principles were blended with the strengths-based principles of the Good Lives Model (GLM) and other empirically supported principles, including the provision of aftercare.

With its large participant population and multi-dimensional curricula, the IDATP operated to a complex scheduling structure. Approximately **10 treatment groups** were operating at any one time, with groups comprising a maximum of 15 participants. Program facilitators typically delivered 20 hours of group-based treatment per fortnight per group. Program facilitators were also responsible for the case coordination of the participants' treatment plans, in addition to all services. The facilitator to participant case coordination ratio was approximately **1:10-15**. The program schedule included allocations for community meetings, staff meetings and training days. In the Treatment stage, the IDATP worked towards a target of a minimum monthly program dose for each participant. This program dose totalled approximately 70 hours of intervention per month across active treatment, education/employment, community meetings, drug testing and contingency management components.

Minimum Program Dose Per Month[1]

- *10 x therapeutic groups (20 hours)*
- *10 x days of employment or education*
- *4 x community meetings*
- *4 x drug tests*
- *4 x weekly feedback sessions*
- *1 x multidisciplinary Case Review Meeting*

The program's design was found to be integrated on a number of levels. It provided a living-learning context (community members exert a mutually therapeutic influence). Both officers and therapeutic staff were involved in role-modelling, treatment delivery, monitoring and discipline. Participant progress was measured against a range of target behaviours, including attendance, commitment, engagement, prosocial behaviour, drug use and criminal conduct. A team of 31 staff (excluding education staff and custodial officers) was dedicated to the treatment component of the program. A further 80 custodial officers and 10 educational staff worked across the entire correctional centre, which included the IDATP.

Program Uptake

In the first 30 months of operation, around 1,300 NSW prisoners were candidates for the IDATP, in that their characteristics matched the program's eligibility criteria.

In these 30 months, 313 prisoners had actually commenced the program and 220 had exited the program. The overall program completion rate was 53%. The IDATP completion rate was comparable to those reported on prison-based TCs in the United Kingdom. The large majority of non-completers (80%) were involuntarily discharged from the program. Generally, TCs have been found to have lower completion rates than other programs. Profile statistics indicated that the program was admitting participants of considerable risk and need for intervention. Young prisoners and those with robbery offence profiles and longer sentences were disproportionately represented among the program's population when compared with the prison population eligible for the program.

Operational and Therapeutic Interface

The corrections literature has identified the therapeutic community (TC) model as one of the most complex treatment models to implement and operate in a prison environment. This is because TCs rely on significant revision to the values and operating culture of prisons and substantial commitment and cooperation from staff to make the programs operationally workable. In correctional settings, tension among staff is common, whereby the operational stream prioritises security and managing risk and the therapeutic stream prioritises rehabilitation efforts. Whilst staff from both the therapeutic and operational streams in the IDATP reported some tension in integrating their respective roles, there were some positive signs of collaboration. Both program staff and custodial officers participated in cross-training and attended the participants' community meetings. The entire multidisciplinary team (custodial officers, treatment, education and industries personnel) was involved in treatment monitoring and discipline. Further, custodial officers were given carriage of a program module.

Overall Program Quality

The Corrections Program Checklist (CPC) was selected to objectively assess the quality of the program. All the CPC indicators have been correlated with reductions in reoffending. The CPC covers the domains of leadership style, staff characteristics, assessment and treatment dosage and approaches and quality assurance mechanisms. In all five domains, the quality of the IDATP was assessed as very satisfactory. Areas identified for improvement were program documentation and more formalised policies and procedures for aftercare.

Changes to the Program Plan

In addition to the planned site change, which was beyond the immediate control of program management, the program's design had been refined since inception. This was chiefly in the areas of admission criteria, the preparatory program and drug testing protocols. That said, the program's primary behaviour change mechanisms - the 100-hour *Pathways* program and the residential community context had been constant.

Conclusion

The IDATP achieved its first stated aim, which was to establish a multidimensional therapeutic program for higher risk offenders with substance abuse issues.

To date, the IDATP has been continually operating for 30 months. In addition to its large capacity, the establishment of the IDATP has added value to the provision of drug treatment within CSNSW in a number of ways. From the outset, there has been state-wide access to the program for both alcohol and illicit drug users and those of varying security classification levels. Moreover, the IDATP's design was intensive and multi-modal, integrating a range of needs-based program enhancements, such as adjunct Opioid Substitution Therapy, embedded education and employment components, aftercare and a dedicated women's program.

The planned expansion of the program will presumably require a strengthening of staff and financial resources to ensure program quality is safeguarded.

RECOMMENDATIONS

Overall, the IDATP's design was deemed to be of high quality. The following strategies are intended to inform continual improvement of the program. The strategies reflect evidence-based and consensus-based principles and standards in the correctional and drug treatment literatures.

Recommendation 1

While the cornerstone program *Pathways* has a comprehensive manual, generic manuals should be developed to guide and safeguard the implementation of the integrated IDATP program, including a program manual, management plan and staff training manual.

Recommendation 2

Rigorous diagnostic assessment is foundational to treatment effectiveness. Current assessments should be reviewed to ensure differential and responsivity issues are appropriately addressed. Influential risk and need factors such as patterns of drug-related offending and drug use, primary drug problem, drug treatment history and overdose history should be recorded in standardised and electronic form to enable efficient access for clinical and evaluation purposes. Consistent with the RNR model, risk level should be taken in account when assigning participants to groups.

Recommendation 3

Frequent community meetings are integral to the therapeutic community (TC) model. Subject to feasibility, two community meetings per week should be held to enable more time for self-disclosure and reflection, interpersonal skill building and discussion around commitment to change. In line with the customary practice adopted by TCs, all community meetings should commence and conclude with the program's motto or vision statement.

Recommendation 4

Aftercare is critical to treatment effectiveness. While individualised aftercare pathway plans were developed for all participants, more formalised policies and processes should be developed to optimise planning and strategic post-program partnerships. Individual aftercare plans should be delineated into intensive and less intensive pathways, to either community-based or prison-based services and programs, whichever applies.

Recommendation 5

A communication strategy should be developed for dissemination of program information to correctional, criminal justice and community services agencies under the auspices of the Steering Committee. This strategy is intended to maximise the program's coverage.

Recommendation 6

As a matter of course, any future changes to program policy and procedures should be formally documented, including underlying rationale and standardised date referencing. Program manuals and documentation should be reviewed mid-way through the process evaluation with a view to setting in time and space, any major changes to program design since the initial review. This should allow future evaluation efforts to separate-out participant cohorts subject to different program conditions over time.

1. INTRODUCTION

Prisoners and Drugs

Regardless of jurisdiction, alcohol and drug-related crime is widespread among prison populations. Equally in New South Wales (NSW), more than two in three prisoners repeatedly link their most recent criminal activity to their drug use (Kevin, 2013a). It is also concerning that Indigenous offenders are not only over-represented in the NSW prison population, but also in drug-related offending (84% of Indigenous versus 69 % of non-Indigenous prisoners) (Kevin, 2013a).

Drug abuse has been identified as one of the top eight criminogenic needs areas (Andrews, Bonta & Wormith, 2006). Drug-related offenders are among those offender groups at highest criminogenic risk of reoffending. A U.S. study found that 70% of drug-abusing offenders return to prison within three years of their last discharge to freedom (Langan & Levin, 2002). Similarly in NSW, prisoners with drug-linked offences are more likely to have served a prior prison sentence (64%) when compared with those whose offences are not linked to drug use (42%) (Kevin, 1992).

Illicit drug users comprise a large proportion of the NSW prison population and there is consistent evidence of high rates of illicit drug misuse and dependence (Kevin, 2010; Indig et al. 2010). NSW prisoners show high occurrence rates across a range of drug-problem markers (Kevin, 2013a), including:

- recent illicit drug use (73%)
- recent use of heroin, amphetamine or cocaine (50%)
- recent injecting drug use (35%)
- drug withdrawal on reception to custody (36%)
- drug treatment history (86%)
- illicit drug use during their current prison episode (37%).

NSW prisoners also have comparably high rates of serious infectious diseases, such as hepatitis C (32%) (Indig et al. 2010).

A constant challenge for correctional management is that prisoners with drug problems typically present with complex, inter-related needs, including problems with poor health, psychological disorders, interpersonal relationships and managing anger, education and employment (Belenko, 2006). Further, for some prison represents a continuum in their drug using behaviour. As Belenko and Peugh (1998) have posited, previous unsuccessful attempts at abstinence tend to reinforce a negative self-image. This in turn, increases the likelihood that these individuals will use drugs when attempting to deal with stress or conflict.

High rates of co-occurring drug use and mental illness are evident among prisoners. A recent study into the mental health of NSW prisoners found the prevalence of any drug use disorder to be 55%. Co-occurring drug use and mental illness was in the order of 30% (25% of males & 46% of females). The authors underscored the need for appropriate mechanisms to assess, treat and manage those prisoners with co-occurring disorders (Butler, et al. 2011).

Contemporary correctional practice recognises that drug-involved prisoners are at a crisis point in their lives and imprisonment affords a critical threshold for intervention. In NSW for instance, drug treatment has been provided to prisoners since the 1980s. Importantly, ten per cent of NSW prisoners with drug problems report their only experience of psychology-based drug treatment was during an episode of imprisonment (Kevin, 2013a). Nonetheless, 58% of potential treatment candidates (NSW prisoners with both drug-related offences and a Medium or higher risk reoffending risk level) did not participate in drug treatment during their current prison term (Kevin, 2013b).

In addition to serious harm at an individual level, drug-related crime also inflicts a significant social burden. With the current NSW prison population approaching 11,000, there is a growing pool of drug treatment candidates. This trend renders a strong case for increasing capacity to deliver high standard drug treatment in NSW prisons at this critical juncture in the lives of drug-involved offenders. Otherwise, these offenders are being released into the community without appropriate treatment and at considerable risk of returning to drug-related crime.

Explanations of Drug-Related Crime

Contrary to the simple unidirectional explanation that drugs cause crime, explaining drug-related crime is complex. While for some individuals the drug-crime relationship is chiefly causal, there are those for whom it is reciprocally related. For other individuals drug use is an indirect consequence of their criminal activity or the relationship between the two behaviours can be simply one of correlation (a secondary common cause is involved, such as socio-economic deprivation). A further complicating factor is that the nature of the drug-crime relationship be it cause, consequence or correlation may vary at different points in time for a given individual. The drug crime relationship is commonly bidirectional and multi-factorial.

Recent survey data on the nature of drug-related (including alcohol) crime among NSW prisoners support the basic dichotomy of linking intoxication from alcohol with violent crime (79% of those with a drug-related assault offence) and intoxication from illicit drugs with acquisitive crime (74% of those with a drug-related property offence). Having said that, drug-related crime occurs across the whole spectrum of criminal activity and complex poly-drug and poly-crime patterns are also commonplace (Kevin, 2013a). Drug use has been found to escalate criminal activity and over time drug use and crime can become mutually reinforcing, sustaining behaviours (Stevens et al. 2005). McMurran and Priestly's (2004) work on developmental risk factors for drug-related crime has identified the following risk factors, some of which are dynamic and amenable to change:

- Impulsiveness & hyperactivity
- Poor family management
- Parental models of substance use
- Poor academic achievement & hostile beliefs
- Association with delinquent peers
- Substance use
- Economic hardship
- Criminal lifestyle
- Anti-social rationalisations.

The large majority of prisoners in NSW report that their current offences are related to their drug use (alcohol included) and close to half go on to use drugs in prison (Kevin, 2013a). Establishing

whether the relationship between drug use and crime is chiefly causal for an individual is controvertibly an important consideration in prioritising drug treatment candidates. Further, risk factor research suggests that treatment programs should simultaneously address the dynamic risk factors associated with drug-related crime, such as criminal thinking, hostility and employment and education to reduce the likelihood of further drug-related criminal activity.

Current Paradigms in Offender Rehabilitation - Principles and Frameworks

Current approaches to offender rehabilitation are guided by a number of research-based principles or frameworks associated with recidivism risk reduction, rather than a specific type of program or treatment modality (Wexler et al. 2013).

Reducing reoffending is the central focus of offender rehabilitation. The Risk-Need-Responsivity (RNR) model asserts to have the capacity to predict, influence and explain offending behaviour (Andrews & Bonta, 2003). Given the principal aim of the Risk-Need-Responsivity (RNR) model is to reduce the risk of reoffending and protect community safety it is not surprising that RNR is the dominant paradigm guiding the delivery of offender programs. The RNR model first featured in the criminological literature in 1990. Since its inception, research has consistently shown that programs that adhere to RNR principles and other empirically supported principles of offender rehabilitation are associated with significant reductions in reoffending (Wexler, et al. 2013).

The RNR model draws on the 'What Works' literature and personality and social learning theory. The model espouses adherence to the principles of *risk, need* and *responsivity* in the delivery of offender programs. In brief, this involves targeting intensive programs to offenders at greatest risk of reoffending, targeting dynamic criminogenic needs that are directly related to criminal behaviour and adhering to principles of *general* and *specific responsivity.*

The *risk* principle advocates that high-risk offenders should receive more intensive programs or a greater dosage of treatment. According to early literature, a drug offender required at a minimum 100 hours of treatment over four months to affect recidivism outcomes (Gendreau, et al. 1996). A more recent study of 620 offenders provided confirmatory evidence that treatment dosage significantly predicts recidivism (Bourgon & Armstrong, 2005). The prescribed 100-hour intervention dosage was only found to significantly reduce reoffending among moderate risk offenders. Whereas, for those with high risk or multiple needs profiles, 200 hours of intervention was required to significantly reduce reoffending. The authors advocated that for those with both high risk and multiple needs profiles, an excess of 300 hours may be required to affect reoffending.

The *needs* principle distinguishes between criminogenic and non-criminogenic needs. Criminogenic needs are risk factors for reoffending. Dynamic criminogenic needs are considered to be amenable to change. Andrews, Bonta and Wormith (2006) have identified eight central domains of need as the primary targets of intervention. Antisocial attitudes/orientations, antisocial peers, antisocial personality and anti-social behaviour patterns comprise the top four as they have been found to be the most significant predictors of recidivism. Drug abuse, dysfunctional family, education/employment and absence of prosocial recreational/leisure activities are also considered to be primary targets. The RNR model advocates that non-criminogenic needs should not be addressed in programs for offenders.

Factors associated with *responsivity* are widely regarded as critical mediators of treatment effectiveness (Brown, 1996). *General responsivity* involves applying cognitive-behavioural, social

learning and behavioural interventions. Of these; role modelling, graduated practice and skills training are most predictive of reductions in reoffending (Andrews & Bonta, 2003). *General responsivity* also refers to providing a context conducive to rehabilitation and ensuring staff are qualified, trained and supervised (Dowden & Andrews, 2004). The RNR model espouses the use of actuarial risk assessment tools to determine an individual's risk and needs. It also espouses the principle of program integrity, such that programs are delivered as intended. The Stages of Change model (Prochaska & DiClemente, 1992) and Motivational Interviewing (Miller & Rollnick, 1991) are now recognised as *general responsivity* principles (Andrews, Bonta & Wormith, 2006). *Specific responsivity* involves targeting interventions in a way that addresses individual characteristics, such as learning styles and abilities, motivation, gender and culture.

The Good Lives Model (GLM) is a more recent and alternative perspective to the RNR model. The GLM espouses that criminal behaviour is a maladaptive response to meeting human needs (Ward & Maruna, 2007). It is a strengths-based approach, whereby offenders are provided with opportunities and experiences to assist them in meeting their needs in a socially responsible way. While this model does address risk, supportive approaches and opportunities take precedence. These are designed to motivate the individual to develop a new identity and alternative future and ultimately to desist from offending. The offender's goals and values are considered in this approach. Therefore, unlike the RNR model, the GLM addresses non-criminogenic needs if they are of concern to the offender.

On the face of it, the RNR and the GLM perspectives are at variance; RNR is risk reduction and GLM is strengths-based. Though, Ward and Stewart (2003) argue that targeting non-criminogenic acute needs may be necessary to engage and motivate the offender prior to addressing criminogenic needs. Similarly, Kennedy (2000) holds that *specific responsivity* can involve identifying other (non-criminogenic) individual needs and issues that may prevent an offender from benefiting from an intervention. It follows that these deficits may need to be addressed prior to or concurrently with a risk-based program. This interpretation of *specific responsivity* shows some degree of convergence with the GLM. With this more expansive interpretation of *specific responsivity,* the GLM may be seen to complement the RNR model through attention to opportunities and experiences designed to enhance well-being and motivation; despite these needs being non-criminogenic *per se*. Proponents of the RNR concede the theory is still evolving and *specific responsivity* is an understudied principle (Andrews & Bonta, 2006). To date, the GLM has not been empirically tested.

As previously mentioned, rather than advocating a single treatment modality, correctional rehabilitation is currently guided by a number of evidence and consensus-based principles and approaches. In a similar vein, the drug research literature has also identified research and consensus-based principles to guide treatment delivery. The US National Institute on Drug Abuse (NIDA) has identified a set of principles for the effective treatment of addictions and more specifically, for criminal justice populations with substance abuse disorders (NIDA, 2012). According to NIDA, the existing research provides a compelling case for the effectiveness of drug treatment with those involved in the criminal justice system on outcomes of drug use, crime, health and well-being. NIDA concedes substance abuse can be intractable, relapse is common and multiple episodes of treatment may be necessary.

There is considerable overlap between the principles advanced for the treatment of addictions in general and criminal justice populations with substance abuse problems. A key point of difference in treating criminal justice populations is the practice of targeting criminal thinking.

An abridged list of NIDA's treatment principles to guide substance abuse treatment with criminal justice clients follows:

- Comprehensive, holistic assessments - including mental health evaluations
- Sufficient duration of treatment (three-month minimum)
- Tailored treatment – including the general principles of motivational enhancement, problem solving, skills building and supplanting drug use with constructive activity
- Drug testing
- Contingency management – with an emphasis on non-monetary social reinforcers and graduated sanctions
- Treatment provided in tandem with corrections personnel
- Targeted at criminal thinking – cognitive skills training
- Availability of pharmacotherapies
- Harm reduction prevention and treatment strategies
- Integrated mental health treatment for those with co-existing disorders
- Post-release transition to community-based treatment and services – continuity of care is seen as essential.

In a similar vein, Perdoni and colleagues (2008) have proposed a set of evidence-based practices (EBP) that should be implemented in correctional settings with substance abusers to improve offender management and reduce recidivism. There is considerable overlap with the aforementioned principles identified by NIDA as both are based on research evidence and consensus panel review. In addition to those principles already identified by NIDA, Perdoni and colleagues advocated the following practices:

- Standardised substance abuse assessment tools
- Risk assessment tools
- Evidence-based approaches, namely therapeutic communities, behaviour modification and cognitive behaviour therapy
- Comprehensive treatment methods that address the multiple needs of offenders
- Involvement of family in the treatment or corrections process
- Inter-agency systems integration to provide services for drug-involved offenders.

The preceding principles and practices reflect the current drivers in the corrections and drug treatment literatures; these involve the identification of those factors most commonly associated with effective programs. Research has demonstrated that, when treatment is appropriate, offender recidivism can be reduced by up to 35% (Andrews & Bonta, 2010).

Evidence on Treatment Effects

There is a large corpus of literature on drug treatment effectiveness. Internationally, positive treatment effects have been reported from both discrete (Prendergast, et al. 2002) and large multi-site studies (American Drug Abuse Outcome Study (DATOS) (Simpson et al. 2002); English National Treatment Outcomes study (NTORS) (Gossop, et al. 2002); Drug Treatment Outcomes Research Study (DTORS, 2009); and the Australian Treatment Outcome Study (ATOS) (Darke et al. 2005). In their review of literature, a Beckley Foundation collective concluded that the evidence weighs in favour of drug treatment, with reported improvements in health, well-being and employment and reductions in drug use and to a lesser extent crime (Stevens et al. 2003).

A number of more recent systematic, meta-analytical reviews have concluded that drug treatment reduces recidivism. Generally strict inclusion criteria are used in meta-analysis, such as randomised control or comparison groups, a total participant pool and multivariate analysis. A meta-analytical review of 28 studies conducted in the UK reported substantial reductions of between 29 per cent and 36 per cent post-treatment, when compared with a comparison or control group. Therapeutic Communities (OR; 2.5), post release supervision (OR; 2.5), and opioid substitution therapy (OR; 1.6) were among the most effective modalities. Whereas drug courts and drug testing (OR; 0.91) and alternative programs (OR; 0.81) showed no evidence of effectiveness. The review also showed that high intensity programs (i.e. high dose, duration and continuity) were more effecting than low intensity (OR; 1.5) (Holloway, et al. 2006).

A Campbell Collaboration meta-analysis of 66 in-prison drug treatment evaluation studies reported that prison drug treatment was associated with modest reductions in reoffending. Notably, this review found that effect size varied with treatment modality (Mitchell, et al. 2006). When compared with other modalities, TC programs were most likely to demonstrate treatment effectiveness in terms of reductions in drug use and crime. Further, those programs that had an intensive focus, like TCs, showed the most consistent and strongest reductions in reoffending. These findings were upheld across different offender samples, suggesting that TCs can be applied with a range of offenders. Drug treatment programs that addressed other problem areas were also associated with better outcomes and mandatory aftercare enhanced the effect size across treatment modalities. Further confirmatory evidence of the effectiveness of certain drug treatment modalities on recidivism comes from a meta-analytic study conducted by the Washington State Institute for Public Policy (2006). Prison-based TCs with community aftercare and cognitive behavioural programs both showed an average recidivism reduction of seven per cent. Basic education programs and correctional industries programs showed reductions of five per cent and eight per cent respectively. In their review of the empirical literature on drug treatment evaluation, Bahr and colleagues (2010) claimed to have paid particular attention to how studies controlled for selection bias. The authors concluded that rigorous evaluations of CBT, TCs and drug court programs generally recorded successful outcomes in terms of reduced drug use and crime. Effectiveness was enhanced through a focus on high risk offenders, strong program inducements, intensive intervention and more than type of intervention and also aftercare.

Collectively the above reviews have demonstrated the effectiveness of drug treatment on the measure of reduced reoffending behaviour; with reductions ranging from seven per cent to 36%. That said, these positive findings are potentially tempered by a publication bias, whereby only those studies that find differences are submitted for publication. In order to qualify for inclusion in these reviews, individual evaluation studies had to be classified at Level 3 or higher on the Scientific Methods Scale (Farrington, et al. 2002) or similar standard. In practical terms, this means these evaluations demonstrated comparability between treatment and comparison groups by controlling for important pre-existing factors, such as age, gender and criminal history. However, it was not always made clear to what extent the quasi-experimental comparison studies controlled for self-selection bias, such as personal motivation. Notwithstanding, when compared with treatment seekers in the community, the assumption of self-selection is not so straightforward within correctional settings. This is a complex area of analysis. It is common practice for prisoners' conduct while in custody, including program participation, to be linked to incentives, such as increased liberty and privileges within the correctional system. Hence, program participation and other indicators of prosocial functioning while in custody do not necessarily reflect a genuine regard for programs or motivation to change.

Factors Associated with Program Success

Treatment duration and retention are considered as crucial determinants of outcome (Maxwell, 2000) with several months, ranging from three months to 12 months being optimal (Lang & Belenko, 2000; Prendergast, Podus, et al. 2000; Farabee, Shen et al. 2001; Gossop, Marsden et al. 2001). The Australian Treatment Outcome study (ATOS) identified the importance of drug treatment stability or 'a stable dose' in relation to outcome (Darke, et al. 2005). Simpson and colleagues (1999) proposed that implementing techniques early in treatment to enhance motivation would improve treatment engagement and retention.

A range of participant characteristics have proven to be predictive of retention and longer-term outcomes. These include older age, high motivational level, higher socio-economic status, higher self-efficacy, higher employment and education, higher social functioning, lower hostility, good mental and physical health and softer drug class usage (Stevens, et al. 2003; Hiller, et al. 2006; Kevin, 2010, Aydin, et al. 2013). It has been argued that motivation is the strongest predictor of retention and engagement (Simpson, et al. 1999). Conversely, Florentine and colleagues (1999) suggest that treatment characteristics are more important than the initial motivation of individuals. It is intuitively coherent that an individual's perception of treatment utility and related factors (e.g., respecting the provider and feeling positive towards the treatment provided) may predict treatment retention and outcome as reported by Florentine and colleagues.

