Residential Treatment of Antisocial behaviour in Youth?

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Background

- Residential treatment are the most commonly used intervention for youth with antisocial behaviour.
- There has generally been little systematic knowledge about ”what works”.
- Very often we do not have information about the treatment or about the effects of the treatment.
- **Residential Treatment are often based more on beliefs about effects than on documented knowledge.**

- Expert conference in Norway -97:
  - Home-based interventions gives the best effects
  - Implement of MST in every counties in Norway

- We still need residential treatment. What about these?

The Residential Treatment Project

1. Review of the research (2001-2002). Published in Norwegian and Swedish in 2003.

2. Development of a model for residential treatment based on the research (2003-2004).

3. Implementing of residential treatment model in Norway and Sweden (2005).

4. Evaluation of the treatment model

Review of the research on residential treatment

- Initiated by The Behavioural Centre (Terje Ogden) and sponsored by the Ministry of Family Affairs in Norway (BFD), The National Board of Institutional Care (SiS) and Centre for Evaluation of Social Services (CUS) in Sweden.

- Residential treatment may give relatively large positive effects on behaviour, but residential interventions are not equally effective. Some gives no or negative effects.

- The research reveals important factors that discriminate between effective and ineffective residential treatments.

The research

- There are no controlled (RCT) Nordic studies. Nordic studies are mostly –post studies without comparison group and without measures of function before treatment.

- Conclutions about ”what works” are based on international research.

- The Nordic studies describes the same problems in residential treatment as the international studies.

Known Problems in Residential Treatment

- ➔ Small mean effects
- ➔ Some youth become more antisocial as a result of residential treatment.
- ➔ Some youth drop-out from treatment because of high rates of violent and run-away behaviour.
- ➔ Residential treatment produce positive effects for some youth, but for a large part of these the problem behaviour returns within short time after returning to the society.

Effective interventions should focus on these problems.

WHERE IS THE RESEARCH?

➔ **Nordic countries:**

No effect-studies, some –post studies. Some studies on spesific topics in residential treatment. Mainly qualitative studies.

➔ **England:**

A large body of research regarding secure and open residential treatment.

➔ **USA/Canada:**

A large body of research regarding secure, open and small family like residential treatment (TFH).

➔ I addition there are a great part of research from other countries, both european and non-european.

There is a large amount of international research

- Single studies
- Reviews of the research
- Meta-analyses

Meta-analyses

- Garrett (1985): 111 studies on youth in residential treatment
- Gensheimer et al. (1986): 35 studies on treatment of youth
- Whitehead and Lab (1989): 50 studies on treatment of youth
- Izzo and Ross (1990): 46 studies on rehabilitation of youth
- Andrews et al. (1990): 154 studies on treatment of criminal youth and adult
- Lipsey (1992, 1997, 1998): 500 studies, 83 studies on youth in residential treatment
- **Redondo et al. (1997, 1999):** 32 studies, 5700 youth and adult
- Andrews and Bonta (1998): 290 studies on youth
- Dowden and Andrews (1999): 229 studies
- Dowden and Andrews (2000): 35 studies on treatment of violent criminals (youth and adult)
- Bonta (2000): 85 studies
- Lipsey, Chapman and Landenberger (2001): 14 studies

Results from the review:

- ⇩ Interventions outside institutions generally gives the best effects, but not for all youths. For some youth residential treatment are neccesary.

- ⇩ It is possibly to get good results from residential treatment, but not from all types. It is also possibly to influence the youth in a negative direction. The question is not **if residential treatment works**, but **what type of residential treatment works**?

- ⇩ Even if the research does not give all the answers, it points to important differences between effective and less effective interventions.

What does not work?

- Interventions based on psykodynamic approaches, non-structured interventions, or sociological explainations on antisocial behaviour.
- Interventions which focus on relations without focus on anticriminal changes
- Interventions which focus on punishment (Boot camps, prison, etc.).

What does not work?