It is generally accepted that treatment effectiveness is an interaction between the participant and treatment. It follows that a focus of treatment should be to cultivate and reinforce self-selection factors like motivation (De Leon et al. 2000). Intensive drug treatment has been found to have an iatrogenic effect on high risk, highly motivated prisoners. On average, negative change in anxiety levels was observed in the first six months of treatment. Unlike other subgroups, there were no psycho-social improvements for those who were high risk & highly motivated. Findings suggested that for this subgroup, it may be necessary to address psychological and social functioning needs in the early stages of treatment (Welsh, 2010).

The combined work on individual characteristics found to moderate and mediate program outcomes underscores the need to attend to *specific responsivity* at treatment entry through comprehensive assessment and case formulation.

Program characteristics in the areas of context and content have been found to affect outcome. Numerous factors have been linked to better outcomes, including high program integrity, high staff/client-ratio, multidisciplinary teams, drug testing, motivational and cognitive behavioural therapy, high number of group therapy sessions and aftercare (Stevens et al. 2003). Several studies have associated therapeutic alliance and peer support with engagement and retention (Welsh & McGrain, 2008). Similarly, strengthening social supports within programs has been linked to reduced reoffending (Klebe & O'Keefe, 2004). Finally, studies on quasi compulsory treatment (QCT) have found that programs which process drug tests and case reviews more quickly are associated with better retention and longer-term outcomes (Bean 2002; Young & Belenko 2002; cited in Stevens et al. 2003). An early meta-analysis of 44 rigorously controlled offender treatment studies identified six factors significantly associated with program efficacy. In addition to *needs* and *responsivity* principles, the authors identified the following factors to be significantly associated with treatment efficacy; sound conceptual model, multi-faceted programming (more than one method), role playing and modelling and social cognitive skills training (Antonowicz & Ross, 1994).

Treatment Approaches

Motivational Interviewing (MI) is an approach that was initially developed to address barriers to towards behaviour change; such as ambivalence in relation to drug and alcohol use (Miller & Rollnick, 1991). More recently, this approach has also been applied to other problem behaviours, such as criminal behaviour (McHugh, et al. 2010). MI is a brief motivational enhancement intervention that is typically offered in an individual format in the early stages of treatment (McHugh et al. 2010). MI relies on the formation of a counsellor-client relationship. It is a directive, client centred approach aimed at resolving motivational barriers and assisting the individual to move through the stages of change in problem resolution (Prochaska & DiClemente, 1992). It has proved effective when combined with other approaches, but not as a stand-alone intervention (Stevens et al. 2006).

Cognitive Behavioural Therapy (CBT) is underpinned by the premise that thoughts determine behaviour. Therefore, CBT focuses on thinking patterns and beliefs. CBT assumes that treatment clients have maladaptive thinking patterns that need to be altered (Bahr et al. 2012). CBT assists individuals to recognise and then restructure distorted thinking and perceptions. This is designed to affect positive behaviour change. CBT also provides participants with the specific skills to address their problems and places responsibility for change with the participant. Standard techniques are modelling, graduated practice, role-playing and high levels of reinforcement for prosocial behaviours (Bourgon & Armstrong, 2005). CBT is the dominant treatment modality in correctional settings and can be generalised across different types of offenders. Clark (2010) notes that generally CBT with offenders is designed to improve thinking patterns and beliefs in the following areas:

- social skills
- means-ends problem solving
- critical reasoning
- oral reasoning
- cognitive style
- self-control
- impulse management
- self-efficacy.

According to Mackenzie's 2013 summary of the evidence, cognitive change is the precursor to living a noncriminal lifestyle and programs should aim to change thinking through cognitive methods to bring about cognitive transformation. CBT with offenders should directly target criminal thinking styles and attitudes that support criminal behaviour, such as self-justification, inability to interpret social situations and difficulty accepting responsibility for their actions (Lipsey et al. 2007).

As previously mentioned, CBT has been found to be a more effective treatment modality with offender populations on the measure of recidivism reduction. Outcome evaluations that have demonstrated the positive effects of prison-based CBT programs have typically measured recidivism at six and 12 months and more confirmatory research on longer term effects is needed (Wexler et al. 2005). Drug treatment effectiveness research has also proven CBT to be effective in terms of reduced drug use, particularly when combined with pharmacotherapies and contingency management (Stevens et al. 2006).

Relapse Prevention (RP) is an adaptation of cognitive behavioural therapy that was originally developed as a maintenance strategy in the treatment of addictions (Marlatt & Gordon, 1985). Wanberg and Milkman (2008) have since applied RP in the treatment of criminal behaviour. RP involves the functional analysis of cues for the addictive behaviour (particularly high risk situations or triggers, such as cravings) and systematic training of alternative responses (coping skills) to these cues (McHugh et al. 2010). The key element of RP is the acquisition of effective coping skills (Marlatt & Gordon, 1985).

In brief, the technique involves:

- decision review
- positive self-statements
- enduring feelings until they subside
- pursuing distracting activities (McMurran & Priestly, 2004).

Contingency Management (CM) and Community Reinforcement Approaches (CRA) are based on the notion that problem behaviour is initiated and maintained by environmental factors and therefore is amenable to change by altering the behaviour's consequences. These approaches reflect operate learning theory and behavioural economics theory. CM is grounded in the assumption that the problem behaviour should decline as its cost increases. The corollary assumption is that the problem behaviour should decline when substitute rewards in sufficient magnitude are made available (Moss, 2007). CRA is a complementary approach that increases the likelihood of rewards from employment and other social activities (Moos, 2007). In essence, CRA endeavour to rearrange the individual's social environment and provide rewards to compete with problem behaviours.

In CM, incentives are applied to make continuation of the problem behaviour less attractive and desistance more attractive. Essentially, rewards are used to positively reinforce desired behaviour. The critical elements of CM are close monitoring, tangible rewards, including support and encouragement and the withholding of rewards when the problem behaviour is identified. CM protocols use either stable or escalating reinforcement schedules (reinforcer value increases with duration of abstinence of problem behaviour).

Specifically with criminal justice clients, when sanctions are applied they should be clear, definite and immediate (Lang & Belenko, 2002). Petry (2000) also identified specific characteristics of effective CM, including:

- 4:1 ratio of rewards to sanctions
- schedule that increases rewards for compliance
- reset to zero for non-compliance and sanctioning of only serious violations.

A noted limitation of CM is that with discontinuation of rewards, the desired behaviour is not maintained (Bahr et al. 2012). Therefore, usually these are not stand-alone approaches, but integrated with other interventions, most notably CBT (Stevens et al. 2006). Similarly in drug treatment, CM is most effective when positive incentives are used rather than sanctions (Gowing et al. 2001). A meta-analysis found CM to be effective in terms of abstinence from drug use during treatment, but also recommended that CM be combined with other approaches associated with sustained improvement (Prendergast, et al. 2006).

The Therapeutic Community (TC) model has emerged as the most widely adopted and successful drug treatment paradigm in prison-based settings (DeLeon & Wexler, 2009). TCs are a mature paradigm having been implemented in prison-based settings for 25 years. They tend to be the most intensive and long term of the prison-based treatment programs. The rationale for TCs in prisons is that commonly prisoners have extensive drug problem histories and, by extension, this population requires high intensity treatment that endeavours to restructure attitudes and thinking (De Leon & Wexler 2009). Generally, in a TC, the community is both the forum and therapeutic agent (Community as Method) and educational and work activities are standard inclusions (Welsh, 2013). TCs are commonly staged programs with a focus on socialisation, intensive therapy, behaviour modification and gradually increasing responsibilities (Belenko & Peugh, 1998; National Institute on Drug Abuse, 2002). Explicit stages are structured to provide incremental degrees of psychological and social learning (Peters & Wexler, 2005). Social norms may be addressed and reinforced with specific rewards & sanctions directed towards developing self-control and responsibility (Welsh, 2010).

There have been two main interpretations of the TC model - American hierarchical concept-based and British democratic (Vandevelde et al. 2004). A defining characteristic of the hierarchical model is a tenure-based structure, with the use of work as an organising activity. Hierarchical TCs also use former graduates in program delivery and emphasise self-help principles and aftercare (Lipton, D. in Shuker & Sullivan, 2010). The hierarchical model views drug abuse as a multi-dimensional disorder of the whole person; therefore treatment is holistic. According to DeLeon (2000), hierarchical TCs are designed to improve social functioning; habilitation, rather than rehabilitation is the treatment goal as the individual is being socialised maybe for the first time to live prosocially. In the British democratic model, the treatment focus is on the community as a whole and equality amongst members is a key organising principle. The democratic model relies on professional staff rather than former members, treatment is less structured and aftercare is not systematically offered.

The prison version of the TC commonly operates as a Modified Therapeutic Community (MTC). When compared with hierarchical TCs, MTCs are less likely to feature a tenure-based participant hierarchy and confrontational group therapy. MTCs tend to incorporate a range of treatment strategies and employ more professional staff, as opposed to former participants. The MTC model has limitations. Even though MTC programs may be mature, they are commonly affected by organisational changes beyond their immediate control (Linhorst, et al. 2001). Also, treatment attrition from TCs is considerably higher than other modalities (Deleon, 2001; Darke et al. 2005). By way of example, prison-based drug treatment TCs in the UK have documented completion rates ranging between 50% and 62% (Biggs, 2011). The most recent development in the field involves integrating the proven TC and CBT approaches with high-risk offenders. Welsh and colleagues (2013) argue that the two approaches are complementary and when integrated offer the best outcomes for these offenders.

Even though TCs vary, there are a number of common elements:

- separated unit accommodation
- high intensity
- social learning principles
- treatment programs that foster a prosocial environment.

Opioid Substitution Therapy **(OST)** in the form of Methadone Maintenance therapy is a well-established treatment for heroin dependency (and to a lesser extent cocaine dependency) in both drug treatment and correctional settings. Methadone is a long-acting agonist; essentially heroin dependence is substituted with methadone dependence. The dosage is controlled to facilitate sustained abstinence from heroin and stability of life. Methadone has proven to be highly efficacious on measures of post-index treatment, drug use, health, recidivism and cost-effectiveness (Dolan et al. 2003; Darke et al. 2005; Thomas & Buckmaster, 2007; Kinlock et al. 2008; and Bao et al. 2009). Reportedly, the positive effects of opioid substitution therapy increase with treatment duration and when paired with psycho-social treatment (McGovern et al. 2003; Darke et al. 2005; Mollica, 2000 cited in Stevens, et al. 2003).

Therapeutic Alliance (relationship between treatment provider and client) is identified as a non-technique-based agent for change (McGovern at al. 2003). Therapeutic Alliance is gaining increasing recognition in terms of its importance in treatment effectiveness. A recent review of drug treatment effectiveness indicated that up to 40% of the variance in treatment effectiveness may be related to the relationship between client and provider (Meier et al. 2005). One study asserted that a strong alliance is beneficial in and of itself, regardless of other psychological interventions (Martin et al. 2000).

Structured Aftercare has been identified as critical to maintaining positive drug treatment effects and sustaining the individual in the recovery process (Pelissier, 2000; Welsh, 2007). Evaluations of prison-based TCs have consistently shown that community aftercare is essential to prevent relapse and recidivism (Peters & Wexler, 2005). Wexler and colleagues (1999) found significant reductions in recidivism were achieved up to one year after release from prison-based treatment, but this declined sharply at three years post-release, unless followed by at least three months of aftercare. The authors advocated that three months community-based treatment was needed subsequent to prison treatment to produce significant reductions in reoffending and drug use. According to recent research from the U.S., mandatory aftercare has been implemented in California as only 20-30% of prison TC participants were opting for aftercare (De Leon & Wexler, 2009). The need for continuity of care subsequent to discharge from drug treatment has been underscored in published principles of treatment effectiveness to guide both the drug treatment and offender rehabilitation fields (NIDA 2012; Taxman & Belenko, 2012). In the offender literature, this is couched in terms of assisting the individual in generalising change to community contexts.

Summary: Treatment Approaches

Correctional drug programs and community-based drug treatment share a number of common features. The two most widely implemented approaches in corrections, cognitive behavioural therapy and therapeutic communities are also well established in drug treatment settings. Several approaches commonly adopted in correctional programs had their genesis in the addictions treatment area, including the Stages of Change Model (Prochaska & DiClemente, 1986), Motivational Interviewing (Miller & Rollnick, 1991) and Relapse Prevention (Marlatt & Gordon, 1985). Contingency contracting and aftercare or follow-up are advocated in both literatures. According to McMurran & Priestley (2004), what differentiates correctional programs from their community drug treatment counterparts is:

Duration - typically correctional programs are of longer duration
Documentation – greater degree of manualisation
Scrutiny – greater degree of monitoring and auditing.

Correctional programs are also more sociocentric, in that they are concerned with reducing future risk of reoffending and improving community safety.

Program Quality

Program quality is recognised as a critical feature of correctional program effectiveness and as such is an identified principle of the RNR framework (Andrews & Bonta, 2010). Certain markers of program quality, such as having a strong theoretical foundation and program integrity were flagged as key features of effective correctional programs in the *What Works* literature (McGuire & Priestley, 1995). A strong theoretical foundation is denoted by a well-articulated theory of change or program logic. Program integrity is evidenced by the adherence to treatment design manuals by well-trained, supervised and supported staff.

The relative importance of program quality has been underscored in a recent study which found a 22 percentage point difference between programs assessed as high quality and controls on reoffending outcomes. In contrast, for those assessed as low quality programs, the difference was just 1.7% (Lowencamp, Latessa & Smith, 2006). A Campbell Collaboration systematic review of CBT programs with offenders concluded that the quality of program implementation and provider training are the most decisive factors in the effectiveness of CBT programs, rather than the superiority of one program type over another (Lipsey, et al. 2007).

Process is an important facet of program evaluation as it provides a measure of program quality and can explain why and how programs succeed or fail. Process evaluation can also be used to improve program performance. If a program is poorly designed, as evidenced by unclear goals and a lack of understanding of what activities will produce the desired outcomes, then this flaw may prevent it from achieving its desired outcomes. Further, the program may fail to achieve its desired outcomes if activities are not taking place due to implementation difficulties, rather than ineffective program design; this is known as type iii error. Moreover, effective programs that aren't clearly described and documented can't be replicated.

Correctional research has neglected the measurement of program quality, even though the examination of program quality can greatly assist program and policy planning and provide meaningful information to the design of outcome evaluations (Welsh & Zajac, 2004).

2. EVALUATION RATIONALE AND AIMS

Rationale

The IDATP was an election-mandated, high profile and innovative program. The comprehensive evaluation of this program was a government priority. The CSNSW Corrections Research, Evaluation & Statistics Unit (CRES) was asked to undertake the current process evaluation to coincide with the outcome evaluation being undertaken by the NSW Bureau of Crime Statistics & Research (BOCSAR). Process evaluation aims to explain the dynamics of program implementation. In this way, the program is not only be evaluated according to its aims relating to drug-related offending, but also against its implementation objectives. This provides a more accurate picture of the program. The process evaluation of the IDATP is both longitudinal and mixed-method to enable collateral validation. It was also designed to be useful in identifying markers of program success, program impediments and areas for refinement during the life of the program. A specific intention was to move beyond a so-called 'black box' evaluation – such that, what happens during program implementation is identified and analysed using a range of methods. In turn, this information assists the outcome evaluation and provides context to any observed program effects.

While process evaluations are critical to explaining why prison programs succeed or fail, published studies are considerably lacking. Those that are in the public domain are generally limited to staff and participant feedback, as opposed to more objective approaches, such as structured systematic observation and the triangulation of diverse information sources. The current study attempted to redress the lack of information on program characteristics evident in the literature.

Aims

The overriding aim of the process evaluation of the IDATP was to examine the effectiveness of the program in delivering a service and meeting its stated program implementation goals and objectives. The evaluation also aimed to make recommendations to inform improvements to this and other correctional drug treatment programs. The aim of this first study was to examine program establishment, design and appropriateness.

Figure 1 summarises the process evaluation's four key lines of investigation, with the first-stage, preliminary study highlighted in white.

3. METHODOLOGY

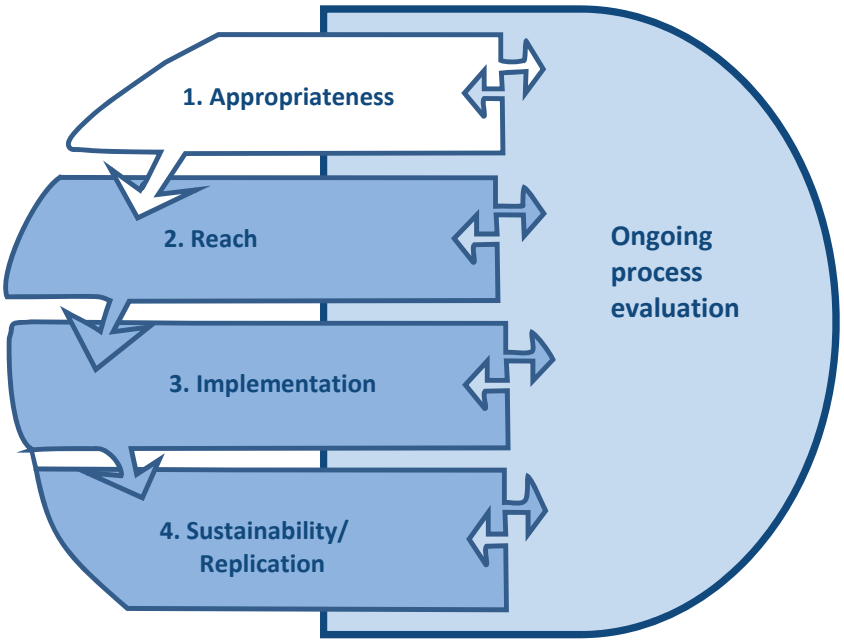
Focus Area 1. Appropriateness - How well has the program been established and designed?

Research Questions

1. What is the background to the program – identified need, planning process and establishment?
2. What is the evidence-base and underlying assumptions of the program?
3. How do program elements and goals align?
4. What are the characteristics and context of the program and in what ways is it a Modified Therapeutic Community?
5. Does the program provide culturally appropriate services?
6. What resources and training are provided?

7. What is the nature and quality of program governance?
8. Are there appropriate administrative systems in place for monitoring and reviewing the program?
9. What is the initial evidence of program uptake?
10. Are there any potential or emerging problems that suggest changes to the program plan?
11. What is the level of program quality? - to what extent, does program design adhere to recognised standards for effective correctional programs?

Figure 1: Flowchart Summary of the Process Evaluation Focus Areas



Design

This was a qualitative, mixed-method study, including a range of process and monitoring methods. Data collection methods included literature review, review of program records and data systems, focus groups, personal interviews, data extraction and standardised assessment of program quality against validated correctional program standards.

Data Collection and Analysis

1. Program documentation was sourced for the purpose of describing and reviewing program history and design. This information was predominantly obtained from Local Operating

Procedures (LOPs), individual protocol documents, Steering Committee meeting minutes and other program resources that were stored electronically on a centrally located, shared network drive for access by all staff.

2. Two short focus groups (key informant consultations) were conducted with treatment management and operational management in order to document any changes to the design plan, any impediments encountered and also any facilitators to implementation. In addition, informal briefings were sought with program staff for purposes of clarification on program components.

3. Data extraction included program activity data and participant characteristics sourced from the Offender Integrated Management System (OIMS). This is the main operational platform for recording and managing offender records. Some data were sourced from dedicated information systems developed at site-level for monitoring participant behaviours targeted by the program.

4. Overall program quality was assessed using the Corrections Program Checklist (CPC) standardised scale. The Corrections Program Checklist (CPC) is a factor-analysed refinement of the Correctional Programs Assessment Inventory (CPAI), which was developed for assessing program quality. Essentially, these instruments assess the degree of adherence to the principles of the RNR model and can identify areas for program improvement. The CPC examines program components, such as dosage, calibre of staff, leadership style, quality assurance mechanisms, management information systems, aftercare services, evaluation and monitoring. In addition to removing some of the original CPAI items, the CPC has given more weight to some items than others. This information was sourced from program documentation and self-completion surveys completed by the therapeutic management team.

5. Treatment management staff (n=3) self-completed an adjunct survey that captured information required to complete the CPC (Lowencamp, 2004). To ensure inter-rater reliability, the checklist was ranked by three researchers and a consensus score was determined for each item.

6. The final component of the methodology that was not specified a priori, was the development of a logic model by the researcher. This came about after a review of program records failed to identify either a statement that depicted a theory of change or a model of program logic to provide a blueprint for the program in its entirety. According to process evaluation literature, it is acceptable practice for the evaluator to develop a program logic model as part of a design evaluation, without comprising the independence of the evaluation [Brouselle & Champagne, 2011]. Furthermore, the logic model enables the integration of process and outcome results (Devine, 1999).

As a predominantly qualitative study, any analysis was descriptive and statistics limited to percentages and measures of central tendency relating to program activity and participant characteristics.

4. FINDINGS

4.1 Program Background and Establishment

Rationale for the Initiative

The establishment of a dedicated prison-based metropolitan drug treatment facility to house up to 300 prisoners with drug-related crimes was a 2011 election commitment of the NSW Liberal National Coalition, the former opposition party and current government in NSW (see Appendix 1 for official media release). The aim of the initiative was to increase the capacity of CSNSW to provide drug treatment for offenders serving prison-based sentences. The NSW Government's specifications also underscored the need for a rigorous control regime of drug testing, monitoring and surveillance within the facility and a new approach to rehabilitating drug offenders.

Subsequent to the March 2011 election, CSNSW was asked by the Attorney General and Minister for Justice to propose a number of program models for further consideration that could deliver on the Government's commitment. According to a Briefing Paper[1], the proposed models included a dedicated correctional centre in-line with the initial proposal with staged program implementation and also smaller drug treatment wings located at various correctional centres around the state. The Minister's preferred model was the establishment of an Intensive Drug and Alcohol Treatment Program (IDATP) for male prisoners at John Morony Correctional Centre (JMCC) and another for female prisoners at Dillwynia Correctional Centre (DCC). Both these centres are located within the John Morony Correctional Complex in Windsor, an outer metropolitan suburb of Sydney. Prior to the IDATP initiative, JMCC was dedicated to a program for young adult offenders. A staged transition process was also endorsed under the approved model.

At the time of the proposal, CSNSW estimated that more than four thousand prisoners (46%) were suitable candidates for such a program, in that they had a reoffending risk level of medium or higher combined with a need for drug treatment according to formal assessment. Of these, more than one thousand were assessed as having a severe drug problem (alcohol included) requiring intensive intervention. These early phase projections of the potential pool of treatment candidates did not take into account length of prison term and other factors that may preclude program suitability, such as security classification and special placement restrictions.

The Intensive Drug and Alcohol Treatment Program (IDATP) became a significant business priority for CSNSW in September, 2011 when the NSW Government identified the establishment of a metropolitan drug treatment facility as a NSW 2021 (NSW ten-year strategic plan) Priority Action. Given the imperative, the planning and implementation of the IDATP was subject to government scrutiny and a tight time-frame for establishment.

Planning and Establishment

The approved IDATP model provided a total of 300 treatment places, comprising 250 beds for male prisoners and 50 beds for female prisoners. The first stage of the IDATP program opened in late February 2012 with 62 beds for male prisoners in JMCC. Reportedly, at the time of opening, it was practicable to recruit eligible candidates already housed in the centre, a substantial number of

[1] The IDATP Background Briefing Paper

whom were participating in a young adult offenders program. The second stage was completed, providing a further 62 beds. As of May 2014, half of the JMMC beds were allocated to IDATP participants.

While the IDATP participants were housed separately, half of the centre's beds were allocated to mainstream (non-IDATP) prisoners. The IDATP was to use the existing custodial officer staffing complement. This required officers to be rostered across both the IDATP and mainstream areas of the prison. The custodial officers were given the option to transfer to another centre should they not be interested in working with the program.

Stage Three, which provided for a further increase of 124 beds, was due to be opened in July, 2013. This stage was postponed due to system-wide operational capacity pressures, which saw an unanticipated spike in the overall NSW prison population. At this time, correctional administration reallocated the planned beds for the IDATP to accommodate mainstream remand and transit prisoners received through the court system. It is also worth noting that in mid-2013, some 18 months after the program had commenced, a new Director was appointed to the program.

According to several program stakeholders, the Government's political imperative resulted in a short lead-in time for establishing the program and this presented challenges to foundation building. At the time of planning, there was a number of existing drug treatment modalities being delivered in the state's prisons. These included structured group programs of short duration, the Ngara Nura residential pre-release program, the Compulsory Drug Treatment Correctional Centre (CDTCC) and also pharmacotherapies. It was envisaged that with the introduction of the IDATP, capacity to reach the large numbers of prisoners with drug problems would be strengthened while providing a high standard of drug treatment. By way of comparison, the CDTCC was a specifically legislated, court-directed, compulsory drug treatment correctional facility of 72 beds for sentenced male offenders with illicit drug problems that opened in 2006 (Decker et al. 2010). The CDTCC was innovative, in that participants were given the opportunity for early release into the community subject to satisfactory performance on the program.

Clearly from the IDATP's design documentation, the program adopted several operating principles and program elements evident in the existing suite of drug programs, particularly the CDTCC. The CDTCC had been operationally effective for a number of years. Consonant with the CDTCC, the IDATP's approach to the assessment, treatment and management of participants was based on the principles of therapeutic practice. The specific program features transposed from the CDTCC included intake assessment measures, the core drug treatment curriculum and therapeutic principles.

As admission to the IDATP was managed within the prison system, program intake was responsive to the dynamics in the actual program population. Reportedly, as program places became available, recruitment drives were initiated by the treatment team which offset inefficiencies in capacity building. It is worth noting that in July, 2013, the centre's medical clinic introduced adjunct Opioid Substitution Therapy (OTS) with a maximum of 31 available places for the IDATP participants.

In terms of value-adding through the establishment of the IDATP, when referenced against the CDTCC and other CSNSW drug treatment programs, the following points of difference were evident in the IDATP's design:

How the IDATP Added Value to Drug Treatment in NSW Prisons

- *Large projected capacity (n=250 places)*
- *Admission was managed within the state-wide prison system at any stage of a prison sentence*
- *Eligibility allowed for both alcohol and illicit drug involved offenders*
- *Eligibility allowed for minimum, medium & escapee* security classification levels*
- *Education and employment components were embedded into program*
- *Prescribed program duration of nine months*
- *Adjunct Opioid Substitution Therapy*
- *Dedicated female program (planning phase; n=50 places)*

**Some escapee categories excluded*

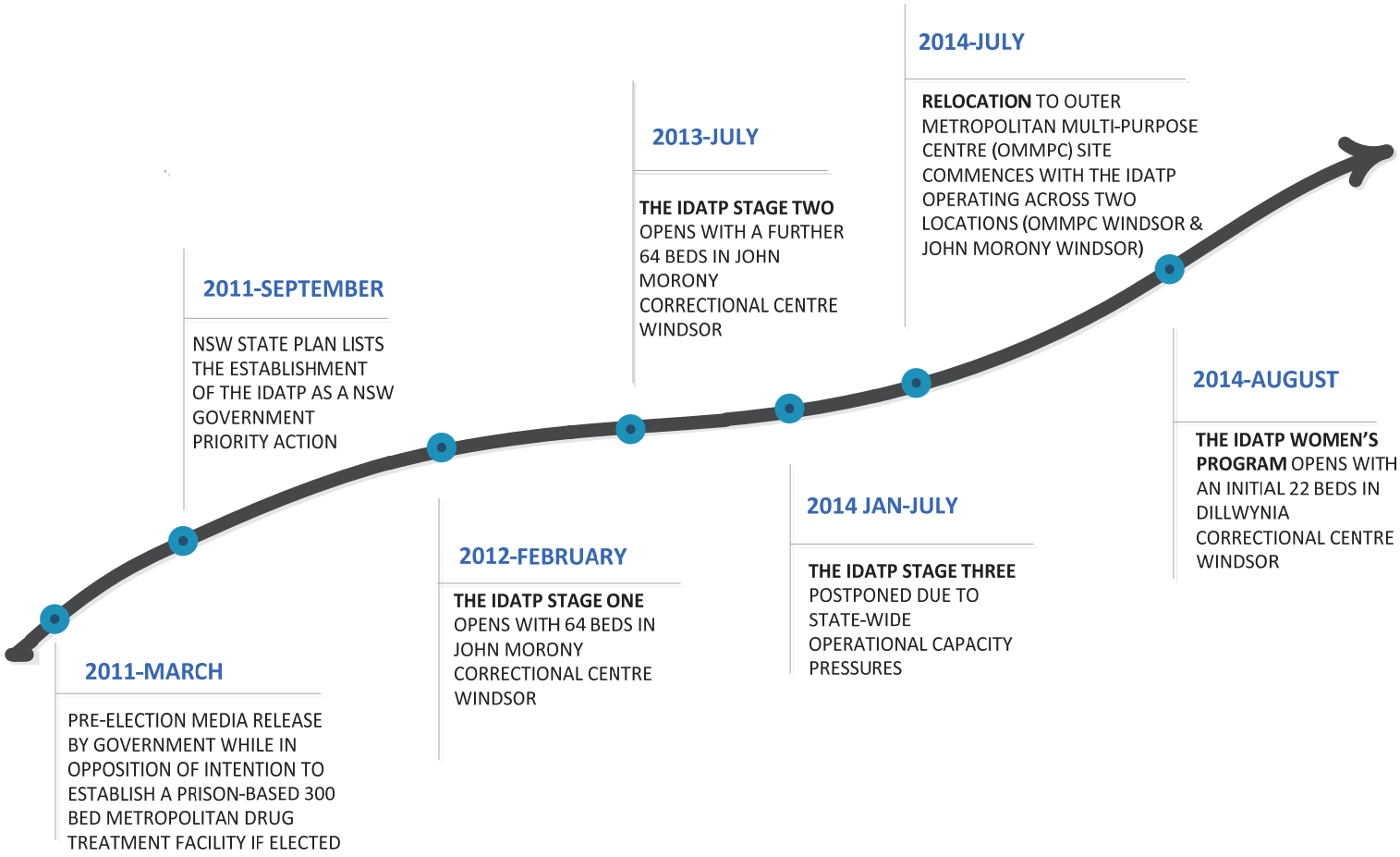
In addition to capacity building, the Government's vision was to implement an innovative treatment program to address the rehabilitation needs of drug-involved offenders and thereby mitigate drug-related crime. As envisaged by the Government, the IDATP was designed to manage risk through secure containment and a drug restricted environment, but more importantly to provide a modified therapeutic community offering a combination of "group involvement and peer support in combination with cognitive behavioural programs and harm reduction philosophy"[2]. Within-program risk was to be monitored and prevented using the standard interdiction strategies of drug testing and searches (drug dogs, cell & body searches) and informal social controls that arise from the Community as Method approach. In line with the evidence, behavioural infractions and drug relapse were to be managed according to the therapeutic principles of social learning theory.

Due to the already noted operational capacity demands within the NSW correctional system, in May 2104 a decision was made to relocate the IDATP program to the Outer Metropolitan Multi-Purpose Correctional (OMMPC) in order to make available cells at JMMC for the increasing numbers of prisoners being received from the court system who required a higher level of security. It is worth noting that as part of this relocation plan, the entire OMMPC facility would be dedicated to the IDATP program. The new IDATP site existed within the same correctional complex; however the facility was built to minimum security standards, with cells configured in a unit-style arrangement, including cooking facilities. As a physical space, the OMMPC had more open spaces and improved amenity. As both medium security and minimum security prisoners were eligible for the IDATP, the transfer of the IDATP participants was to be staged due to the infrastructure works required for a medium security facility with an estimated completion date in early 2015. In the interim, an identical program was to be run concurrently across both centres – JMCC and OMMPC.

At the time of writing (mid-2014), there were 93 participants in the program. Reportedly, a low population state was being maintained due to the period of transition between the two sites. Figure 2 presents as an ascending timeline of program milestones from inception to the first stage of the relocation process. Since the program opened, the maximum number of participants at any point in time was 157.

[2] The IDATP Background Briefing Paper

Figure 2: Time-Line of the Establishment of the IDATP



4.2 Program Goals, Principles, Theoretical Assumptions and Evidence-Base

At that time of writing, the IDATP was the single largest offender program in the NSW correctional system. Early phase program documentation[3] conceptualised the prison-based IDATP as follows:

A treatment facility that recognises the multidimensional treatment needs of alcohol and/other drug dependent offenders, therefore incorporating a range of therapeutic, health, education, vocation, employment and life-skills programs aimed at addressing substance dependence and offending behaviour.

A key assumption underpinning the IDTAP's conceptual framework was the cumulative effect of the multi-dimensional programs and methods would address the Government's remit to provide an innovative, targeted, intensive and effective approach to drug treatment within CSNSW.

According to the IDATP's design documents, the specific aims of the program were to:

- Provide a multi-dimensional, therapeutic program to address the rehabilitation needs of offenders with substance abuse/addiction issues and at considerable risk of reoffending;
- Prevent recidivism;
- Prevent relapse to alcohol and other drug use and dependence, and
- Improve social functioning, health and well-being and post-release prospects.

The corresponding mission statement follows:

> ***The IDATP Mission Statement***
>
> IDATP is committed to working with participants to bring about positive change to all aspects of their lives in order to reduce crime and addiction and to advance their health and contribution to society through a multimodal approach in a supportive community environment

Program Principles

As envisaged by the NSW Government, the program was designed to strike a balance between meeting treatment needs and managing risk. Program design documents stated that the IDATP was underpinned by the principles of effective intervention[4]. The program's design followed the principles of Risk-Needs-Responsivity (RNR). In addition, the program integrated RNR principles with the principles of the Good Lives Model (support physical, social & psychological needs), modified therapeutic community (MTC) and other empirically-evidenced approaches. The Good Lives Model with its strengths-based focus was designed to address *specific responsivity*, participant engagement and well-being. The Australian Therapeutic Community Association (ATCA) principles and values were embedded in program documents to guide the living/learning context. These principles espoused mutual respect, social support and responsible community living.

[3] IDATP protocol document
[4] IDATP protocol document

Both Risk-Need-Responsivity (RNR) principles and the *What Works* literature were embedded in the program's implementation guidelines. The target population included those at a higher risk of reoffending and considerable need for drug treatment as determined by the widely implemented Level of Service Inventory (LSI-R). The program's duration and intensity concorded with the minimum 200-hour dosage level recommended for higher risk offenders.

The MTC approach adopted by the IDATP was an evidence-based approach. TCs are designed to create conditions that are favourable to prosocial behaviour change. The IDATP's interventions and services were, for the most part, cognitive-behavioural in nature, thus meeting the *general responsivity* principle of correctional treatment.

The delivery of an intensive 100-hour core program developed for offenders whose criminal activity is related to drug abuse provided *specific responsivity* for the primary treatment targets of criminal activity and drug abuse. *Specific responsivity* was also addressed through assessment tests and individualised treatment and reintegration plans designed to target criminogenic needs, learning and vocational needs, mental and physical health, and social responsibility respectively.

Summary: Goals & Principles

In short, the IDATP aimed to reduce reoffending, prevent relapse to drug use and improve the psycho-social functioning of participants. While the risk management focus of the program was consonant with the Risk-Need-Responsivity (RNR) model, the IDATP blended these principles with the strengths-based Good Lives Model (GLM). As previously mentioned, there are parallels between RNR's *specific responsivity* and the GLM's emphasis on individual needs. The IDATP addressed *responsivity* through an integrated treatment model and the formulation of individual treatment and reintegration plans.

Program Theory

The establishment of the IDATP was grounded in the assumption that treatment is effective with offenders with drug-related problems (that is, there is a general treatment effect).

To some extent, the IDATP's theory of change was implicit in the adopted treatment model, which was an amalgamation of empirically-supported approaches, namely the Modified Therapeutic Community context and the CBT-based core program *(Pathways)*. As noted, the IDATP integrated a further approach - *the Good Lives Model* of offender rehabilitation (essentially a human services, strengths-based approach). However, these broad descriptions are insufficient to capture the sequence of conditions and activities that lead to the program's intended outcomes.

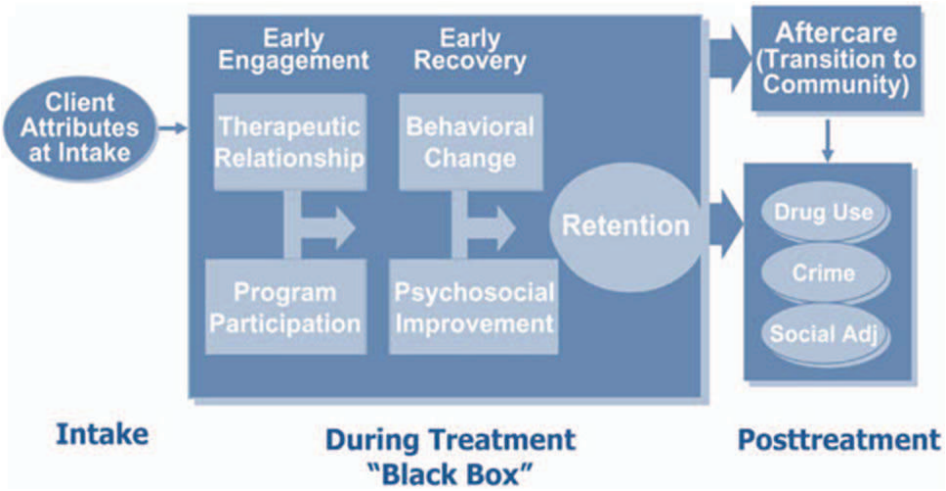
A review of the IDATP's documentation failed to identify either a statement that depicted a detailed theory of change or a model of program logic that provided a blueprint for the program in its entirety.

According to process evaluation literature, should program logic be lacking, it was acceptable for evaluators to develop a logic model as a component of the design evaluation (Brouselle & Champagne, 2011).

A simplified program logic model of the assumptions and mechanisms that generally apply to drug programs for offenders is illustrated in **Figure 3**. The model highlights several key evidence-based

principles of effective programs; address individual responsivity, establish therapeutic alliance, facilitate early engagement, participation and retention and provide program aftercare to achieve the intended results of reduced drug use, criminal activity and social adjustment. Implicit to this model is that retention is a proxy measure for longer-term outcomes.

Figure 3: Simplified Program Logic



Source: TCU Treatment Process Model (Hiller et al. 2006).

While the IDATP's approach was generally consonant with the above model, it was also a complex, multi-faceted program and any program logic should reflect the same. The program logic model developed by the researchers drew on the IDATP Local Operating Procedures, briefing documents and also published prototypes (Hiller et al. 2006; Office of Justice Programs; 2002; University of Wisconsin, Extension Program; 2008). The IDATP logic model is shown in **Figure 4.** Briefly, this is a diagrammatic blueprint of the delivery model that links rationale, theory, resources, activities and results or how the program is expected to achieve its intended results. This model can form the framework for a more detailed management plan. It is progressive, in that results at any point are determined by the elements that precede it (Hiller, et. al, 2006). The draft IDATP logic model was canvassed with program management and the Steering Committee to ensure that it accurately reflected the program in its entirety. The IDATP logic model revealed a highly complex, holistic program with the intended program outcomes linked to many sequential elements. The program's complexity was considered logical, given the complex, interrelated needs of offenders with drug-related problems.

The IDATP's theoretical approach assumed that the amalgam of well-established principles and empirically-supported methods and techniques would bring positive change in participants. The following statement endeavours to integrate the theories and assumptions underpinning the IDATP's approach:

***IF** the program targets prisoners who have a medium or higher risk of reoffending and a high need for drug treatment, undertakes comprehensive assessment, identifies their needs and addresses responsivity through individualised treatment plans, creates a therapeutic environment to provide treatment, delivers current empirically-supported approaches for offenders with drug problems, addresses related criminogenic needs, such as vocational and social functioning needs and augments treatment with an achievable aftercare plan, **THEN** prisoners will be better prepared for reintegration into their communities and their drug use will be reduced or eliminated, thereby reducing the demand for drugs and drug-related criminal activity*[5].

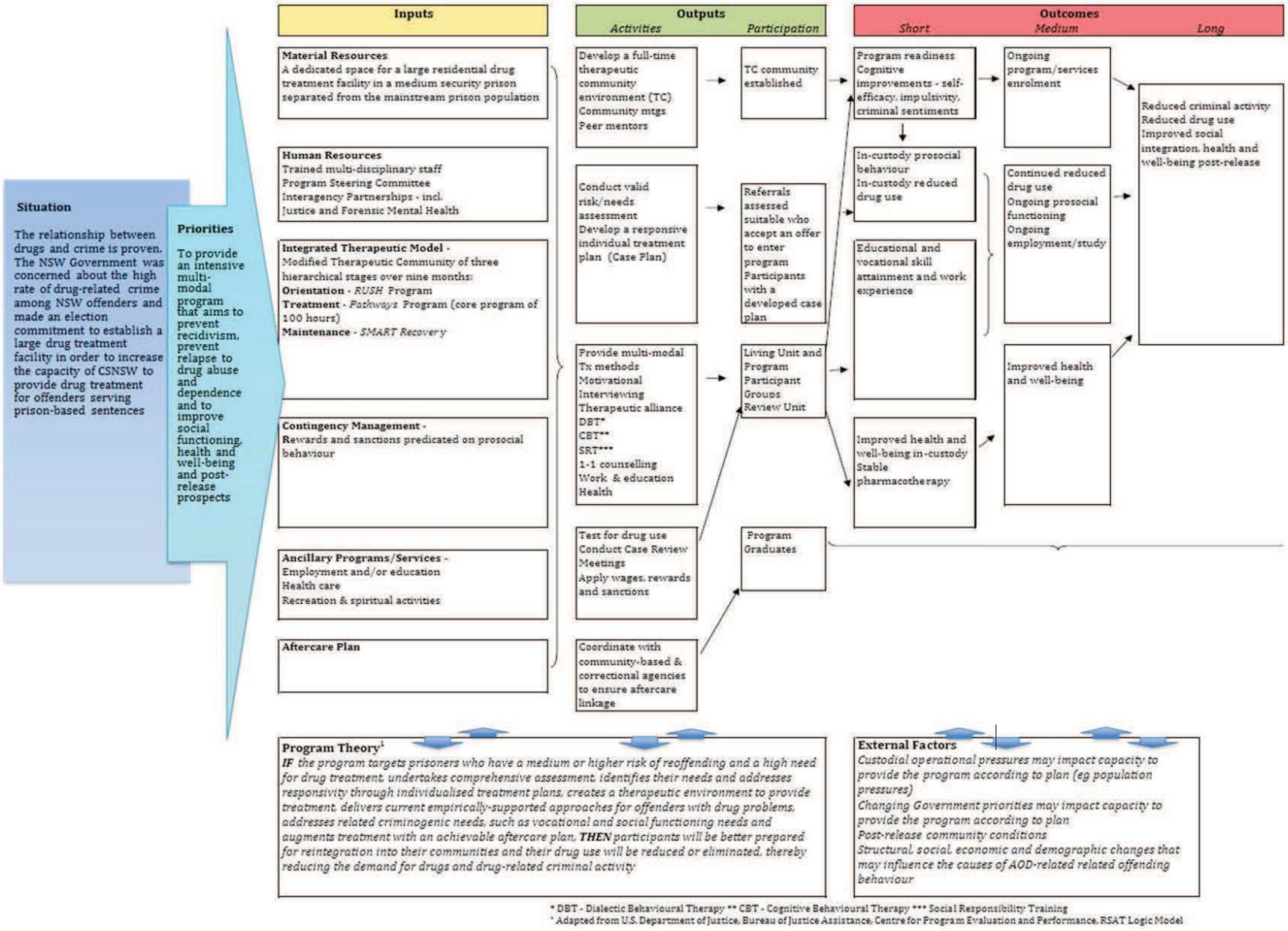
Summary: Theoretical Assumptions & Evidence-base

At a macro level, the IDATP appeared to be congruent with both the correctional and drug treatment literatures. It targeted a higher risk, higher needs population, using a range of needs-based assessment tools to address suitability and *responsivity.* It provided a risk-focussed program of sufficient dosage (> 200 hours) that also addressed related-needs with interventions and techniques proven to affect positive behaviour change. Such interventions and techniques included motivational interviewing, cognitive behavioural therapy, relapse prevention, Community as Method, drug testing, contingency management and therapeutic alliance. It also provided individualised aftercare planning. Further, the IDATP provided what has been described as the most promising approach in drug treatment with offenders; an integration of modified therapeutic community & cognitive behavioural therapy models. These two approaches offer the best outcomes for offenders (Welsh, et al. 2013).

The program's conceptual framework was found to be based on sound principles and evidence. The impetus for the program was well-grounded given the large number of drug-involved offenders and the significant social burden that ensues. Once program capacity is realised, the program community provides the context that is favourable to positive behaviour change and this is supported by an amalgam of principles and treatment approaches endorsed in the correctional and drug treatment effectiveness literatures.

[5] Adapted from Office of Justice Programs; RSAT Logic Model (2002).

FIGURE 4: DETAILED PROGRAM LOGIC MODEL OF THE IDATP



* DBT - Dialectic Behavioural Therapy ** CBT - Cognitive Behavioural Therapy *** Social Responsibility Training

[1] Adapted from U.S. Department of Justice, Bureau of Justice Assistance, Centre for Program Evaluation and Performance, RSAT Logic Model

4.3 Program Overview

Synopsis

The IDATP was a nine-month, prison-based, residential program in NSW targeted at medium to high risk male offenders with drug problems and related dynamic criminogenic needs that match those targeted by the program. The IDATP operated as a modified therapeutic community (hereafter referred to as MTC).

The program was provided by Corrective Services, NSW in collaboration with Justice Health & Forensic Mental Health (JH&FMH). Program documentation emphasised that all centre staff participate in the program and that a multi-disciplinary approach be adopted in the management of prisoner participants. It also set-out guidelines for respectful interactions and adherence to Human Rights principles.

The IDATP MTC purview was to provide a nine hours per day, five days per week, living-learning program for prisoners with drug problems whose primary criminogenic risk and needs factors were targeted, whilst simultaneously addressing psychological, social, health and vocational needs in accordance with the Good Lives Model.

In essence, the program adopted an integrated MTC and CBT model; combining elements of CBT provided in the manual-guided treatment curriculum which was delivered and reinforced through a living-learning therapeutic community approach. Skills building and cognitive restructuring were the primary CBT techniques employed. The program also included health and living skills modules and compulsory educational or employment programs.

According to program documentation, the program endeavoured to strike a balance between the standard correctional priorities of risk management and compliance and the establishment of a therapeutic environment. The merging of therapeutic and risk management approaches has been described as sociotherapeutic therapy (Wanberg & Milkman, 2008).

The IDATP Integrated Treatment Model Summary

Social & Social Responsibility Skills Building
& Cognitive Restructuring
delivered within a context of
Community as Method

The Local Operating Procedures (LOPs) specifically stated that the IDATP contributes to the effective management of risk and the maintenance of security, safety, discipline and the overall good order of the centre. Program design documents asserted this achieved by adherence to therapeutic principles. The program adopted principles from social learning theory and role theory. Additional risk management strategies were the informal social controls that come about from a strong community framework, frequent drug testing, close monitoring by all program staff and the usual search and surveillance measures. All of these strategies were integrated into the standardised contingency management contract that was implemented with all participants.

Program admission was structured around set group intakes rather than an open or rolling group format. The program was delineated into three hierarchical stages – Orientation, Treatment and

Maintenance**.** The stages were compatible with the stages of change theoretical framework in problem resolution - precontemplation, contemplation, action and maintenance (Prochaska & DiClemente, 1992). The program allowed for temporary regression to a Program Review Unit (PRU).

The implementation of the three stages was guided by documented LOPs. These set-out policy framework, aims and objectives, program elements and procedures and staff roles and responsibilities. At the time of writing, there were LOPs for the Orientation and Treatment stages and the progression regression unit (PRU) and Rewards and Sanctions framework. LOPs for the Maintenance stage were under development. Having said that, there were individual protocol documents and training sessions in place to guide the implementation of the Maintenance stage. LOPs were reviewed annually.

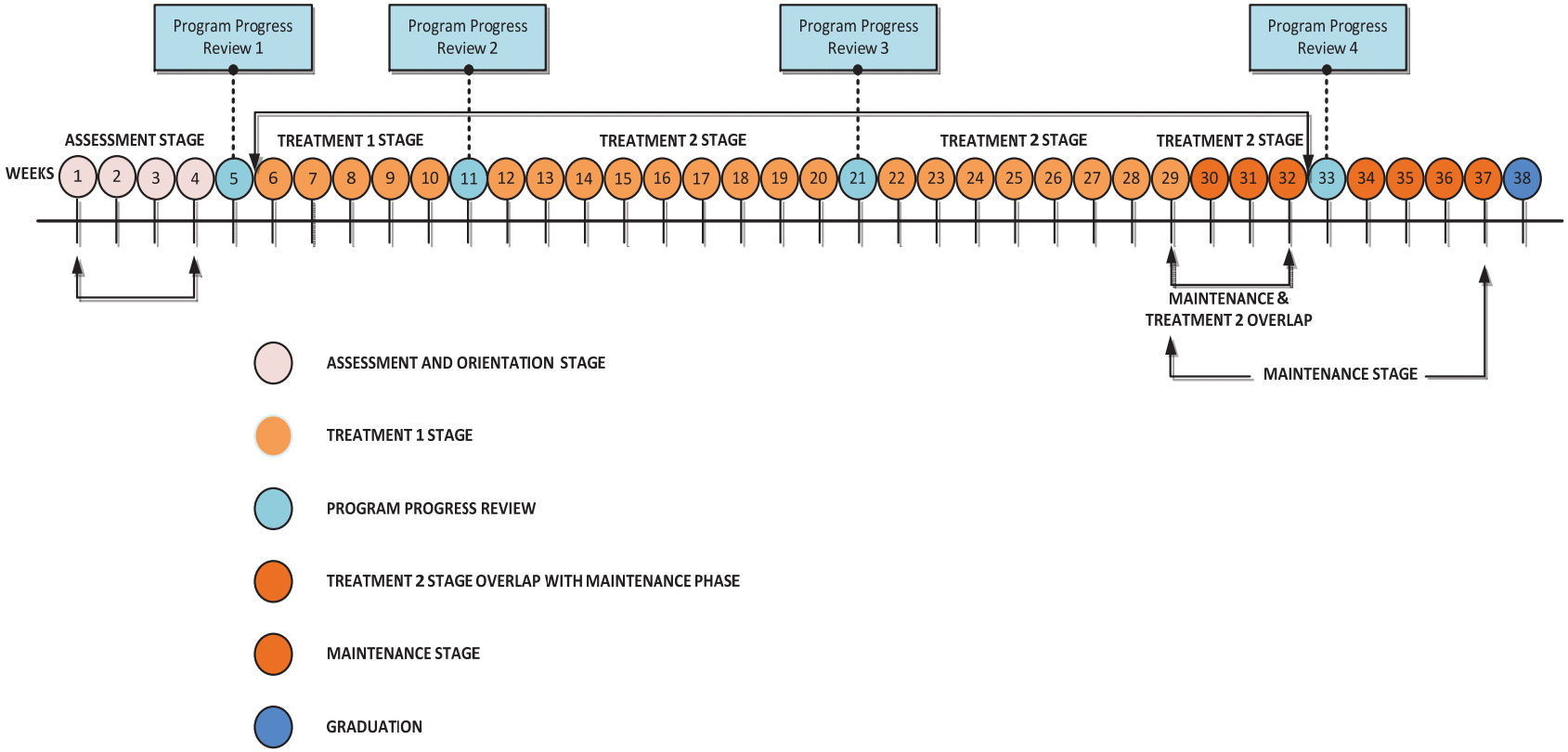
At the completion of the program a graduation ceremony was held. Graduating participants were either transferred to another correctional centre to serve the remainder of their sentence or released into the community with an aftercare plan. A timeline of the IDATP stages across the nine-month, 36-week duration of the program is presented in **Figure 5**.

Program Stages

The **Orientation** stage was a one-month induction, intensive assessment and treatment planning stage with an emphasis on building motivation and therapeutic alliance and imparting the program's values, philosophy and expectations. In brief, Orientation consisted of information days and experiential learning and team building activities for participants. On entry to the program participants engaged in four days of experiential learning activities delivered by trained custodial and non-custodial staff. These activities were designed as an introduction to the program and aimed to promote group cohesiveness and team work prior to engagement in the Treatment stage. In addition, a number of short workshops were delivered during this phase, including Health Survival and Workplace Health & Safety, Job Seeking and Goal Setting. A Participant Handbook was also issued at this time. The Handbook outlined the program format and participant rights and responsibilities. It also differentiated the IDATP accommodation units from mainstream prison as community living environments. The participants, as community members were to accept responsibility for their living environment.

During this stage, an assessment interview was undertaken in consultation with the participant with the purpose of developing the individualised treatment plan or case plan (ICP). Design documents stated that the ICP should address individual *risk, need* and *responsivity* issues and how they link into future treatment planning. Treatment targets included triggers to drug use, criminal behaviour and problem areas that may be impediments to prosocial living (self-control and impulsivity issues, coping skills, education, employment, health and accommodation). To further assist treatment planning, participants also completed a battery of psychometric assessments focused on identifying criminogenic and individual treatment needs. These tests were generally administered in the first week of the program. The suite of psychometric tests is listed in **Appendix II.** These tests were also used for progress monitoring purposes and were administered at the completion of the Treatment stage.

Figure 5: The IDATP Program Timeline[6]



[6] Sourced from program records

The **Treatment** stage was of six months duration and the most intensive component of the program. It included therapeutic group work and individualised counselling. Treatment commenced with a standardised preparatory program titled Real Understanding and Self-Help (RUSH) which is based on Dialectical Behaviour Therapy - a derivative of CBT. The cornerstone program was the 100 hour CBT-based *Criminal Conduct and Substance Abuse Treatment: Strategies for Self-Improvement and Change – Pathways to Responsible Living* (Wanberg & Milkman, 2008). This is a risk-based program, targeting criminal attitudes and substance-related criminal behaviour.

During the Treatment stage, participants were also partaking in education or employment, community meetings, drug tests, rewards and sanctions contingency and case review meetings. The standardised treatment programs, core elements and adjunct services and programs are examined in detail in a further chapter **(see Treatment Facts: 4.6)**.

Treatment group membership was aligned with the living unit location (community units) to foster a sense of community. The LOPs stated that during this stage the program provides intensive behavioural management to participants. Congruent with the Community as Method approach, the units were designed to create a community living environment and to maximise engagement of participants by improving their coping strategies and ability to manage situations in socially appropriate ways.

The **Maintenance** stage was the post-treatment and final stage. It was of two-month's duration. It involved the consolidation and reinforcement of skills and the development of post-program pathway plans, either community or custody-based. Participants were required to attend weekly SMART Recovery® maintenance meetings. SMART Recovery® is a cognitive-behavioural maintenance program that follows a self-help group work structure with open discussion and process. As it is available in community settings, there is the opportunity for post-release continuity. In Maintenance, the focus was on ensuring that participants were released with structured support plans in place and there was a greater number of individualised counselling sessions. Re-settlement plans were developed for all participants, whether subject to parole supervision or release without supervision. Participants continued with education and/or employment until graduation.

The Maintenance service delivery model was designed to improve post-release prospects by forming effective multidisciplinary and multiagency working partnerships with other correctional centres, Probation and Parole Services, relevant government agencies & non-for-profit community service agencies. In verbal briefings, management advised that partnerships had been established with several pre-release correctional centres across the state to facilitate integrated throughcare strategies, as well as opportunities for ongoing consultation and joint case management of offenders at the completion of the IDATP.

At the time of writing, the IDATP had entered into a formal partnership with a community-based therapeutic community residential centre in the local area with a view to providing aftercare residential placements to participants on release into the community.

Graduation was a formal ceremony held for all those who completed Maintenance. Participants could nominate family and friends whom they would like to invite to the graduation and all staff were encouraged to attend. Participants were awarded a graduation certificate, both staff and graduates made speeches and a meal was served to celebrate the occasion.

The IDATP as a Modified Therapeutic Community

Therapeutic Community elements within the IDATP

- Community living environment separated from mainstream prisoners
- Staged structure
- Community meetings
- Peer mentors
- Hierarchy of privileges
- Emphasis on social responsibility

The MTC approach was designed to increase functionality across bio-psycho-social domains and provide participants with the skills to successfully integrate into the community. Standard MTC elements included fostering a community living environment and a focus on social responsibility, program stages, community meetings, peer mentors and a hierarchy of privileges. The 60 bed accommodation units were intended to function as a therapeutic community and participants as community members accepted responsibility for the operation and maintenance of their unit. The program was facilitated by professional staff, but also included participant mentors. According to the program's design, both participants and staff were seen as community members and the community structure was designed to assist participants to be socially responsible. All staff - therapeutic, industries, education, parole and custodial officers was trained in the MTC approach and involved in program management. The IDATP MTC blended features from both the British Democratic and the U.S. Concept-based TC models. Consistent with the Concept-based model, in the IDATP the community was regarded as both the context and method of change. However, the IDATP did not use a tenure-based hierarchical structure, but relied more on professional staff, as opposed to former graduates, which was more congruent with the British Democratic model. Program management had made modifications to infrastructure in order to distinguish the program from the prison proper. Reportedly, the IDATP accommodation units had been refurbished, including a different colour scheme to create a distinct community living environment. Community meetings and the availability of peer mentors within the units also differentiated the program environment from the mainstream units. Peer mentors held a senior role within the community and their rank accorded a higher wage. The contingency management contract outlined the hierarchy of privileges leveraged on progress through the program and acceptable behaviour.

Summary: Program Overview

The IDATP was a prison-based, nine-month drug treatment program, offering multiple interventions with both standardised & tailored elements. The program was structured as a MTC. The primary modalities were residential context, therapeutic groups, education, employment and health services. The main treatment strategies were motivational enhancement, cognitive behavioural therapy, dialectical behavioural therapy, psycho-education, and relapse prevention. These treatments were underpinned by the general principles of psychotherapy and counselling. The program design integrated these general treatment principles with the correctional principles of safety and security, compliance and social accountability. The IDATP MTC blended elements of the British democratic and Concept-based TC models. Future endeavours to further distinguish the MTC from mainstream prison could be in the form of physical and content enhancements, such as display boards, including the display of a program motto to foster a distinctive, therapeutic environment and ownership of the program. The community meetings could be held more frequently to enable more time for self-disclosure and reflection, interpersonal skill building and discussion around commitment to change. In line with the accepted practice adopted by TCs, all community meetings should commence and conclude with the program's motto or vision statement.

4.4 Admission to Program and Termination from Program

Eligibility for the IDATP was assessed by CSNSW subsequent to imprisonment rather than through the Court system. That said, a Court could recommend an offender undertake the program during his prison sentence. This recommendation was recorded in the Judge's comments at the time of sentencing and corrections staff had access to these comments.

Eligibility Criteria

Inclusion

- Sentenced with no further court matters
- Have at least 12 months remaining in prison sentence
- Assessed as Medium or higher risk of re-offending on the LSI-R with an A&OD domain score of 5 or above
- Medium or lower security classification level (includes some escapee types)

Exclusion

- Subject to a current protection order*
- Child sexual offence conviction
- Experiencing the acute phase of mental illness
- Recent serious institutional misconduct prior to program entry*[1]

*Prisoners willing to sign-off protection were considered. *[1]Recent serious misconduct referred to any segregation placement in the two months preceding program entry.

Sentenced inmates who met the criteria, which included a documented history of problem drug use (alcohol included) and offending behaviour were eligible to be referred to the program. To aid the identification of treatment candidates, a computer-generated list that identified all prisoners across the state who qualified for the program (satisfied the eligibility criteria), was forwarded to program management on an as-needed basis. The program attempted to actively recruit participants based on this information. Aside from within-program referrals and court recommendations, referrals to the program were initiated from a variety of sources. These included staff within the existing centre, the Probation and Parole Service, other CSNSW staff and self-referred prisoners located in correctional centres across the state. Once a prisoner was referred, the IDATP management team requested a referral assessment for suitability be undertaken by the program's assessment team. This assessment interview was conducted either in person or by phone or video-link. According to documented procedures, prisoners could refuse to participate in the program at four separate points of contact during the referral process: (i) at first point of contact and offer of referral; (ii) on completion of the referral interview; (iii) prior to the suitability assessment and (iv) subsequent to being offered a place on the program.

At the time of preparing this report, the program's Steering Committee was considering strategies to encourage more referrals from the Court system.

Suitability

According to the IDATP's Assessment and Orientation Local Operating Procedures (LOPs), the program was most suited to those offenders who had a lengthy history of drug dependence and a history of drug-related offences. This was determined by way of personal interview and reference to official records, such as Judge's sentencing remarks, pre-sentence and psychological reports. The suitability assessment took into consideration the level of risk of drug-related offending, criminogenic needs and individual *responsivity* factors and how they related to treatment planning and management within the program. These included drug use & offending history, physical and mental health, cognitive functioning, drug treatment history and institutional history. Any security or safety alerts that precluded certain prisoners from associating with each other were also taken into account (e.g., exclusions pertaining to prisoners from opposing motor cycle gangs). In addition, certain complex medical conditions may have precluded a prisoner from participating, should the centre's medical clinic not have the resources to adequately manage these conditions.

According to protocol documents on the assessment interview, staff was to adopt a motivational approach with the purpose of raising self-awareness and motivation to change in the applicant. On completion, the assessor made a recommendation, which was forwarded with the referral interview package to the Referral Assessment Committee for consideration. Candidates were advised of the outcome of their assessment in writing. Successful candidates were placed on a waiting list with priority placement determined by their earliest release date. Those assessed as ineligible/unsuitable were also formally advised and referred to other program options.

Discharge and Termination

There were six possible types of program discharge; successful completion, temporary relocation to the Participant Review Unit, temporary relocation to another centre due to a Court or medical intervention or permanent relocation to another centre due to termination (involuntary discharge) or self-discharge (voluntary discharge) or administrative discharge (system discharges, such as early release into the community).

At the time of writing, there was no formalised policy on program termination. Verbal briefings with management indicated that this had been a deliberate decision. The rationale being it was preferable to determine termination action on a case-by-case basis. This decision was undertaken by a multi-disciplinary team, with a view to examining the participant's conduct over the duration of his program. Even so, serious threats to safety and/or security were broadly cited as grounds for dismissal. The most obvious examples were; threats or acts of violence to staff or other prisoners, trafficking contraband, or highly disruptive behaviour which poses risk to the good order and discipline of the centre.

4.5 Day to Day Operation of the Program

The IDATP operated to a complex scheduling structure. From the outset, the program presented a number of organisational challenges for management; a multi-dimensional curricula and large participant population combined with the operational restrictions of a medium security prison environment. The IDATP schedule had evolved to accommodate these contingencies.

The current program operated on a fortnightly schedule delineated into two colour-coded timetable groups for clarity. Each participant followed either a purple or yellow schedule which

includes all their program activities – active treatment groups, community meetings, case review meetings, education or employment, medical treatment, recreational activities and time for homework and personal reflection. The schedule period covered the out-of-cell hours for the facility - 8.30am to 17.30pm, five days per week.

In terms of ongoing case management there were four types of formal meetings:

i. Daily Unit Briefing - each week day morning the staff team (therapeutic and custodial) participated in a program briefing, whereby any changes to the daily schedule, any relevant operational or participant issues was addressed. By way of example, should a program facilitator be absent for the day, another facilitator was assigned to deliver their treatment sessions.

ii. Weekly Participant Review – a progress review occurred on a weekly basis for each participant, usually involving the participant and the program facilitators/case-coordinators. An implicit role for these meetings was to ensure *responsivity* to individual needs. Details were electronically recorded as case notes.

iii. Monthly Multidisciplinary Case Team Review – a more formal review to address drug use, behavioural issues and overall progress occurred on a monthly basis. This meeting was attended by staff involved in the case management of the participant. The participant had input into discussions and outcomes. A behavioural management contract may have been drawn-up at this time. Failure to comply with the contract could lead to increased sanctions, such as intensive management, regression to the Program Review Unit or program termination with return to mainstream prison.

iv. Program Stage Review – at the completion of the program stages a meeting was held to review progress relative to program goals, such as prosocial behaviour and personal goals. The Treatment stage was subject to two reviews, post-preparatory and post-core program. Should a participant's behaviour be deemed satisfactory, he would progress to the next program stage. Alternatively, the outcome of this review could involve the participant not progressing to the next stage, but rather remaining in the current stage, being regressed or dismissed from the program.

An average of **10 Treatment Groups** were operating at any one time

At the time of writing, drug testing (either by way of urinalysis or the presumptive Pro-screen test) was conducted approximately on a fortnightly basis. The drug testing procedures were being reviewed by the Steering Committee with a view to increasing the frequency of testing to once per week as a minimum standard.

Program Schedule Outputs

Approximately 10 Treatment stage groups were operating at any one time, with groups comprising a maximum of 15 participants. Treatment stage and Maintenance stage groups were co-facilitated by a Senior Services and Programs Officer (Snr SAPO) and a Services and Programs Officer (SAPO). These program facilitator teams typically delivered ten groups each per timetable, representing a total of 20 hours of group work delivery per fortnight. Protocol documents stated that the program was designed to provide the participant with the opportunity for therapeutic alliance with staff.

1:10/15 ratio

Program facilitator to program participant

Each facilitator assumed responsibility for the case coordination of approximately half the participants in each of the groups they facilitated and provided the key therapeutic relationship to these same participants over the duration of the program. This represents a facilitator to participant case coordination ratio of approximately **1:10-15** at any given time. Groupwork was supplemented with one-to-one counselling sessions, which were conducted by the assigned facilitators.

In terms of active psychological intervention, participants attended five, two-hour treatment groups across a fortnight (i.e. 10 hours of groupwork per fortnight). The timetable also included education/employment, community meetings, and Case Review Meeting commitments.

The IDATP worked towards a target of a minimum monthly program dose for each participant in the Treatment stage, as shown opposite. This program dose totalled approximately 70 hours of intervention across active treatment, education or employment, MTC community meetings, drug testing and contingency management components. The schedule also allowed daily access to medical treatment, spiritual practice and recreational activity.

Minimum Monthly Program Dose*

- 10 x therapeutic groups (20 hours of CBT)
- 10 x days of employment or education
- 4 x Community Meetings
- 4 x drug tests
- 4 x weekly feedback sessions
- 1 x multidisciplinary Case Review Meeting

* Source: IDATP protocol documents

The program schedule included allocations for staff meetings and training days. There was a monthly meeting for the entire staff complement and a treatment staff meeting once per week.

4.6 Treatment Facts - Structure and Content

The Treatment stage of the IDATP can be defined as an integrated Modified Therapeutic Community/CBT approach. The Community as Method approach combined with the program titled *Criminal Conduct and Substance Abuse Treatment: Strategies for Self-Improvement and Change – Pathways to Responsible Living* (hereafter referred to as *Pathways*) were the central behaviour change mechanisms in the IDATP.

Preparatory Program – RUSH

The Treatment stage commenced with a standardised, manual-guided, preparatory program titled RUSH - Real Understanding of Self-Help. RUSH had superseded the initial preparatory, 22 session Personal Effectiveness Program (PEP), which was also manual-guided. According to agency documentation, RUSH is a Dialectical Behavioural Therapy (DBT)-based program adapted for an Australian forensic population (Eccleston & Sorbello, 2002). RUSH utilises the DBT training modules of Linehan (1993) and is skills-oriented.

DBT is derived from CBT and has been explained as one of the third wave CBT modalities (Ost, 2008). It diverges from CBT in its emphasis on self-understanding, self-validation and self-help in managing emotions. While designed specifically for Borderline Personality Disorder, DBT has been applied to a range of maladaptive behaviours. DBT focuses on the psychosocial aspects of treatment and how a person interacts with others in different contexts. According to DBT, observation and acceptance of uncomfortable thoughts, feelings and behaviours is an important facet in a process of change. Interrelated skills are taught simultaneously, such as self-regulation and managing a restrictive environment, understanding and practising acceptance, dealing with change and emotional restructuring and emotional regulation (Eccleston & Sorbello, 2002).

Preparatory Program

RUSH - Dialectical Behavioural Therapy

3 modules over 46 hours

- Mindfulness/Distress tolerance
- Emotional regulation
- Interpersonal effectiveness

Goal *– to assist in reducing distress, increasing motivation and developing new life skills that can help participants potentially lead better lives*

The RUSH program incorporates cognitive, behavioural and acceptance-based techniques. A fundamental assumption of RUSH is the dynamic interaction between the restrictive prison environment, combined with offender maladaptive coping styles, elevates the risk of dysfunctional behaviours, such as impulsivity, distress intolerance, emotional instability, self-harm and interpersonal disregulation (Eccleston & Sorbello, 2002). The developers advocate that offender programs need to move beyond the risk management paradigm and also address psychological distress in order to better equip offenders with the skills to improve their lives.

The CSNSW adaptation of RUSH comprises three modules - mindfulness and distress tolerance, emotional regulation and interpersonal effectiveness. The program consists of 23, two-hour sessions run twice per week over 10 weeks. It is delivered in a group-based setting via a co-facilitation model (a psychologist and a Services and Programs Officer). Program providers receive two days of training in the understanding and delivery of the program

While RUSH does not target criminogenic needs *per se*, its focus on psychosocial competency is consistent with the principles of the Good Lives Model. It is also consistent with the broader interpretation of the *responsivity* principle, which requires attending to individual needs to enhance engagement and maximise gains from offence-related programs. According to the RUSH program manual, the program can be used to assist with both behavioural stabilisation and successful engagement and completion of criminogenic programs. Under this rationale, it would appear to be a suitable preparatory program for an intensive, residential program, such as an MTC. Also, given the majority of the IDATP participants had convictions for violent offences (robbery or assault), they appeared well-matched to DBT (**see Table 5 & 6).** Rush had been piloted in both Victorian and NSW prison settings.

Cornerstone Program - PATHWAYS

In the Treatment stage, the CBT-based *Pathways* combined with the *Community as Method* context provided the central behaviour change agents.

Pathways was the core component of the Treatment stage and the most intensive program element in the IDATP. *Pathways* is essentially a stand-alone, fully manualised program nested within the IDATP MTC. Even though the program is designed to primarily target risk, it does incorporate therapeutic practices such as, a motivational enhancement and therapeutic alliance and in the latter stage addresses individual well-being. It is curriculum-guided for group delivery and precisely structured around three phases of treatment. The 50, two-hour sessions are delivered over six months which concords with the recommended minimum treatment dosage of 100 hours for offender populations. Further, the program content is reinforced by individualised counselling sessions and the community meetings.

Pathways is designed to address co-occurring substance abuse and criminal behaviour. According to the manual, it also targets known criminogenic factors, such as antisocial thinking, pro-criminal attitudes, social supports for crime (associates/friends), and family/marital relationships (Wanberg & Milkman, 2008). The program's core treatment strategies are psycho-education, CBT & relapse prevention.

The stated goals of *Pathways* are to prevent recidivism, prevent relapse and assist participants to live a responsible and meaningful life. The developers propose that these are achieved by changing antisocial thoughts and values, interpersonal and social skills training (cognitive self-control skills, relationship skills and community responsibility skills), comprehensive relapse and recidivism change plans, and interactive, role-play, skills practice, and homework (Wanberg & Milkman, 2008).

According to the facilitator manual, *Pathways* is explained by five foundational strategies:

- multi-dimensional screening and assessment;
- enhancing therapeutic alliance and motivation to change;
- tailoring treatment objectives to the participants' stages of change; and
- cognitive-behavioural treatment and relapse (and recidivism) prevention.

Also foundational to Pathways is social responsibility through Social Responsibility Therapy (SRT). The underlying assumption is that effective offender programs are sociocentric and impart responsibility to others and the community. Program material focuses on increasing interpersonal consideration and moral functioning and responsibility (Wanberg & Milkman, 2008).

The program is applicable to various treatment modalities and closed (set intake date) and open (rolling intake) group delivery formats. Guidelines and parameters are provided for an open delivery format. *Pathways* has a comprehensive facilitator manual that fully articulates the conceptual underpinnings and strategies and operational policies and procedures of the program.

Complementary facilitator and participant manuals assist program fidelity. A program requirement is that each participant has the entire workbook at the beginning of the program. The workbook is described as the participant's handbook for change. The workbook has been written to a grade eight level. The program developers advise that session content, concepts and interactive exercises should be delivered unmodified. However, they also acknowledge that experienced facilitators may

incorporate into the program, skills and exercises they have found to be effective. In this regard, the developers state they encourage creativity with a caveat that the facilitators always address the objectives, theme and purpose of each session (Wanberg & Milkman, 2008).

The developers further emphasise that program efficacy and effectiveness depends on a positive relationship between provider and participant.

A conceptual framework and results chain for the *Pathways* program in its entirety is shown in **Table 1.** This explanatory framework is structured around the three treatment phases and the corresponding stages of change paradigm. The framework identifies and links delivery and treatment goals, facilitator skills and facilitation methods and techniques and treatment strategies.

Pathways Program Curriculum

Pathways is divided into three sequential phases, comprising 12 modules of 50 treatment sessions. These phases are *Challenge to Change, Commitment to Change* and *Taking Ownership of Change* (Wanberg & Milkman, 2008). These phases are designed to correspond with the Stages of Change paradigm of Pre-contemplation, Contemplation and Action.

Phase I, Challenge to Change is designed to set the platform for change. The stated goal is to motivate participants to identify specific areas of change and to commit to changing. Phase I comprises seven modules delivered over 20, two-hour sessions. This phase is mainly reflective-contemplative and motivational. It utilises the techniques of self-disclosure, self-awareness raising and trust building. Phase I also involves gaining an understanding of the cognitive behavioural perspective and mapping individual pathways to behaviour change. Phase I, Module 1 is the program's introduction session and also a pre-requisite for undertaking the entire program. Rules of behaviour for participating in the program are outlined.

Phase II, Commitment to Change corresponds with *Action* in the Stages of Change Model. Phase II chiefly involves practicing and strengthening of acquired basic change skills and learning methods for changing thoughts and behaviour that contribute to drug use and criminal behaviour. The associated techniques are cognitive restructuring and self-control, social & relationships skills building and skills in

Pathways Phase I:

Challenge to Change

Seven modules delivered across 20 therapy sessions with a focus on motivational, psycho-educational and skills acquisition activities

Goal *- Identify specific areas of change and to commit to that change*

Pathways Phase II:

Commitment to Change

Three modules across 22 therapy sessions with a focus on consolidation of cognitive restructuring, prosocial skills and development of relapse prevention skills for both drug use and recidivism

Goal *– Strengthen commitment and take definite action to change*

Pathways Phase III:

Taking Ownership of Change

Two modules across eight, therapy sessions with a focus on critical thinking and review, conflict resolution and planning alternatives to drug use and criminal behaviour

Goal *– Take ownership of change and demonstrate maintenance of change*

developing a prosocial relationship. Phase comprises three modules, delivered over 22 sessions.

PHASE III, Ownership of Change and Review is the maintenance phase of the *Pathways* curriculum. The content focus is on reinforcement of commitment to established changes. This phase addresses lifestyle balance and alternatives (to drug use and criminal behaviour) and community resources, such as recovery groups. To strengthen established changes, methods such as role modelling and mentoring are included in this phase. Phase III comprises two modules of eight therapy sessions.

The IDATP delivery of *Pathways* deviated from the developers' guidelines on several fronts. The IDATP did not issue the *Pathways* Workbook to the participants, but rather relied on worksheets. Also, it did not use the *Pathways* battery of baseline & progress assessments or Individualised Treatment Plan (ITP), but rather locally designed alternatives.

Finally, the IDTAP implemented *Pathways* over a shorter time-span (five months). *Pathway*s was followed by SMART Recovery® self-help groups in the Maintenance Phase. SMART Recovery® also adopts CBT-based techniques. The advantage of SMART Recovery® is that it provides peer support and a therapeutic bridge between prison and the community.

Summary: Treatment Structure & Content

In the IDATP, the MTC model provided the context for multi-modal interventions across the Orientation, Treatment and Maintenance stages. The interventions included motivational interviewing across the Orientation and Treatment stages, dialectical behavioural therapy (DBT), cognitive behavioural therapy (CBT), relapse prevention (RP) and contingency management contracting across the Treatment and Maintenance stages and pathway planning for aftercare.

Importantly, the core program *Pathways*, targets criminal thinking and attitudes and relapse prevention planning for both substance use and criminal behaviour. The *Pathways* process of change and the techniques on which it relies, link to stages of change theory. All three programs, RUSH, *Pathways* & SMART Recovery® are underpinned by social learning theory and the application of cognitive behavioural techniques. The behaviour change orientation of these programs is increased skill acquisition and improved self-management.

Based on the documentation available, a current gap in the IDATP's service delivery model is formalised processes for aftercare. Aftercare is consistently identified as a significant determinant of positive post-release outcomes.

Table 1: *Pathways* Program Conceptual Framework and Results Chain

TREATMENT PHASES	CHALLENGE TO CHANGE	COMMITMENT TO CHANGE	TAKING OWNERSHIP OF CHANGE
CHANGE PROCESS	**UNDIFFERENTIATED**	**DIFFERENTIATED**	**INTEGRATIVE**
ASSESSMENT	Screening/in-depth	Progress and Change	Progress and Change
COUNSELLING AND THERAPY GOALS	Participants tell story Unpack thoughts, feelings and problems	Help participants hear their story Identify thoughts/feelings	Help participants act on their story Make and reinforce change
COUNSELLING AND THERAPY SKILLS	Responding attentiveness Encourages to share Reflective acceptance	Reflection skills Therapeutic confrontation Correctional confrontation Change clarification	Change Reinforcements
FACILITATION METHODS AND TECHNIQUES	Interactive teaching Interactive work sheets/ journaling Multi-media presentations Role playing Skills rehearsal Group processing		
TREATMENT AND CORRECTIONAL GOALS	Build trust Caring environment Self-evaluation Self-disclosure Build on AOD, CC an CB knowledge base Resolve ambivalence Thinking change MAP R&R prevention & plan	Maintain trust *Caring environment* Self-awareness Apply knowledge Self-control Prosocial attitudes and behaviour Revise/extend	Maintain trust Caring environment Self-change
TREATMENT STRATEGIES	Psycho-education Therapy alliance Stages of Change/MI Basic CBT skills R&R prevention Partnership with program Cognitive behavioural (CB) map Phase 1 closure	Cognitive restructuring Interpersonal skills Social Responsibility Therapy CB Map-Step method Phase 11 closure	**Balanced/healthy lifestyle** **SCC graduation**
TRANSTHEORETICAL STAGES OF CHANGE	Pre-contemplative Contemplative	Preparation Action	Continued action Maintenance

Source: Wanberg & Milkman (2008)

4.7 Core Program Components Implemented Across Program Stages

Individual Responsivity and Culturally Appropriate Services

Following is the IDATP statement of purpose on addressing individual needs and *responsivity*[7].

"The program tailors treatment to meet individual needs - participants will differ in terms of age, culture, cognitive capacity, level of drug/alcohol dependence and level of supervision required. Participants will also respond differently to treatment approaches and staff. The goals of rehabilitation include enhancing participant treatment readiness, reinforcing problem-solving skills, and understanding behavioural consequences. Identification and consideration of mental health or cognitive capacity issues will be made with reference to program responsivity. Support will also be required for culturally and linguistically diverse participants and Indigenous participants."

Individual needs (identified as physical-psycho-social, education, training and employment) were primarily addressed through the development of an Individualised Case Plan in consultation with the participant during the Orientation stage. According to program records, this included consideration of the nature and level of drug misuse, motivation, social skills, health, supervision need, cognitive style, education and training needs.

The Individualised Case Plan was designed to outline the direction and priorities for the Treatment and Maintenance stages. One to one counselling sessions, weekly and monthly case review meetings were all designed to address specific individual needs and allow for tailored treatment approaches. End of program transition and reintegration plans provided a further avenue to address culturally sensitive pathways.

With the exception of a dedicated cultural course for Indigenous participants, there were no other culturally-specific programs or services documented in the program's compendium. Having said that, all participants were encouraged to pursue customary spiritual activities and program staff was required to undertake a single-day course that addressed cultural inclusiveness.

Importantly, the *Pathways* Provider's program manual flags the importance of cultural *responsivity* and identifies provider attributes that mark cultural competence. The manual also identifies strategies for mitigating and managing cultural biases and prejudices that may emerge among group participants.

Education, Training and Employment

Education, vocational training and employment were regarded as integral to the program curriculum. An implicit assumption of the program is the proven effectiveness of these elements in improving work attitudes and reducing criminal behaviour.

Concurrent participation in education or employment was an IDATP requirement

[7] Sourced from program Local Operating Procedures

A dedicated adult education facility addressed the areas of education, vocational training and employability. Educational courses ranged from literacy and numeracy programs to information technology and business studies.

IDATP provided 76 employment opportunities with Corrective Services Industries

In addition to correctional centre employment, two commercial-based business units employed program participants on a part-time basis, with each work location providing a range of opportunities for participants to develop vocational skills and qualifications. Employment opportunities ranged from clerical and ground maintenance to engineering. Participants could also enrol in accredited traineeship programs that led to qualifications in selected fields, such as welding, small motors, horticulture or painting (see Appendix III for the complete employment, education and training curriculum).

Participants were expected to complete either education or employment programs during the Treatment and Maintenance stages of the program. During the Orientation and Assessment stage of the program participants were assessed on numeracy & literacy and received work health & safety education. In addition, participants had the opportunity to provide industries management with a brief resume of their previous work experience, trade skills, or any relevant qualifications along with a preference of prison employment location. This was reviewed at a personal job interview, prior to employment being allocated.

Education or employment modules comprised a large apportionment of the program timetable. During the Treatment and Maintenance stages, participants undertook either education or industries-based employment for a minimum of two days every week.

At the time of writing, 76 industry placements were available to the IDATP program participants. Approximately one-third of participants were employed in industries, one-third was enrolled in education and the remaining third was unemployed.

Health and Mental Health Services

The Justice Health & Forensic Mental Health (JH&FMH) Service was responsible for providing primary health care to prisoners held in correctional centres across NSW. JH&FMH worked in partnership with CSNSW in implementing the IDATP. As drug users often have complicated health needs, health personnel were involved in determining the suitability of program candidates during the Orientation and Assessment stage. All candidates needed to be cleared by JH&FMH before they were accepted onto the program. On occasion, those with chronic and complex needs required higher levels of medical care than could be supported within the program.

IDATP provided 31 places for Opioid Substitution Therapy

Health personnel conducted health awareness and harm minimisation training during the Orientation stage of the program. The medical clinic attended to participants' physical and mental health treatment needs during the course of the program. This included the management of daily medication regimes. The IDATP offered up to 31 places for program participants who were clinically indicated to require Opioid Substitution Therapy (OST) in the form of methadone maintenance, as an adjunct to their treatment program. Participants were required to be on a stable methadone dose and were also provided with regular clinical review by specialist AOD medical staff to assess ongoing OST needs. The program accepted candidates who were stabilised on hepatitis C

medication. These services were being provided within the existing health budget allocations for the centre. The specialised AOD medical staff included an AOD nurse on a twice weekly basis and a Doctor on a fortnightly basis. In addition, a specialised mental health service was provided weekly which included a mental health nurse and psychiatrist.

At the time of writing, approximately 27% (n=25) of the IDATP participants were receiving methadone maintenance and 30% (n=28) were receiving psychotropic medication.

Contingency Contracting - Rewards and Sanctions

The primary purpose of contingency contracting within the IDATP was to promote engagement with the program and program retention, and to positively reinforce abstinence from drug use and socially responsible behaviour. Contingency contracting was applied for the entire duration of the program. In the IDATP, contingency contracting (via a hierarchy of rewards and sanctions) was predicated on four areas of behaviour –

- Program and employment session attendance
- Social conduct
- Drug use
- Progression through the three program stages

In brief, contingency contracting within the IDATP provided an escalating positive reinforcement scale that reset to zero for not meeting conditions and the sanctioning of continual or serious violations. The ratio of rewards to sanctions was in excess of four to one.

Rewards and Sanctions leveraged behaviours

- Program/employment session attendance
- Ongoing pro-social conduct
- Abstinence from drug use
- Completion of program stages

Rewards and sanctions were leveraged on session attendance at treatment and education or employment activities. Participants were paid a weekly wage; the total value of their wage was leveraged on hours of attendance at both employment and therapeutic group work. The wage level ranged from $15 AUS per week (standard unemployed rate for prisoners in NSW) to approximately $39 AUS per week. Wages were docked for unauthorised absences. Given the size and complexity of the program, to maximise attendance at program sessions, management had established a clear schedule whereby participant groups were coloured-coded. Each participant had a colour identification card. This corresponded with a color-coded schedule which set-out the daily routine for attendance at either therapeutic groups or employment and education.

In terms of social conduct, contingency contracting was built on a dynamic case management approach. Each week, custodial officers & professional staff were involved in the monitoring and recording of instances of prosocial & antisocial behaviour, drug test results and institutional infractions. A composite scoring matrix was applied to these behaviours. Staff members met with participants on monthly basis to formally review behaviours in terms of whether they satisfied the 'community standard' and individual plans.

Ratio of rewards to sanctions of more than 4:1

Program progression rewards were commensurate with program stage completion and subject to review relative to program and personal goals. Rewards included a monthly wage bonus and enhancements to personal property, meals and amenity entitlements. The wages established for each of these stages were in line with Corrective Services Industry (CSI) policy. Program stage regressions resulted in a loss of reward.

In order of intensity, sanctions escalated from a warning in the first instance. This was followed by a one-to-one intervention and behavioural contract, temporary loss of personal property, placement to the Program Review Unit and ultimately program dismissal.

During Orientation, participants were provided with a behavioural contract that outlined rewards and sanctions procedures. In essence, participants were informed they had access to simple rewards and that privileges were earned via progression through the community structure and prosocial behaviour. Individual accountability, drug abstinence and compulsory attendance at program and employment activities were emphasised. Each participant signed a behavioural contract, which was witnessed by their group facilitator.

It is worth noting, the developers of the *Pathways* program assert that an ongoing positive and therapeutic relationship serves as the most powerful reinforcer of prosocial attitudes and behaviour (Wanberg & Milkman, 2008).

Drug Testing

Drug testing via urinalysis or Pro-Screen – presumptive test

According to verbal briefings, it was current policy for drug testing to be conducted on a fortnightly basis. This was done either by urinalysis or the presumptive Pro-Screen test. Current practice allowed for participants to self-declare drug use prior to testing and hence the need for a test was adverted. A self-declaration also influenced the contingency contract, whereby a lower sanction level was imposed to encourage responsibility taking. When a presumptive test showed a positive result, a urinalysis test was also conducted and the sample sent to a laboratory for verification. At the time of writing, there was not a formalised drug testing policy document as the policy was being reviewed by the Steering Committee. Drug use behaviour was factored into the Rewards and Sanctions LOPs as outlined above.

Case Team Reviews Meetings

Case Team Review Meetings provided a monthly forum to review behavioural progress. They involved a collaborative behavioural management approach. These meetings were also convened should a participant be deemed to require further intervention due to ongoing behavioural issues or drug use. Under normal circumstances, this review involved only the participant and his case coordinators. Should the matter be more serious, a full multidisciplinary case review was convened. Those in attendance for such matters included the participant, professional staff (psychologists and case coordinators) a senior custodial officer, and a health representative. The structure of the intervention allowed for formal and informal communication. The stated purpose of the case review was to identify any issues that had arisen for the participant and to work together with regard to implementing a workable behaviour management plan. The orientation of the meeting was one of prevention and the modelling of prosocial behaviour; such that, behaviour risks were identified before rule violations could occur. In terms of formal responses, participant progress on

target behaviours and compliance with requirements counted towards (mostly non-monetary) rewards and lack of adherence brought about graduated sanctions. An implicit role of these meetings was to ensure *responsivity* to individual needs.

***Participant Review Unit** (PRU)*

The Participant Review Unit (PRU) provided a means by which challenging behaviour could be managed and participants retained within the IDTAP. The PRU was a separate residential unit designed to accommodate up to 10 participants who were assessed to be in need of intensive intervention in the short to medium term. This occurred as a result of ongoing or high risk drug use or significant behavioural problems and usually on the request of the IDATP staff. Self-referrals could also occur. In such instances, a participant may have felt vulnerable or in need of time-out. Once placed in the PRU, the participant received additional assessment and intensive one-to-one therapeutic intervention by their case coordinator and/or psychologists. The intervention was tailored to maximise the participant's coping strategies and manage risk, with a view to program reintegration. In some cases the participant would continue to attend their specific therapeutic group program whilst returning to the PRU (accommodation) on completion of the session. As with the program proper, the Rewards and Sanctions policy, structured program timetable and weekly community meetings applied. Once a participant was considered stable and suitable for discharge it was routine practice for a behavioural management agreement to be documented. It was possible for a participant to be deemed unsuitable for program reintegration.

At the time of writing, there were two participants in the PRU.

Community Meetings

Weekly Community Meetings

Consistent with the therapeutic community model, participants were required to attend regular community meetings. Program management considered the weekly community meetings to be a vital component of the IDATP and the living-learning experience. Community meetings occurred across the entire duration of the program. They were facilitated alternatively by professional staff and custodial officers. The meetings were designed to continue building therapeutic alliance and to give participants a more informal forum where they were able to discuss any issues that had arisen in the previous week. The meetings were minuted with identified issues highlighted and reviewed at subsequent meetings. To enhance the therapeutic process, an IDTAP Peer Mentor was required to be in attendance at all community meetings.

From a therapeutic perspective, peer influence, mediated through the group process and group rules, was used to assist participants to learn and assimilate social norms and improve their social skills.

Peer Mentors

Peer mentors held a senior role within the community

Peer mentors were participants who served as role models to provide guidance and support to the other participants. Their role was designed to be motivational; to facilitate program engagement, retention and progress of other participants. Mentors were assessed and trained by staff to perform this role and were subject to a three-month trial period before qualifying. This was regarded as a senior role within the

community and there were incentives to being a peer mentor, in terms of wages and entitlements. Performance was reviewed biannually.

At the time of writing, there were two appointed peer mentors in the program.

4.8 Innovative Program Elements

The scale of the program model was principally innovative; both in terms of operational capacity and in the integration of multi-faceted program elements. This included blended MTC & CBT drug treatment, pharmacotherapy, employment and education. Specific innovative program elements included strategies to maximise program completion, integrated contingency management, the Living Skills Kitchen and the co-location of counselling rooms in accommodation blocks.

The IDATP had instituted the following integrated strategies to mitigate program attrition:

- regular case review meetings
- temporary regression to an intensive residential unit (PRU) and
- the motivational role of the peer mentors.

In case review meetings, a number of senior staff met with the individual participant on a regular basis to discuss and review progress and to respond to any infractions, such as drug use. At this time, an individual behaviour management contract may have been drawn-up for the participant to follow. The PRU offered more intensive individualised counselling. It was possible for a participant to regress to the PRU of their own volition or on the recommendation of the therapeutic team. The characteristics of the PRU have been detailed in Section 4.7.

Contingency management was dynamic, in that program participants' target behaviours *(session attendance and prosocial behaviour)* were continuously monitored, recorded and reviewed. As previously outlined, these behaviours were reviewed weekly with the participant relative to the community standard to determine weekly wage levels. Formal rewards or sanctions were applied on a monthly basis. According to the LOPs, the entire multidisciplinary team was involved in treatment monitoring and discipline.

The Living Skills Kitchen was essentially a blended program with literacy and numeracy skills embedded in a domestic skills course and delivered in a kitchen setting. In the course, literacy, numeracy, information and communication technology along with other electives were delivered through the medium of food preparation skills. Practical cooking lessons were conducted once a fortnight where inmates learned to prepare and cook healthy, nutritious meals within a set budget.

In 2013, a trial was initiated which involved the provision of program facilitator counselling rooms in the accommodation block. The standard configuration in the accommodation units was two levels of prisoner cells and a centrally located custodial officer's station, usually staffed by two officers. The purpose of co-locating facilitators in the accommodation units was to provide access to counselling and by inference to facilitate trust between staff and participants and create a more therapeutic community environment. The initiative was cancelled after two weeks into the trial when the custodial officers union put forward a case for closure, reportedly due to perceived safety and security risks. According to program management, the initiative would be re-trialled at the new program site. It was also envisaged that participants would facilitate the weekly community meetings at the new site. Staff members currently facilitated the meetings. Expos were information

days attended by exhibitors from various community-based agencies. The Expos were designed to provide participants with education and more importantly direct linkage with community-based services and programs that they may access on release from prison.

At the time of writing, two Expos had been held.

4.9 Program Resources, Governance and Review

Staff Establishment

According to program documentation, the delivery of the IDATP relied on an integrated multidisciplinary treatment team, including psychologists, program facilitators, teachers, industrial officers, medical staff, custodial officers and parole officers. A brief statement of positions and responsibilities is provided below.

- Director – leadership and direction
- General Manager – leadership and custodial management
- Justice Health & Forensic Health staff – leadership and medical service delivery
- Manager of Security – custodial risk management
- Therapeutic Managers – treatment oversight and clinical supervision
- Senior Program Development Officer – administrative management
- Psychologists – treatment delivery
- Senior Services and Programs Officers and Services and Programs Officers – treatment delivery
- Throughcare and Placement Officers – aftercare coordination
- Parole officers - community supervision requirements
- Education Officers – program delivery
- Custodial and Industrial Officers – security, supervision and program delivery
- Administrative Assistant

31 staff positions dedicated to the program

At the time of writing, there was 31 staff (excluding education staff and custodial officers) involved in the treatment component of the program. In addition, approximately 80 custodial officers and 10 educational staff worked across the entire correctional centre, which included the IDATP. As stated, the IDATP's staffing model was described as an integrated, multidisciplinary team. It relied on this integrated approach to achieve the dual objectives of managing risk factors (safety, security, drug use and antisocial behaviour) and meeting the treatment needs (psychosocial, health and educational) of the participants in a highly complex program.

Staff Training and Supervision

Formal staff training and supervision occurred on a monthly basis as a minimum

As previously mentioned, the program schedule included allocations for both staff meetings and staff training days. There was a monthly meeting for the entire staff complement and a weekly meeting for staff involved in treatment delivery. Also, off-site *Team Away Days* were held on a biannual basis to provide an informal forum for all staff to contribute to program review and planning. Formal supervision meetings for treatment delivery staff occurred on a monthly basis for two hours in total, being delineated into group supervision and individualised supervision. However, should

the staff member be a provisional psychologist or new to the program, supervision and/or performance appraisal increased up to two hours per week.

The IDATP training schedule stipulated approximately 30 days of compulsory training for non-uniformed program staff and 14 days for custodial officers. There was program induction training for new staff. At the time of writing, an induction training manual was under development.

The program offered both on-site and off-site training. There was site-based monthly training for all centre staff, with a needs-driven agenda. In addition, there was a dedicated monthly training day for the IDATP program staff. This was identified as cross-training, whereby the centre's operations stream (custodial officers) was encouraged to attend, in addition to those directly involved with the program. The training schedule included compulsory and optional training modules. Course topics ranged from therapeutic themes (e.g., understanding therapeutic communities and group work facilitation) to risk management (e.g., security awareness and protocols).

Off-site training was provided by the CSNSW Corrective Services Academy. The Academy offered an extensive training program to all staff, including the required training for staff involved in treatment program delivery. The agency's Offender Services and Program division had recently introduced new training program requirements for those involved in the delivery of offender programs; the completion of which culminated in a certificate in correctional practice. The training included a professional development plan and completion of a comprehensive program of work-based (100 hours), on-line (50 hours) and face-to-face (33 days) delivery modes. The program requirements could be offset, in part, by recognised prior experience. In-line with agency policy, the IDATP program providers needed to meet these requirements.

Governance & Quality Assurance

A multi-disciplinary, inter-agency Steering Committee convened bi-monthly. The Committee's remit was to monitor and review progress and engender quality assurance. It addressed macro-level therapeutic and operational challenges that arose and provided oversight for the establishment of special project sub-committees (e.g., the drug testing sub-committee). The Steering Committee included CSNSW program and operations management, inter-agency stakeholders, program evaluators and invited experts on special areas of interest.

The IDATP Clinical Governance Committee, a sub-committee of Steering Committee had the remit of ensuring that high standards of clinical practice were adhered to and that continuous improvements were applied to the quality and safety of participant care. The Committee monitored the quality and safety of the health services provided, with the view that services should be commensurate with those available in the general community. The Committee also reviewed any critical incidents that occurred within the program. The membership included the IDATP therapeutic and health staff, visiting medical officers and a service user representative (program participant). This Committee also convened bi-monthly.

Documentation, Monitoring and Review

At the time of writing, the IDATP program manuals, with the exception of the *Pathways* and *RUSH* manual-guided programs, were still under development. Notwithstanding, there were documented Local Operating Procedures (LOPs) for the Orientation and Treatment stages, Rewards and Sanctions and the Participant Review Unit (PRU) to provide overall direction and a step-by-step

implementation guide for staff. In addition, individual protocol documents and other program resources were stored electronically on a centrally located, shared network drive for access by all staff. Program information booklets for participants, staff and the correctional system at large were also available.

The IDATP in conjunction with the Offender Service and Programs division had designed a comprehensive information system for monitoring and reviewing program activity and program evaluation needs. This included a detailed range of program markers designed to capture decisions on the following:

- summary information on overall participant progress in the program, from initiation of a referral to graduation
- level and nature of progression/regression in the program's subsidiary stages
- level and nature of participation in the program's various components.

This information was comparable to that collected on the agency's other intensive offender programs. It was recorded and maintained in the Offender Integrated Information System (OIMS), which was the main electronic platform for managing offender information. This information was also reported as part of the agency's Quarterly Performance Report (QPR) on program activity numbers and rates for all the agency's programs. The program had recently commenced recording the participant's Individualised Case Plan on the agency's standardised Case Plan electronic template.

In addition to centralised information capture, a number of stand-alone, electronic information systems, usually spread sheets, had been developed locally to record program information that the main electronic platform did not capture. These data spread sheets captured program decisions around targeted participant behaviours for contingency contracting purposes, such as attendance at programs and employment, drug test results, rankings on program engagement and social conduct and also the wages system for participants. Treatment staff tasked with the data entry role were trained and provided with manuals to aid data quality.

At the time of writing, gaps in the recording of program activity data had been identified and were being addressed by management. Subject to the existing program information systems being consistently maintained and accurate, the program is thoroughly auditable. Independent process and outcome evaluation studies of the program are also underway.

Summary: Program Resources, Governance & Review

The IDATP had a complement of 31 staff dedicated to the program. The program facilitator to participant ratio was 1:10/15. The program supported a significant staff training component and formal staff supervision was conducted at regular intervals. The program had established mechanisms for governance, in addition to a comprehensive information gathering system for monitoring and reviewing program activity.

A current limitation and risk to program fidelity was the lack of finalisation of program manuals, including an overall program description and implementation document, management plan and training manual.

4.10 Early Evidence of Program Uptake – Reach and Participant Characteristics

The IDATP targeted prisoners with a medium or higher risk of offending, a documented history of problem drug use (alcohol included) and at least one year left to serve in their sentence. At the time of writing, the IDATP had been operational for 30 months. During this time, around 1,300 NSW prisoners had been potential candidates for the program; in that their characteristics matched the program's eligibility criteria at three months into the current sentence. The three-month window was used for identification of potential candidates as this allowed time for standard assessments and security classification and placement to be completed. It should be noted that this estimate of the potential pool of candidates did not capture suitability criteria, which was a more nuanced assessment. Suitability assessment will reduce the number of program candidates. According to design documents, suitability included an assessment of history and severity of drug-related offending and health, safety and security risk assessments, such as whether certain prisoners were precluded from associating with each other (e.g., members of opposing motor cycle gangs) [8].

During the period February, 2012 to July, 2014, **313 prisoners had participated** in the program and 220 had exited the program as either completers (53%) or non-completers (47%) **(Table 2)**. Of those who did not complete the program (drop-outs), the great majority (80%) were involuntary discharges, a further 11% were voluntary discharges, with the remaining 10% comprising system discharges (administrative transfers, such as early releases, court appearances or medical conditions) **(Table 3).**

Table 2: Program Throughput February 2012 – July 2014*

Completion Status	No.	%
Completion	117	53.2
Non-completion	103	46.8
Total	**220**	**100.0**

*Base n=220 with a program completion status

Program completion was defined as graduation

Source: OIMS & OPU

Table 3: Program Identified Reason for Participant Non-Completion*

Completion Status	No.	%
Involuntary discharge	82	79.6
Voluntary discharge	11	10.7
System discharge	10	9.7
Total	**103**	**100.0**

*Base n=103 non-graduates

The majority of involuntary discharges were for misconduct (55%). Of the remaining involuntary discharges, 27% were for drug use, 13% for lack of engagement with the program and 5% for mental health issues. **Table 4** shows a breakdown of temporary program regressions to the Program Review Unit (PRU) by program status. Around half of those who had regressed went on to be involuntarily discharged from the program. At the time of writing, there were **93 participants**. Of current participants, just under one in ten had regressed at some stage.

Participant demographic and criminal history data are presented in **Table 5.** Of participants, 19% were not Australian-born and 28% were of Indigenous background. After English (91%), the next most commonly spoken language was Arabic (5%). The median age was 25 years, which was comparatively younger than the median age (32 years) of those who met the eligibility criteria within the overall prison population over the same time period. At 36 months, the median sentence length was longer than the median sentence length (32 months) served by the eligible prison

[8] Robust program referral data were not available for inclusion in this report.

population. Participants were most commonly imprisoned for robbery (37%), assault (30%) or property (21%) offences as their principal offence. A higher proportion of participants had robbery offences when compared with the prison population eligible for the program (27%). The majority of participants had served a prior prison term (64%) and 19% had a current Apprehended Violence Order (AVO) against them.

Table 6 presents the participants' criminogenic risk and needs derived from standardised assessments administered during the current sentence term. Almost all participants satisfied the key eligibility criteria of a medium or higher re-offending risk level (98%) and alcohol and/or other drug domain score of 5 or more (94%), which indicates a considerable need for improvement in this domain. In addition, the majority of participants were ranked as having need for improvement in the following criminogenic domains: criminal attitudes/orientation (85%); education/employment (81%); and emotional/mental health (59%). Two-thirds (63%) reported that their alcohol and/or other drug use contributed to their current offences and 29% reported to be withdrawing from alcohol and/or drugs on reception for their current prison term. In addition, around one-third (31%) had a history of psychiatric treatment and 13% had a history of self-harm or attempted suicide.

Table 4: Regression to Program Review Unit (PRU) During Time in Program by Program Status

	Completers n=117		**Non-Completers** n=103		**Current** n=93		**Total 313**	
	No.	%	No.	%	No.	%	No.	%
Without regression	113	96.6	89	86.4	85	91.4	287	91.7
With regression	4	3.4	14	13.6	8	8.6	26	8.3
	117	**100.0**	**103**	**100.0**	**93**	**100.0**	**313**	**100.0**

*Base: Of the 313 participants who participated, n=26 regressed to the PRU

Summary: Program Uptake and Participant Characteristics

Overall, the foregoing profile statistics indicate that the program was admitting participants of considerable risk and need for intervention. Also noteworthy is that young prisoners and those with robbery offences and longer sentence profiles were disproportionately represented among the program's population when compared with the prison population eligible for the program. Over 300 prisoners had participated in the program in the 30 months since it opened. The overall program completion rate was 53%. Most non-completers were involuntarily discharged from the program (80%). Generally, therapeutic communities (TCs) have been found to have lower completion rates when compared with other programs. The IDATP completion rate is comparable to those reported on prison-based TCs in the UK (50%-62%). Further, the program had a disproportionate number of young and serious offenders and by inference this population may have been more difficult to treat and retain.

Table 5: Participant Background and Criminal Characteristics (n=313)

CHARACTERISTICS	Male participants	
PERSONAL	**No.**	**%**
Australian born*	251	80.7
Age		
18-24	142	45.4
25-34	112	35.8
35-44	48	15.3
45+	11	3.5
Median age	25 years	
Indigenous background	89	28.4
English usually spoken at home***	237	91.2
Arabic usually spoke at home***	13	5.0
Principal Offence (current Most Serious/Principal Offence)*		
Robbery	114	36.7
Assault	93	29.9
Property/fraud	65	20.9
Breach legal order	15	4.8
Drug	12	3.9
Miscellaneous	8	2.6
Sexual Assault	2	0.6
Driving	2	0.6
Sentence term (median months)**	36 months	
Prior prison term as an adult*	199	64.0
Median number of prior prison terms*		4
Prior contact with CSNSW*	262	84.2
Current **Apprehended Violence Order** against (AVO) *#	54	19.2

*2 missing cases; **4 missing cases; ***53 missing *#32missing cases.

Table 6: Participant Criminogenic Risk/Needs and Other Needs Areas

LSI-R (actuarial assessment of reoffending risk) #	No.	%
High	47	15.8
Med-High	133	44.8
Medium	111	37.4
Medium-Low	6	2.0
Low	-	0.0
Offence pathways: violence/property/other (all current offences)		
Violence (includes robbery) only	132	42.2
Property/Violence	71	22.7
Property (includes fraud) only	53	16.9
Other combinations	40	12.8
None of these offences (minor offences)	17	5.4
Criminogenic needs		
LSI-R **Alcohol or other Drug** Domain - **Considerable** need for improvement #	280	94.3
LSI-R **Attitudes/Orientation** Domain - need for improvement #	252	84.8
LSI-R **Education/ Employment** Domain - need for improvement #	239	80.5
LSI-R **Emotional/Personal** Domain - need for improvement #	176	59.3
Correctional assessments (additional identified needs)		
Current AOD-related offences*#	177	63.0
Withdrawing from drugs and/or alcohol on reception to prison*#	81	28.8
History of psychiatric medication/Tx*#	87	31.0
History of self-harm or suicide attempt*#	37	13.2
History of community-based counselling/mental health Tx *#	147	52.3

#LSI-R 16 missing cases *# 32 missing cases.

4.11 Changes to the Plan since Implementation and Lessons Learned

Information on problems encountered, solutions initiated and actual changes to the original plan was collected by way of key informant interviews and focus groups with the IDATP's therapeutic management team and senior corrections personnel associated with the program.

External Influences

As previously outlined, in mid-2014 there were 93 active participants as compared to a projected program population of 250 male participants. Despite this shortfall, the program remained the largest prison-based residential program in the southern hemisphere. The planned growth of the program was impeded in the second year of operation, largely due to external issues within the NSW correctional system. The scheduled roll-out of Stage Three (an additional 124 beds) in June 2013 was postponed due to competing operational priorities. A significant increase in the NSW prison population, which commenced in 2013, resulted in state-wide overcrowding and the reallocation of designated IDATP housing to mainstream prisoners on remand and in transition. This situation also led to staged transition of the program to an alternative minimum security site.

In addition, as part of a state-wide restructure of the workforce, many program staff were required to reapply for available positions in mid-2014. This resulted in some turnover of IDATP staff and the associated administrative pressures of recruiting, inducting and training new staff. According to the therapeutic management team, the restructure also hampered program momentum.

Operational and Therapeutic Interface

The TC model has been identified as one of the most complex treatment models to implement and operate in a prison environment. This is because TCs rely on significant change to the values and operating culture of prisons and substantial commitment and cooperation from staff to make the programs operationally workable (Peters & Wexler, 2005).

The interface between operational and therapeutic objectives and strategies and also cultural boundaries were identified as impediments to the implementation of the IDATP therapeutic community. This a common tension in correctional settings, whereby the operational stream prioritises security and managing risk and the program stream prioritises rehabilitation efforts. At the time of writing, there were two streams of management in the prison, custodial/operational and the IDATP treatment delivery staff. Custodial officers were rostered across both mainstream and IDATP areas of the prison. Reportedly, the spilt management structure posed challenges in meeting the program's objective of establishing a modified therapeutic community within a mainstream prison.

Having said that, the program demonstrated some positive signs of collaboration between therapeutic and custodial streams. By way of example, both program staff and custodial officers had participated in cross-training on the program. In addition, custodial officers had carriage of a program module during program Orientation and importantly, both streams attended the participant community meetings.

Reportedly, the considerable size of the staff complement also presented a number of challenges. According to program management, an issue not envisaged during planning was the constant need for cross-training of custodial and programs staff. Maintaining an adequately trained workforce had

been a key challenge. Managing a large participant population also presented significant administrative pressures.

Program Modifications since Inception

Program modifications were chiefly in the areas of program admission, preparatory programs, pharmacotherapy and drug testing protocols and program location.

The initial participant eligibility criteria had been expanded in order to increase program admissions. The requirement of an LSI-R AOD Domain score of seven was reduced to a score of five (thus making criteria more inclusive). Not with standing, both these scores fell within the equivalent classification level indicating a considerable need for improvement. Importantly, in the first year of operation, admission to the program was compulsory. After that time, program admission had required the consent of the prisoner.

Formalised policies and procedures for drug testing were being refined at the time of writing, as were documented manuals to guide the program. According to staff, various drug-testing technologies were trialled in the first year of the program. In mid-2012, the presumptive drug test, Pro-Screen was selected as the optimal testing tool due to immediacy of result and affordability. It is worth noting that immediacy has been identified as a key element in the efficacy of rewards and sanctions.

As already noted, the co-location of program facilitator offices in the participants' accommodation units was trialled in July, 2013. The purpose of this initiative was to enhance the community environment. Operational management eventually overturned the trial due to perceived safety risks put forward by custodial officers.

Treatment options were enhanced in July, 2013 with the introduction of Methadone Maintenance Therapy.

4.12 Potential/Emerging Issues that Suggest Further Changes to Existing Plan

Therapeutic management was of the opinion that the planned relocation of the entire program to a new dedicated centre in early 2015 would provide some protection against bed loses and allow for capacity building. It was also envisaged that a dedicated centre and a more open physical layout would be more amenable to establishing and maintaining a therapeutic climate.

According to therapeutic managers, in order to create a therapeutic climate, they needed to be able to directly influence the operational culture. A policy of specifically recruiting custodial officers who had a stated interest in working in a therapeutic context was already in place. It was further suggested that program management should have responsibility for custodial officer recruitment and the staffing roster in order to enable consistency in program delivery (e.g., consistent staff representation in community meetings and case review meetings) and to fully realise the goal of establishing a modified therapeutic community.

The management team envisaged that the planned relocation of the program to an alternative correctional centre would provide scope to fine-tune existing policies and practices. The team acknowledged there would be some disruption to program delivery given the program was to be split between two sites for approximately six months. A risk management strategy had been

developed to prepare treatment groups for membership change and also the re-location of some members to the minimum security facility. Conceivably, as the new correctional centre would be entirely dedicated to the IDATP program, this would safeguard program stability and program integrity.

During the focus group, the management team flagged several aspirational strategies to further enhance the program's therapeutic role as follows –

Summary: Potential/Emerging Issues

- Target suitable prisoners earlier in their sentence
- Minimum program duration to be six months
- Transition from set group intake to open or rolling program admission
- Celebrate completion of each program stage as a rite of passage
- Broaden the use of peer mentors within the program
- Greater involvement of custodial officers in facilitating community meetings and program curriculum

4.13 Program Quality – Adherence to the Principles of Effective Correctional Programs

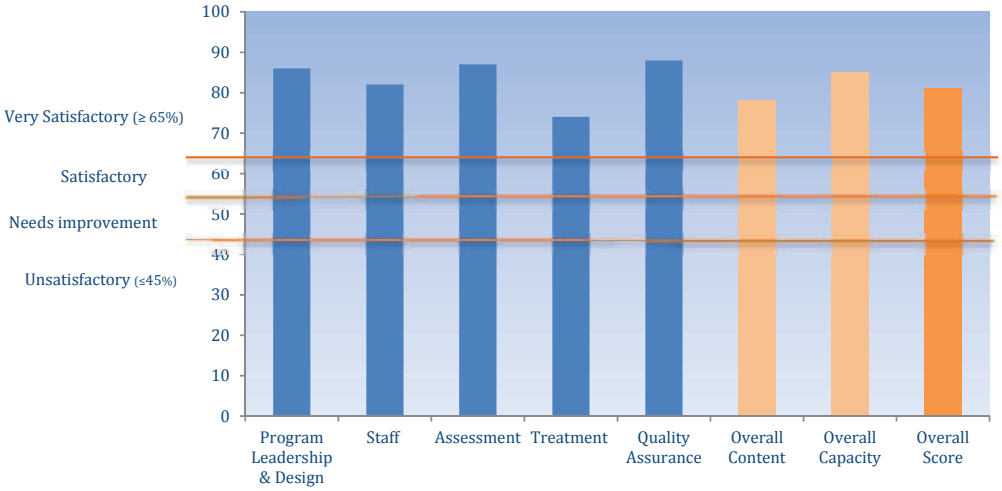
An objective of this study was to provide a preliminary assessment of program quality using a standardised measure. This was intended to provide the program with feedback on those aspects that are compatible with effective interventions and also areas for improvement. It also provides scope for benchmarking. The current assessment was limited to design documentation and interviews with management. Over the course of the program, the repeat administration of this assessment will include input from all staff and additional measures of program implementation. Repeated measurement should provide a more definitive picture of program quality.

Program quality or the extent to which the IDATP's development and design reflect the principles of effective correctional programs was assessed using the Corrections Program Checklist (CPC) and the corresponding ancillary surveys (Lowencamp, 2004). The CPC criteria are based on empirically proven principles of effective programs. All the indicators have been correlated with reductions in reoffending (Hanson & Lay, 2010). The CPC is delineated into two areas of program quality – Overall Capacity and Overall Content. Capacity covers the domains of leadership style, staff characteristics and quality assurance mechanisms **(Figure 6)**. Content covers the substantive domains of assessment and treatment, dosage and approaches. The sum of the scores for these two areas provides an Overall Score of program quality. The CPC comprises 77 discrete indicators across the five domains from which a maximum raw score of 83 is derived (refer to Appendix IV for the CPC instrument).

Instances where the program did not discretely demonstrate a principle, yet the principle was addressed by the overarching policies or procedures of the agency, were scored as being met by the program.

In terms of Overall Program Quality, the IDATP was accorded a ranking of 'very satisfactory' (81%).

Figure 6: The IDATP's Level of Adherence to Standards for Correctional Programs (CPC*)



*CPC - Corrections Program Checklist

Overall Content and Overall Capacity were ranked as 'very satisfactory' (78% and 85% respectively). These scores are suggestive of a highly effective program. Program content was of high quality as it was congruent with the *Risk-Need-Responsivity* model and current evidence-based treatment approaches. Capability to deliver treatment was also of a high quality as suggested by the calibre of leadership, staff and quality assurance mechanisms. Across all five domains - program leadership and development, staff characteristics, offender assessment, treatment characteristics and quality assurance the program was rated as 'very satisfactory'. **Figure 6** presents the rankings across the five domains. More details of the assessment process follow.

Capacity - Leadership and Development

This domain examined the qualifications and experience of the program's leadership, his or her involvement in program development and implementation and with staff and participants.

The *Leadership and Development* domain was accorded a high score (86%), which indicated that the foundations of the program; the Director's qualifications and involvement with staff selection and training and also project management, closely adhered to the principles of delivery effectiveness. Briefing papers demonstrated that program development was guided by an extensive literature review. Program development was also guided by an existing program that had been successfully implemented and externally evaluated (the CDTCC). At the outset, a modified version of program was piloted for a period of one month to inform full implementation. However, not all changes to program components had been routinely piloted. The program was assessed as being valued by the criminal justice community and the general community as its stated purpose was to reduce

recidivism, which in turn addresses community safety. Since the inception of the program, funding had been stable.

The areas of this domain that limited the quality of the program were the lack of program maturity (i.e. the program had not been running for three years or more) and the lack of policy on piloting new program components. Further, doubts were raised over the adequacy of current funding to meet the planned expansion of the program.

Capacity - Staff Characteristics

This domain addressed staff qualifications, values, experience, training, supervision and involvement in program development.

The Staff Characteristics domain was accorded a score of 82%. Capacity effectiveness was demonstrated in terms of the relevant experience, supervision, input and training of staff. This domain was also concerned with the appropriateness of personal values and qualities for working in a therapeutic environment.

The NSW state government requires job descriptions, eligibility criteria and recruitment to adhere to standardised protocols and procedures. Relevant job criteria were referenced to assess adherence to minimum standards for qualifications and experience as set out in the CPC. The CPC standard pertaining to qualifications states that 70% of those involved in program delivery should hold an associate degree or equivalent. As the relevant job criteria documents for treatment staff stipulated tertiary qualifications or equivalent experience, it was not possible to verify whether 70% of staff definitively met the standard of an associate degree with the information at hand. The CPC also states that 75% of staff should have a minimum of two years' experience working with offenders. It was also not possible to verify adherence to this standard based on the job criteria documents.

According to program design documents, the program convened formal monthly meetings and conducted formal supervision on a monthly basis. It also had an extensive dedicated training program that involved at least 30 days of training per annum. Further, staff was invited to provide input into the program at formal meetings and team building days. The lead agency had published ethical guidelines that applied to program staff. In addition, staff was required to have training in boundary setting and interactions with prisoners.

An area of this domain that mitigated program quality was the lack of formal information on whether personal qualities and values consistent with therapeutic practice were addressed in the recruitment of program staff. In addition, it was not possible to comprehensively gauge the level of staff endorsement for the goals and values of the program at this point in time.

Capacity - Quality Assurance

Quality assurance was another strong domain of the program being accorded a score of 88%. There were a number of internal and external monitoring systems in place. Participant progress was monitored, assessed and electronically recorded during time-in-program and pre & post-treatment psychometric tests were administered. Program activity and efficiencies were recorded and published by the agency proper.

The current process evaluation was tasked with assessing program integrity and also assisted with articulating the program's model of change. The program was subject to external evaluation in terms of meeting its objectives, including recidivism.

As external providers were not contributing to the program, quality assurance for this indicator was deemed not applicable. Quality assurance was only limited by the program's lack of maturity and therefore the program was untested in terms of proven effectiveness.

Content - Assessment

This domain addressed the extent to which the program assesses *risk, need and responsivity* in the selection of participants and the methods employed.

The Assessment domain was assigned a high score of 87%. The program's Orientation Local Operating Procedures (LOPs) document set-out the process for admission to the program. This included clearly stated eligibility criteria that relied on actuarial assessment of risk and need using the LSI-R. The LSI-R had been validated on the NSW prison population within the past five years. The program complied with the principle of targeting higher risk prisoners for more intensive programs. In addition, it targeted those with a substance domain score indicating a considerable need for treatment. A battery of psychometric tests was used to address *responsivity,* including stage of change & motivation. This was supplemented with a personal interview.

With the exception of motivation, a shortcoming in the assessment protocols was insufficient documentation of procedures for defining and integrating *specific responsivity* factors and a convergent validity process for quantifying an overall level of *responsivity.*

Content - Treatment

This domain examined whether the program targets criminogenic behaviour and the corresponding treatment approaches and techniques, contingency management and the provision of aftercare. It also examined the application of risk, need and responsivity principles in program delivery.

The Treatment Characteristics domain, which is ascribed the most weight, was assigned a score of 74%, placing it in the 'very satisfactory' category. A previously mentioned, the IDATP ran for nine months and integrated MTC & CBT modalities in a physically-separated setting. In a typical week, participants spent approximately half of their 'out-of-cell' time participating programs that targeted criminogenic needs.

The IDATP met the dosage standard, targeted criminogenic behaviour and attitudes throughout program content and followed proven treatment models. Criminogenic needs were targeted in the following domains:

- drug misuse;
- criminal thinking and behaviour;
- treatment readiness;
- CBT skills and relapse prevention; and
- education and employment.

However, the program did not assign group membership according to risk. Further, group size (a maximum of 15 participants) was larger than the recommended size (8-10 participants).

The program taught participants observation and problem solving skills and provided graduated practice in prosocial behaviours in the core curriculum and in more informal contexts, such as community meetings.

The program included highly structured contingency management contracting. This was an integral element of the program, with rewards outnumbering sanctions by a ratio in excess of 4.1. Rule violations were addressed immediately by way of a case meeting. As sanctions were applied monthly, the approach did not meet the standard of immediacy. Further, it was not clear whether prosocial alternatives were taught after the sanction was administered. A limitation of the contingency management framework was that it had not been reviewed for unintended negative effects.

The main behaviour change program within the IDATP *(Pathways)* followed an evidence-based curriculum with a comprehensive provider's manual. However, there was no manual to guide the program in its entirety as an integrated, modified therapeutic community. Further, in terms of *responsivity*, there was no mention in program records of staff/participant matching.

At just over 50%, the current completion rate was below the accepted rate of between 65-85% for correctional programs. Nonetheless, MTCs have been shown to have comparatively lower completion rates due to their longer duration, intensive approach and close monitoring of behaviour. While the program provided individualised aftercare plans, the process could be more formalised via relevant linkages and placements with transitional services. Aftercare plans based on the reassessment of targets and delineated into intensive and less intensive pathways relative to the risk level of the participant would enhance the process. While families were invited to the graduation ceremony, they were not trained to provide support to the participants once they were released from prison. Nonetheless, the feasibility of effectively satisfying this principle in a prison setting is open to question.

Program Quality: Summary

A standardised instrument, the Corrections Program Checklist (CPC) was used to objectively assess the quality of the program's design. All CPC criteria have been correlated with reductions in reoffending. The CPC covers the domains of assessment, treatment, leadership style, staff characteristics and quality assurance mechanisms. Overall program quality was assessed as very satisfactory (81%). A few limitations were identified, chiefly in the area of program content. In terms of program improvements, current findings suggest that the development of program manuals, formalised aftercare policies and procedures and strategies to increase program completion rates should receive highest priority.

With some minor exceptions, such as program activity data, the current assessment was based on program documentation rather than independent assessments of implementation. It is anticipated that the CPC will be re-administered on an annual basis to monitor any changes in program quality. A limitation of the current assessment is that it does not consider system issues and external influences that my affect program integrity.

Overall, this preliminary result is impressive given only six per cent of the 509 correctional programs assessed by the University of Cincinnati were classified as very satisfactory on the CPC (Hanson & Lay, 2010).

5. DISCUSSION

The establishment of a 300-bed prison-based drug treatment facility was heralded as an election commitment of the current NSW government. It was envisaged that with the introduction of the treatment facility, capacity to reach the large numbers of prisoners with drug problems would be strengthened while providing a high standard of drug treatment. The CSNSW Intensive Drug & Alcohol Treatment Program (IDATP), which was established in response to the government's intention, is currently the single largest offender residential program in the southern hemisphere. The adjunct women's program has recently opened.

The Corrections Research Evaluation and Statistics (CRES) division was asked to conduct the current process evaluation. The aim of this first stage of the process evaluation was to examine the appropriateness of the program in terms of its establishment and design.

The scope of this report included documentation of program planning, establishment and design. The report further assessed whether the program's design fits the evidence-base and standards and also clarified goals, program elements and the theory that links to these elements. Finally, the report assessed quality assurance and governance, early program uptake and provided an overall appraisal of program quality.

Planning and Establishment

The IDATP became a significant business priority for CSNSW in September, 2011 when the NSW Government identified the establishment of a metropolitan drug treatment facility as a NSW 2021 (NSW ten-year strategic plan) Priority Action. Given the imperative, the planning and implementation of the IDATP was subject to a tight time-frame for establishment.

The IDAPT was to follow a staggered implementation plan over four stages. It opened in February 2012 with an initial 62 beds in John Morony Correctional Centre (JMCC), which is a medium security facility. To date, the second stage has been implemented according to plan, representing a capacity of 124 beds. The scheduled roll-out of the third stage, which provided for an additional 124 beds in June 2013, was impeded due to externally driven, competing operational priorities. The need arose to accommodate the increasing number of offenders received from the court system and transit prisoners. This in turn, resulted in an unprecedented spike in the NSW prison population and the reallocation of planned program beds for mainstream prisoners.

This impediment to program momentum demonstrates how well-designed, correctional initiatives can be derailed by external influences within the broader criminal justice system. These complexities and challenges are common to prison settings, which are at the end stage of the criminal justice process.

As a result of the operational capacity pressures, in mid-2014 the IDATP implementation plan was revised and a decision made to relocate the program to the Outer Metropolitan Multi-Purpose Correctional (OMMPC), an alternative minimum security centre within the complex. The new centre would be dedicated to the IDATP program. The relocation of the program was to be a staged process due to infrastructure and refurbishment requirements. The program would be delineated across the two centres in the interim due to required capital works at the new centre. Program management had developed a number of transition strategies to manage risk, given the staged relocation would disrupt program cohesion.

Since opening, the program had achieved a maximum population of 156 participants at any one point in time. At the time of writing (mid-2014), there were 93 active male program participants. Reportedly, a low participant population was being maintained due to the transition of the program to the alternative centre.

It was envisaged that the new dedicated centre would allow for capacity building and the more open physical layout should be more amenable to establishing and maintaining a therapeutic environment.

Early documentation conceptualised the IDATP as a treatment program that recognises the multidimensional treatment needs of those prisoners with drug problems, thereby integrating a range of therapeutic, health, education, vocation, employment and life-skills programs aimed at reducing substance dependence and offending behaviour. Program stakeholders reported that due to the short lead-in time for establishing the program, several proven strategies in the agency's existing suite of drug programs were transposed into the program. These included the intake assessment battery, the core drug treatment curriculum and several program principles (e.g., the Good Lives Model).

Aside from its large capacity, what distinguished the IDATP's design from the existing programs was a greater emphasis on the integration of a range of modalities, the Community as Method and peer support approach, intensive contingency contracting, education, employment and a dedicated women's program.

Notably, the design also incorporated what has been described as the most promising approach in drug treatment with offenders; an integration of modified therapeutic community and cognitive-behavioural therapy approaches. The literature suggests these two approaches offer the best outcomes for offenders (Welsh et al. 2013).

Design

The IDATP was a nine-month program, targeted at medium to high risk male prisoners with drug abuse problems and related dynamic criminogenic needs. It operated as a modified therapeutic community (MTC), which provided the context for multi-modal interventions across three explicit program stages - Orientation, Treatment and Maintenance. These treatment stages were designed to bring about incremental degrees of psychological and social learning. The primary modalities were residential context, therapeutic groups, education, employment and health services.

Prima facie, the establishment of the IDATP was founded on the assumption that there is a drug treatment effect. It could be further said, an implicit assumption of the program's design was that an amalgam of well-established and empirically-supported methods and techniques had the potential to bring about positive changes in offenders. However, a detailed theory of change or program logic was not evident in the program's design documents. The current evaluation attempted to derive a program logic and theory of change to conceptualise the program in its entirety. This derived model revealed a highly complex, holistic program with the intended program outcomes linked to many sequential elements. As people with drug problems are complex, the complexity of the program seems both responsive and appropriate. The logic model enables the integration of process and outcome results.

The program's conceptual framework was based on sound foundations. The impetus for the program was justified given the large number of drug-involved offenders and the significant social burden that ensues. Once operating capacity is realised, the program community provides the context that is favourable to positive behaviour change and this is supported by an amalgam of principles and treatment approaches endorsed in the correctional program and drug treatment effectiveness literatures.

The program's design targeted those at higher criminogenic risk and need and addressed responsivity through comprehensive assessment and tailored program elements. It provided a risk-focussed program of sufficient dosage (> 200 hours) that also addressed related-needs with interventions and techniques proven to affect positive behaviour change. These interventions and techniques included, motivational interviewing, therapeutic alliance, Community as Method, cognitive behavioural therapy, relapse prevention, drug testing and contingency management. The IDATP also provided tailored aftercare planning.

The program was integrated on a number of levels; it provided a living-learning context, both officers and professional staff were involved in role-modelling, treatment delivery and discipline and progress was measured by a number of target behaviours, including attendance, commitment, engagement, prosocial behaviour, drug use and criminal conduct. The program also provided staff with frequent supervision and regular training.

Program Efficiency

Since opening, 313 prisoners had participated in the IDATP. Early profile statistics on program uptake showed the program was indeed admitting those of higher criminogenic risk and considerable need for drug treatment. While the program completion rate would appear to be comparatively low (53%) when compared with the accepted standard for correctional programs (65-85%), therapeutic community programs have generally shown higher attrition rates (DeLeon, 2000; Gowing, et al. 2001). The program's overall completion rate was comparable with those reported on U.K. prison-based TCs (50-62%) (Biggs, 2011). The longer duration and more intensive monitoring and review associated with TCs may help to explain the higher rates of attrition. Notwithstanding, in addition to the resource efficiency benefits arising from higher program completion rates, the literature has identified program completion as a proxy measure for longer-term outcomes (Stevens, et al. 2005).

While program's remit was to target risk management and provide a strict control regime in combination with a therapeutic program, strategies to improve program retention could be further investigated. The development of strategies to promote retention would potentially increase program size and overall efficacy. This may see those with repeated drug use violations during their time in program being retained in treatment and more intensively managed. It is generally accepted that drug abuse is a chronic relapsing condition and hence relapse to drug use is to be expected before making real progress (Gowing, et al. 2001).

The IDATP's participant profile showed an overrepresentation of younger offenders and those with robbery offences and longer sentences. These may have been influential factors in program non-completion. Prior to establishment, the facility in which the IDATP is based was dedicated to a young adult offenders' program. Reportedly, at the time opening, it was practicable to recruit eligible candidates already housed in the centre. This targeting would, to some extent, explain the overrepresentation of 18-25 year olds in the participant profile. It was also reported that when the

program first opened, program participation was compulsory for these younger prisoners. These factors may have contributed to the high proportion of discharges from the program due to program violations (80%) and the comparatively low completion rate (53%). Conceivably, younger offenders are more likely to be pre-contemplative about changing their behaviour than their older counterparts.

Program Quality

Overall program quality was deemed very satisfactory. The domains of leadership & design, staff calibre, assessment and treatment were all ranked as very satisfactory. A few program areas were flagged for improvement. Findings suggested those areas that should receive highest priority are the development of program manuals, formalised aftercare policies and procedures and strategies to increase program completion rates. A detailed program manual should describe the program purpose, philosophy and theory, objectives, performance measures and treatment activities. Aftercare policies and procedures should be designed to improve the process of transition between prison and the community and take into consideration duration and intensity based on the level of risk.

The program maintained a comprehensive system for monitoring program activity and participant compliance with the program. Given its aims, it would be instructive for the program to also measure effects on participants' psychological and social well-being post-program. While this is conducted at the end of the Treatment stage, it would be meaningful to gauge these effects post-release. By way of example, former participants who report to Parole Officers or are contactable by some other means could be re-assessed on their psychological and social well-being subsequent to being released into the community.

The program conducted comprehensive diagnostic assessments, including information on patterns of drug use, drug-related crime and drug treatment history, including history of overdose. However, these relied on paper-based records. Ideally, the program should transition to electronic recording of this information to enable efficient access for clinical and evaluation purposes.

For program evaluation findings to have meaning, the program being evaluated should run in a relatively unmodified way for sufficient time. The IDATP's design has been refined since inception. This has chiefly been in the areas of admission criteria, preparatory programming, drug testing protocols and the program's location. With these caveats in mind, the program's primary behaviour change agents - the 100-hour *Pathways* program and the residential community context have been constant.

Concluding Statement

At the time of writing, the IDATP had been continually operational for 30 months. More than one thousand prisoners had met the eligibility criteria for the program during this time. This potential pool of candidates legitimises the establishment of a large capacity, intensive program like the IDATP and is suggestive of the need for strengthening drug treatment within the CSNSW.

The IDATP has achieved its first stated aim, which was to establish a multidimensional therapeutic program for higher risk offenders with substance abuse issues. In addition to its large capacity, the establishment of the IDATP has added value to the provision of drug treatment in CSNSW in a number of ways. From the outset, there was state-wide access to the program for both alcohol and illicit drug users and those of varying security classification levels. Moreover, the IDATP's design

was multi-modal and integrated a range of needs-based program enhancements, such as adjunct Opioid Substitution Therapy, embedded education and employment components and a dedicated female program.

The TC model has been identified as one of the most complex treatment models to implement and operate in a prison environment. This is because TCs rely on significant revision of the values and operating culture of prisons and substantial commitment and cooperation from staff to make the programs operationally workable (Peters & Wexler, 2005). The planned expansion of the program to a 250 bed facility will presumably require a strengthening of staffing and financial resources to ensure program quality is safeguarded.

The next phase of the process evaluation will examine the extent to which the program has been implemented in accordance with its design.

6. REFERENCES

Andrews, D. & Bonta, J. (2003). *The Psychology of Criminal Conduct*. Cincinnati, OH: Anderson.

Andrews, D. & Bonta, J. (2010). Rehabilitating criminal justice policy & practice. *Psychology, Public Policy and the Law, 16 (1)* 39-55.

Andrews, D., Bonta, J. & Wormith, S. (2006). The recent past and near future of risk/need assessment. *Crime and Delinquency, 52(1)*, 7-27.

Antonowicz, D. & Ross, R. (1994). Essential components of successful rehabilitation programs for offenders. *International Journal of Offender Therapy & Comparative Criminology, 38(2*), 97-104.

Aos, S., Miller, M. & Drake, E. (2006). *Evidence-based Adult Corrections Programs: What Works and What Does Not*. Olympia: Washington State Institute for Public Policy.

Aydin, E., Kevin, M., Perry, V. & Xie, Z. (2013). *Evaluation of the Getting SMART Program Study One: Factors Impacting Program Completion*. (Research Publication No. 53). Sydney: Corrections Research, Evaluation and Statistics, Corrective Services New South Wales.

Bahr, S., Masters, A. & Taylor, B. (2012). What works in substance abuse treatment programs for offenders. *The Prison Journal, 92(2),* 155-174.

Bao, Y., Liu Z. & Epstein, D. (2009). A Meta-Analysis of Retention in Methadone Maintenance by Dose and Dosing Strategy. *The American Journal of Drug and Alcohol Abuse, 1*, 28-33.

Bean, P. (2002). *Drugs and Crime.* Devon: Willan Publishing.

Beck, A. & Weishaar, M. (2005). Cognitive Therapy. In: R. Corsini & D. Wedding (Eds.), *Current psychotherapies*. (Vol. 7, pp. 238–68). Belmont: Thomas Brooks/Cole.

Belenko, S. & Peugh, J. (1998). *Fighting Crime by Treating Substance Abuse, Issues in Science and Technology online*. Washington, DC: National Academy Press. Retrieved from www.nap.edu/issues/15.1/belenk.htm.

Belenko, S. (2006). Assessing Released Inmates for Substance-Abuse Related Service Needs. *Crime and Delinquency, 52 (1)* 94-113.

Belenko, S., Patapis, N. & French, M. (2005). *Economic Benefits of Drug Treatment: A Critical Review of the Evidence for Policy Makers.* Philadelphia PA: Treatment Research Institute at the University of Pennsylvania.

Biggs, K. (2011). Phoenix Futures Prison Treatment programme. Retrieved from www.dekiem.be/documents/tekst/PL3Biggs.pdf.

Bourgon, G. & Armstrong, B. (2005). Transferring the Principles of Effective Treatment to a "Real World" Prison Setting. *Criminal Justice and Behaviour, 32 (3),* 3-26.

Brown, M. (1996). Refining the risk concept: Decision context as a factor mediating the relation between risk and program effectiveness*. Crime & Delinquency, 42*, 435-455.

Brouselle, A. & Champagne, F. (2011). Program Theory Evaluation: Logic Analysis. *Evaluation and Program Planning, 34,* 69-78.

Butler, T., Indig, D., Allnutt, S. & Mamoon, H. (2011). Co-occurring mental illness and substance use disorder among Australian prisoners. *Drug Alcohol Review, 30(2),*188-94.

Clark, P. (2010). Preventing Future Crime With Cognitive Behavioural Therapy. *National Institute of Justice Journal, No. 265*, April.

Darke, S., Ross, J. & Teesson, M. (2007). The Australian Treatment Outcome Study (ATOS): what have we learnt about treatment for heroin dependence? *Drug and Alcohol Review, Volume 26(1*) 49-54.

Dekker, J., O'Brien, K. & Smith, N. (2010). *An evaluation of the Compulsory Drug Treatment Program (CDTP)* (Legislative Evaluation Series). Sydney: NSW Bureau of Crime Statistic and Research.

De Leon, G. (2000). *The Therapeutic Community: Theory, model & method*. New York: Springer Publishing.

De Leon, G. (2001). Therapeutic Communities for substance abuse: developments in North America. In B. Rawlings & R. Yates (Eds.), *Therapeutic Communities for the Treatment if Drug Users* (pp. 79-104). London: Jessica Kingsley Publishers.

De Leon, G. & Wexler, H. (2009). The Therapeutic Community for Addictions: An Evolving Knowledge Base, *Journal of Drug Issues, 39,* 161-178.

Devine, P., Christopherson, E., Bishop, S., Lowery, J. & Moore, M. (1999). *Integrated Evaluation Methods, Self-Adjusting Treatment Evaluation Model, Centre for Substance Abuse Treatment (CSAT).* Washington DC: U.S. Department of Health & Human Services.

Dolan, K., Shearer, J., Macdonald, M., Mattick, R., Hall, W. & Wodak, A. (2003). A randomised controlled trial of methadone treatment versus wait list control in an Australian prison system. *Drug and Alcohol Dependence, 72(10)*, 59-65.

Dowden, C. & Andrews, D. (2004). The importance of staff practice in delivering effective correctional treatment: A meta-analytic review of core correctional practice. *International Journal of Offender Therapy and Comparative Criminology, 48(2),* 203-214.

Research, Development and Statistics Division (2009). *Drug Treatment Outcomes Research Study (DTORS) 2009: Final Outcomes Report* (Research Report, 24). London: Home Office.

Eccleston, L. & Sorbello, L. (2002). The RUSH program- real understanding of self-help: a suicide and self-harm prevention initiative within a prison setting. *Australian Psychologist, 37(3),* 237-244.

Farabee, D., Prendergast, M., Cartier, J., Wexler, H., Knight, K. & Anglin, M. (1999). Barriers to Implementing Effective Correctional Drug Treatment Programs. *The Prison Journal, 79*: 150-162.

Farabee, D., Joshi, V. & Anglin, M. (2001). Addiction careers and criminal specialization. *Crime & Delinquency, 47(2)*, 196-220.

Farabee, D., Shen, H., Hser, Y.I., Grella, C. & Anglin, M. (2001). The effect of substance abuse treatment on adolescent criminality. *Journal of Adolescent Research, 16(6),* 679-696.

Farrington, D., Gottfedson, D., Sherman, L. & Welsh, B. (2002). The Maryland Scientific Methods Scale. In L. Sherman, D. Farrington, B. Welsh and D. Mackenzie (Eds.): *Evidenced-based crime prevention,* (pp. 13-21). London: Routledge.

Fiorentine, R., Nakashima, J. & Anglin, M.D. (1999). Client engagement with drug treatment. *Journal of Substance Abuse Treatment, Vol. 17*: 199-206.

Fiorentine, R. & Hillhouse, M. (2000). Self-Efficacy, Expectancies, and Abstinence Acceptance: Further Evidence for the Addicted–Self Model of Cessation of Alcohol- and Drug- Dependent Behaviour. *American Journal of Drug and Alcohol Abuse, 26(4)*, 497-521.

Gendreau, P., Little, T. & Goggin, C. (1996). A meta-analysis of the predictors of adult offender recidivism: What works! *Criminology, 34(4),* 401-433.

Gossop, M., Marsden, J. & Stewart, D. (2000). The UK National Treatment Outcome Research Study and its implications*. Drug and Alcohol Review, 19, (1),* 5-7.

Gossop, M., Marsden, J., Stewart, D., & Treacy, S. (2001). Outcomes after methadone maintenance and methadone reduction treatments: two-year follow-up results from the National Treatment Outcome Research Study. *Drug and Alcohol Dependence. 62,* 225-264.

Gossop, M., Marsden, J., Stewart, D. & Kidd, T. (2002). Changes in use of crack cocaine after drug misuse treatment: 4-5 year follow-up results from the National Treatment Outcome Research Study (NTORS). *Drug and Alcohol Dependence 66*, 21-28.

Gossop, M., Marsden, J., Stewart, D. & Kidd, T. (2003). National Treatment Outcome Research Study (NTORS): 4-5 year follow-up results. *Addiction, 98(3),* 291-303.

Gowing, L., Proudfoot, H., Henry-Edwards, S. & Teeson, M. (2001). *Evidence supporting treatment: the effectiveness of interventions for illicit drug use.* Australian National Council on Drugs research paper 3. Canberra: Australian National Council on Drugs.

Hanson, J. & Lay, G. (2010). *Evidenced-Based Correctional Program Checklist (CPC).* Retrieved from http://www.crimevictimsunited.org/issues/treatment/soar/cpc.pdf

Hiller, M., Knight, K., Rao, S. & Simpson, D. (2002). Assessing and evaluating mandated correctional substance abuse treatment. In Leukefeld, C., Tims, F., & Farabee, D. (Eds.), *Clinical and Policy Responses to Drug Offenders* (pp. 41-56). New York: Springer.

Hiller, M., Knight, K., Leukefeld, C. & Simpson, D. (2002). Motivation as a predictor of engagement in mandated residential substance abuse treatment. *Criminal Justice and Behaviour, 29,* 56-75.

Hiller, M., Knight, K., Saum, C. & Simpson, D. (2006). Social Functioning, Treatment Dropout and Recidivism of Probationers Mandated to a Modified Therapeutic Community. *Criminal Justice & Behavior, 33,* 738-759.

Holloway, K., Bennett, T. & Farrington, D. (2006). The Effectiveness of drug treatment programs in reducing criminal behaviour: A meta-analysis. *Psicothema, 18 (3)*, 620-629.

Indig, D., Topp, L., Ross, B., Mamoon, H., Border, B., Kumar, S. & McNamara, M. (2010) *2009 NSW Inmate Health Survey: Key Findings Report*. Sydney: Justice Health.

Kennedy, S. (2000). Treatment Responsivity: Reducing Recidivism by Enhancing Treatment Effectiveness. Retrieved from http://www.csc-scc.gc.ca/005/008/compendium/2000/chap_5-eng.shtml.

Kevin, M. (1992). *Drug and Alcohol Exit Survey. Part 1. Drug & Alcohol Background of Inmates.* (Research Publication No. 26) Sydney: NSW Department of Corrective Services.

Kevin, M. (2000). *Addressing the Use of Drugs in Prison: A survey of prisoners in New South Wales*. (Research Publication No. 44). Sydney: NSW Department of Corrective Services.

Kevin, M. (2003). *Addressing the Use of Drugs in Prison: prevalence, nature and context. 2nd collection of a biennial survey of prisoners in New South Wales*. (Research Publication No. 45). Sydney: NSW Department of Corrective Services.

Kevin, M. (2010). *Drug-related patterns and trends in NSW inmates: Overview of the 2007-08 biennial data collection*. (Research Bulletin No.27). Sydney: NSW Department of Corrective Services.

Kevin, M. (2011). *Corrections Treatment Outcome Study (CTOS) on Offenders in Drug Treatment: Results from the Drug Summit Demand Reduction Programs*. (Research Bulletin No. 31). Sydney: Corrective Services NSW.

Kevin, M. (2013a). *Drug Use in the Inmate Population – prevalence, nature and context. DUIP NSW – 6th Biennial Data Collection 2009-10: Overview and series trends*. (Research Publication No. 52). Sydney: Corrective Services NSW.

Kevin, M. (2013b). Drugs and Prison: Decade trends, prison subculture and the social context of drug use in NSW prisons, Conference presentation at the Risk, Rehabilitation & Reintegration: The Role of the Psychologist, *Corrective Services NSW 2013 Psychology Conference*, August 2013, Sydney.

Kinlock, T., Gordon, M., Schwartz, R. & O'Grady, K. (2008). A study of methadone maintenance for male prisoners: 3-month post release outcomes. *Crime Justice and Behavior, 35(1),* 34-37.

Klebe, K., & O'Keefe, M. (2004). *Outcome Evaluation of the Crossroads to Freedom House and Peer 1 Therapeutic Communities*. Colorado Springs: University of Colorado.

Lang, M., & Belenko, S. (2000). Predicting Retention in a Residential Drug Treatment Alternative to Prison Program. *Journal of Substance Abuse Treatment, Vol. 19 (2)*, 145-160.

Linehan, M. (1993). *Cognitive Behavioural Treatment of Borderline Personality Disorder,* New York: Guilford Press.

Linehan, M. (2014). *DBT® Skills Training Manual*. New York: Guilford Publications.

Linhorst, D., Knight, K., Johnston, J. & Trickey, M. (2001). Situational influences on the implementation of a prison-based therapeutic community. *Prison Journal, 81,* 436-453.

Lipsey, M., Landenberger, N. & Wilson, S. (2007). *Effects of Cognitive-Behavioural Programs for Criminal Offenders,* (No. 6). Campbell Collaboration.

Lipton, D. (2010). A Therapeutic Distinction with a Difference: Comparing American Concept-Based Therapeutic Communities and British Democratic Therapeutic Community Treatment for Prison Inmates. In R. Shuker & E. Sullivan (Eds.), *Grendon and the Emergence of Forensic Therapeutic Communities Developments in Research and Practice,* (pp. 61-77). Chichester, West Sussex: John Wiley & Sons Ltd.

Lowenkamp, C. (2004). *Correctional Program Integrity and Treatment Effectiveness: A multi-site, program-level analysis*. Dissertation submitted for Doctorate of Philosophy in the Division of Criminal Justice. Cincinnati, OH: University of Cincinnati.

Lowencamp, C., Latessa, E. & Smith, P. (2006). Does Correctional Program Quality Really Matter? The Impact Of Adhering To The Principles Of Effective Intervention 2006. *Criminology & Public Policy, (5)3*, 575-594.

McGovern, M. & Carroll, K. (2003). Evidence-based practices for substance use disorders. *Psychiatric Clinics of North America, 26,* 991-1010.

Mackenzie, D. (2013). First do no harm: a look at correctional policies and programs today. *Journal of Experimental Criminology, 9*, 1-17.

McHugh, K., Hearon, A. & Otto, M. (2010). Cognitive-Behavioral Therapy for Substance Use Disorders. *Psychiatric Clinics of North America, 33(3).* 511–525.

McGuire, J. & Priestley, P. (1995) 'Reviewing "what works": past, present and future', in J. McGuire and P. Priestley (Eds.) *What Works: Reducing Offending Guidelines from Research and Practice*. Chichester: Wiley.

McMurran, M. & Priestly, P. (2004). Addressing Substance-Related Offending (ASRO): A structured cognitive-behavioural program for drug users in probation and prison services. In B. Reading & M. Weegmann (Eds.), *Group Psychotherapy and Addiction* (pp. 194-210). London: Whurr Publishers.

McMurran, M. & Ward, T. (2010). Treatment Readiness, Treatment Engagement and Behaviour Change. *Criminal Behaviour and Mental Health, 20*, 75-85.

Martin, D., Garske, J. & Davis, K. (2000) Relation of the Therapeutic Alliance with Outcome and Other Variables: A Meta-Analytic Review. *Journal of Consulting and Clinical Psychology*, *68(3),* 438-450.

Marlatt, G. & Gordon, J. (1985). *Relapse prevention: maintenance strategies in the treatment of addictive behaviours*. New York: Guilford.

Maxwell, S. (2000). Sanction threats in court-ordered programs: Examining their effects on offenders mandated into drug treatment. *Crime & Delinquency, 46,* 542-563.

Meier, P., Barrowclough, C. & Donmall, M. (2005). The Role of Therapeutic Alliance in the Treatment of Substance Misuse: A Critical Review of the Literature. *Addiction, 100,* 304-316.

Milkman, H. & Wanberg K. (2007). *Cognitive Behavioural Treatment: A Review and Discussion for Corrections Professionals*. National Institute of Corrections. Washington: US Department of Justice.

Miller, W. & Rollnick, S. (1991). *Motivational Interviewing: Preparing people to change addictive behaviour.* New York, NY: Guilford Press.

Mitchell, O., Wilson, D. & Mackenzie, D. (2006). *The Effectiveness of Incarceration-Based Drug Treatment on Criminal Behaviour, Campbell Systematic Reviews*. The Campbell Collaboration. Retrieved from http://www.campbellcollaboration.org.

Mitchell, O., Wilson, D. & Mackenzie, D. (2007). Does incarceration-based drug treatment reduce recidivism? A meta-analytic synthesis of the research*. Journal of Experimental Criminology, 3,* 353-375.

Moss, R. (2007). Theory-based active ingredients of effective treatments for substance use disorders. *Drug & Alcohol Dependence, 88,* 109-121.

National Institute on Drug Abuse (2012). Principles of Drug Abuse Treatment for Criminal Justice Populations: A Research-Based Guide. Washington, DC.: NIH Publication No. 06-5316.

Office of Justice Programs (2002). *RSAT Logic Model.* Bureau of Justice Assistance, Centre for Program Evaluation and Performance. Retrieved from http://www.bja.gov/evaluation/program-substance-abuse/rsat6.htm.

Olver, M., Wormith, J. & Stockdale, K. (2011). A Meta-Analysis of Predictors of Offender Treatment Attrition and Its Relationship to Recidivism. *Journal of Consulting and Clinical Psychology, 79 (1)*, 6-21.

Ost, L. (2008). Efficacy of the third wave of behavioral therapies: A systematic review and meta-analysis. *Behaviour Research and Therapy, 46,* 296-321.

Pelissier, B., Rhodes, W., Saylor, W., Gaes, G., Camp, S., Vanyur, S. & Wallace, S. (2000). *TRIAD drug treatment for drug treatment evaluation project final report of three-year outcomes: Part 1.* Washington, D.C.: Federal Bureau of Prisons, Office of Research and Evaluation.

Pelissier, B., Camp, M., Gaes, G., Saylor, W. & Rhodes, R. (2003). Gender differences in outcomes from prison-based residential treatment. *Journal of Substance Abuse Treatment, 24(2*), 149-160.

Perdoni, M., Taxman, F. & Fletcher, B. (2008). Treating offenders in the community: An overlooked population and a lost public health and public safety opportunity. *Perspectives, 32(2),* 46-53.

Peters, R., Kearns, W., Murrin, M. & Dolente, A. (1993). Examining the effectiveness of in-jail substance abuse treatment. *Journal of Offender Rehabilitation, 19(3),* 1-39.

Peters, R. & Wexler, H. (2005). *Substance Abuse Treatment for Adults in the Criminal Justice System.* Centre for Substance Abuse Treatment, Treatment Improvement Protocol (TIP). Series 44. DHHS Publication No. (SMA) 05-3922, Rockville, MD: Substance Abuse and Mental Health Services Administration.

Petry, N. (2000). A comprehensive guide to the application of contingency management procedures in clinical settings. *Drug & Alcohol Dependence, 58*, 9-25.

Prendergast, M., Farabee, D., Cartier, J. & Henkins, S. (2002). Involuntary treatment within a prison setting: Impact on psychosocial change during treatment. *Criminal Justice Behaviour, 29,* 5-26.

Prendergast, M., Hall, E. & Wexler, H. (2003). Multiple measures of outcome in assessing a prison-based drug treatment program. *Journal of Offender Rehabilitation, 37 (3/4),* 65-94.

Prendergast, M., Podus, D. & Chang, E. (2000). Program factors and treatment outcomes in drug dependence treatment: An examination using meta-analysis. *Substance Use and Misuse, 35,* 1931-65.

Prendergast, M., Podus, D., Chang, E. & Urada, D. (2002). The effectiveness of drug abuse treatment: a meta-analysis of comparison group studies. *Drug and Alcohol Dependence, 67,* 53-72.

Prendergast, M., Podus, D., Finney, J., Greenwell, L. & Roll, J. (2006). Contingency Management for treatment of substance use disorders: A meta-analysis. *Addiction, 101, 11,* 1546-1560.

Prochaska, J., & DiClimente, C. (1986). Toward a comprehensive model of change. In W. Miller & S. Rollnick (Eds.) *Motivational Interviewing: Preparing people to change addictive behaviour.* New York, NY: Guilford Press.

Prochaska, J. & DiClimente, C. (1992). Stages of Change in the modification of problem behaviour. In M. Hersen, R. Eisler, & P. Miller (Eds.), *Progress in behaviour modification* (pp. 184-214). Sycamore, IL: Sycamore Publishing.

Simpson D., Fletcher, B., Hubbard, R. & Anglin, M. (1999). A national evaluation of treatment outcomes for cocaine dependence. *Archives of General Psychiatry, 56(6),* 507–514.

Simpson, D. & Broome, K. (2002). A national 5-year follow-up of treatment outcomes for cocaine dependence. *Archives of General Psychiatry, 59 (6)*, 538-544.

Sherman, L. Farrington, D., Welsh, B. & Mackenzie, D. (Eds.) (2002). *Evidence-based crime prevention*. London: Routledge.

Stevens, A., Berto, D., Kerschl, V., Oeuvray, K., Van Ooyen, M., Steffan., E, Heckman, W. & Uchtenhagen., A. (2003) *QCT Europe Summary Literature Review: The international literature on drugs, crime and treatment.* Canterbury U.K: EISS University of Kent. (www.kent.ac.uk/eiss/projects/qct%20Europe).

Stevens, A. Trace, M. & Bewley-Taylor, D. (2005). Reducing Drug Related Crime: An Overview of the Global Evidence. (Report Five). Beckley Foundation Drug Policy Programme.

Stevens, A., Hallam, C., & Trace, M. (2006). Treatment For Dependent Drug Use. A Guide For Policy Makers. (Report Ten). The Beckley Foundation Drug Policy Programme.

Taxman, F. & Belenko, S. (2012). *Implementing Evidence-Based Practices in Community Corrections and Addiction Treatment.* New York: Springer Series on Evidence-Based Crime Policy Springer.

Thomas, M., & Buckmaster, L. (2007). *'Naltrexone or methadone'? Debates about drug treatments for heroin dependence in the context of drugs policy*. Social Policy Section, Information, Analysis and Advice for the Parliament Research Paper (no. 7). Canberra: Parliamentary Library, Parliament of Australia, Department of Parliamentary Services.

University of Wisconsin, Extension Program (2008). *Development & Evaluation, Program Action Logic Model*, Retrieved from http://www.uwex.edu/ces/pdande/evaluation/evallogicmodel.html

Vandevelde, S., Broekaert, E., Yates, R., & Kooyman, M. (2004). The Development of the Therapeutic Community in Correctional Establishments: A Comparative Retrospective Account of the Democratic Maxwell Jones TC and the Hierarchical Concept-based TC in Prison. *International Journal of Social Psychiatry, 50,* 66-78.

Wanberg, K. & Milkman, H. (2008). *Criminal Conduct and Substance Abuse Treatment: Strategies for Self-Improvement and Change: The Provider's Guide.* Thousand Oaks, CA: Sage.

Wanberg, K. & Milkman, H. (2008). *Criminal Conduct and Substance Abuse Treatment: Strategies for Self-Improvement and Change: The Participant's Manual.* Thousand Oaks, CA: Sage.

Ward, T. & Maruna, S. (2007). *Rehabilitation: Beyond the risk paradigm.* London: Routledge.

Ward, T. & Stewart, C. (2003). The treatment of sex offenders: Risk management and good lives. *Professional Psychology: Research and Practice, 34(4)*, 353-360.

Weiss, C. (1997). How Can Theory-Based Evaluation Make Greater Headway? *Journal of Applied Social Research, 21(4),* 501-524.

Welsh, W. & Zajac, G. (2004). A Census of Prison-Based Treatment Programs: Implications for Programming, Policy, and Evaluation. *Crime & Delinquency, 50,* 108-133.

Welsh, W. (2007). A Multisite Evaluation of Prison-Based Therapeutic Community Drug Treatment. *Criminal Justice and Behaviour, 34*, 1481-1498.

Welsh, W., and McGrain, P. (2008). Predictors of therapeutic engagement in prison-based drug treatment. *Drug and Alcohol Dependence, 96(3)* 271-280.

Welsh, W. (2010). Inmate responses to prison-based drug treatment: A repeated measures analysis. *Drug and Alcohol Dependence, 109*, 37-44.

Wexler, H., Melnick, G., Lowe, L. & Peters, J. (1999). Three-year re-incarceration outcomes for Amity in-prison therapeutic community and aftercare in California. *Prison Journal, 79(3),* 321-336.

Wexler, H., & Prendergast, M. (2010). Therapeutic communication in United States prisons: Effectiveness and challenges. *International Journal of Therapeutic Communities, 31(2),* 157-176.

Wexler, H., Paolantonio, P., Petrozzi, C. & Buraczynski, C. (2013). Integrated Cognitive Behavioral Treatment in Prison-Based Therapeutic Communities. *Offender Programs Report, Vol. 16 (6)* 82-91.

7. APPENDIX I

Media statement by Liberal/National Coalition Monday 7 March 2011

NSW LIBS & NATS ANNOUNCE PLAN TO CRACKDOWN ON RE-OFFENDING RATES

NSW Opposition Leader Barry O'Farrell and Shadow Attorney General Greg Smith SC today announced a comprehensive plan to crackdown on re-offending rates in NSW, including the establishment of a second Drug Court in Sydney.

Mr O'Farrell explained the NSW Liberals & Nationals ambitious plan has the goal of reducing the re-offending rate to below the national average within ten years.

The people of NSW are fed up with a corrective services system which merely acts as a revolving door for offenders as they transition through a life of crime, Mr O'Farrell said.

The NSW Liberals & Nationals are determined to treat crime at its source and this is why we have a comprehensive plan with the goal of reducing the rate of re-offending to below the national average within ten years," he said.

"NSW has the worst recidivism rate of any Australian State with more than 40 per cent of prisoners returning to gaol within two years."

A NSW Liberals & Nationals Government will:

1. Establish a second Drug Court in the Sydney metropolitan area including detoxification facilities, drug testing, monitoring and treatment;

2. Create a specialist Metropolitan Drug Treatment Facility to ensure up to 300 drug addicted prisoners get treatment and are given the opportunity to get off drugs;

3. Provide an additional $20 million over four years for education and training programs in prison; and,

4. Encourage greater use of non-custodial punishment for less serious offenders and create availability and access to diversionary programs.

Mr Smith said reducing re-offending makes sense.

"Every ex-prisoner who returns to gaol costs taxpayers and diverts resources which could be spent on more hospital beds, better public transport or fixing our roads, Mr Smith said.

Prisoners released during 2007-08 who returned to prison with a new correctional sanction within two years –*Australian Productivity Commission, Report on Government Services 2011*

Combined with our commitment to a dedicated Metropolitan Drug Treatment Facility, the NSW Liberals & Nationals plan to reduce recidivism has a strong focus on drug treatment and rehabilitation," Mr Smith said.

APPENDIX II – baseline psychometric assessment tests administered

- Severity of Dependence Scale (SDS)
- Drug Taking Confidence Questionnaire (DTCQ)
- Corrections Victoria Treatment Readiness Questionnaire (CVTRQ)
- Psychological Inventory of Criminal Thinking Styles (PICTS)
- Self-Control Scale (SCS)
- Social Problem Solving Inventory-Revised (SPSI-R)
- Depression, Anxiety and Stress Scales (DASS)
- Paulhus Deception Scales (PDS)
- MacArthur Perceived Coercion Scale (MPCS)

APPENDIX III

The IDATP Education, Vocational Training and Employment Program

Corrective Services Industries (CSI) workshops included -

Metal shop (Engineering) Hygiene (Centre cleaning operations including waste management)
Powder coating (surface finishing of metal products)
Grounds maintenance (gardens and grassed surfaces)
Motor shop (proposed 2013 - repair of CSNSW mowers and other motorised equipment)
Powder coating clerk
Powder coating sweeper
Powder coating general hand/ hanger
Powder coating leading hand

Engineering Positions

General hand
Storeman
Clerk
Fabricator
Welder
Spray painter

Grounds Maintenance

General hand
Leading hand
Machine operator
Hygiene
Leading hand
Wing sweeper
Hygiene operator
Hygiene clerk

In conjunction with the above employment opportunities there was a range of TAFE delivered and accredited courses aimed at enhancing the employability skills of the participants, as follows -

2-Stroke Motor Service and Repair
Certificate II in Business Studies
Test and Tagging (for those who will seek work in construction)
Mentoring and Conflict Management
Welding using Gas Metal Arc (for CSI metal shop workers)
Weld using Manual Metal Arc (for CSI metal shop workers)
Welding and Thermal Cutting (for CSI metal shop workers)
Hygiene (Asset Maintenance – Cleaning Operations)

Powder Coating (Automotive Vehicle Painting)
Food Safety Supervisors
Restaurant Operations
Fitness (an introduction to the work of personal fitness trainers).

The following education opportunities were available to participants -

Pre-Certificate 1 – Assess to Work and Training
Certificate 1 – Assess to Work and Training
Certificate II in Skills for Work and Training
Vocational and Community Engagement
Certificate I in Information, Digital Media and Technology
Certificate II in Information, Digital Media and Technology
Certificate III in Information, Digital Media and Technology
Certificate I in AgriFood Operations
Certificate II in Parks and Gardens
Certificate II in Production Nursery
Aboriginal Culture Program
Literacy and Numeracy
Communications
Job Seeking and Employability Skills
Tutorial Support

APPENDIX IV Evidenced Based Corrections Program Checklist *(CPC) Scoring Sheet*

Name of Program:_____Program serves:____Males____Females____Both
Location (include state:_____Check program type:____Adult_Juvenile

Type of Program:_____(e.g. institutional, halfway house, day reporting, etc.)
Primary Treatment:_____(e.g. substance abuse, sex offenders, general, etc.)
___1st Assessment ___2nd Assessment ___3rd Assessment ___4th Assessment ___5th Assessment

Date of Assessment:_____ Name of Assessor(s): _____

1. Program Leadership and Development	**Check if verified by two or more sources**	
1.1 PD Qualified	____0 or 1	___
1.2 PD Experienced	____0 or 1	___
1.3 PD Selects Staff	____0 or 1	___
1.4 PD Trains Staff	____0 or 1	___
1.5 PD Supervises Staff	____0 or 1	___
1.6 PD Conducts Program	____0 or 1	___
1.7 Literature Review Conducted	____0 or 1	___
1.8 Pilot Interventions	____0 or 1	___
1.9 Valued by CJ Community	____0 or 1	___
1.10 Value by At-large Community	____0 or 1	___
1.11 Funding adequate	____0 or 1	___
1.12 Funding stable past 2 years	____0 or 1	___
1.13 Program 3 years or older	____0 or 1	___
1.14 Gender of groups	____0, 1 or N/A	___
	SCORE____/____	

2. Staff Characteristics		
2.1 Staff Education	____0 or 1	____
2.2 Relevant Experience	____0 or 1	____
2.3 Staff selected for skills & values	____0 or 1	____
2.4 Regular Staff meetings held	____0 or 1	____
2.5 Assessed on Service Delivery	____0 or 1	____
2.6 Clinical Supervision	____0 or 1	____
2.7 Staff Trained on program	____0 or 1	____
2.8 On-going Training	____0 or 1	____
2.9 Staff input	____0 or 1	____
2.10 Staff support treatment goals	____0 or 1	____
2.11 Ethical Guidelines for staff	____0 or 1	____
	SCORE____/____	

3. Offender Assessment		
3.1 Appropriate Clients	____ 0 or 1	___
3.2.Exclusionary criteria followed	____ 0 or 1	___
3.3 Risk Factors Assessed	____ 0 or 1	___
3.4.Risk Methods	____ 0 or 1	___
3.5 Risk Level Defined	____ 0 or 1	___
3.6 Need Factors Assessed	____ 0 or 1	___
3.7 Need Methods	____ 0 or 1	___
3.8 Need Level Defined	____ 0 or 1	___
3.9 Responsivity Assessed	____ 0 or 1	___
3.10 Responsivity Methods	____ 0 or 1	___
3.11Responsivity Defined	____ 0 or 1	___
3.12 Program Targets higher risk	____ 0 or 3	___
3.13 Validation Risk/Needs	____ 0 or 1	___
	SCORE __/___	

4. Treatment Characteristics

4.1 Criminogenic targets	____	0 or 1	___
4.2 Criminogenic target density	____	0 or 1	___
4.3 Type Treatment	____	0,1or 3	___
4.4 Length Treatment	____	0 or 1	___
4.5 Location monitored	____	0 or 1	___
4.6 Manual developed	____	0 or 1	___
4.7 Manual followed	____	0 or 1	___
4.8 Involvement 40-70%	____	0 or 1	___
4.9 Groups separated by risk	____	0 or 1	___
4.10 Intensity varies by Risk	____	0 or 1	___
4.11 Match Treatment and offender	____	0 or 1	___
4.12 Match Staff and offender	____	0 or 1	___
4.13 Match Staff and program	____	0 or 1	___
4.14 Offender Input	____	0 or 1	___
4.15 Use Appropriate Rewards	____	0 or 1	___
4.16 Ratio Favors Rewards	____	0 or 1	___
4.17 Procedures for rewards	____	0 or 1	___
4.18 Appropriate punisher	____	0 or 1	___
4.19 Procedure for Punishment	____	0 or 1	___
4.20 Negative Effects	____	0 or 1	___
4.21 Completion Criteria	____	0 or 2	___
4.22Completion rate	____	0 or 1	___
4.23 Skills Modeled	____	0 or 1	___
4.24 Skill training	____	0 or 1	___
4.25 Graduated practice	____	0 or 1	___
4.26 Groups monitored by staff	____	0 or 1	___
4.27 Group size	____	0 or 1	___
4.28 Significant Others trained	____	0 or 1	___
4.29 Discharge planning	____	0 or 1	___
4.30 Aftercare provided	____	0 or 1	___
4.31 Quality aftercare	____	0 or 1	___

SCORE____/____

5.0 Quality Assurance

5.1 Internal Quality Assurance	____	0 or 1	___
5.2 External Quality Assurance	____	0 or 1	___
5.3 Client Satisfaction	____	0 or 1	___
5.4 Offenders reassessed	____	0 or 2	___
5.5 Recidivism tracked	____	0 or 1	___
5.6 Program evaluated	____	0 or 1	___
5.7 Program effective	____	0 or 1	___
5.8 Evaluator working with program	____	0 or 1	___

SCORE____/____

TOTAL SCORE _____/_____

CAPACITY AREAS: Leadership & Development ____%
Staff ____%
Quality Assurance ____%
CONTENT AREAS: Assessment _____%
Treatment ____%

OVERALL RATING: _____
1= Very Satisfactory (65%+)
2= Satisfactory (55-64%)
3= Needs Improvement (46-554%)
4=Unsatisfactory (45%-)

OVERALL CONTENT _____%
OVERALL CAPACITY _____%
OVERALL _____

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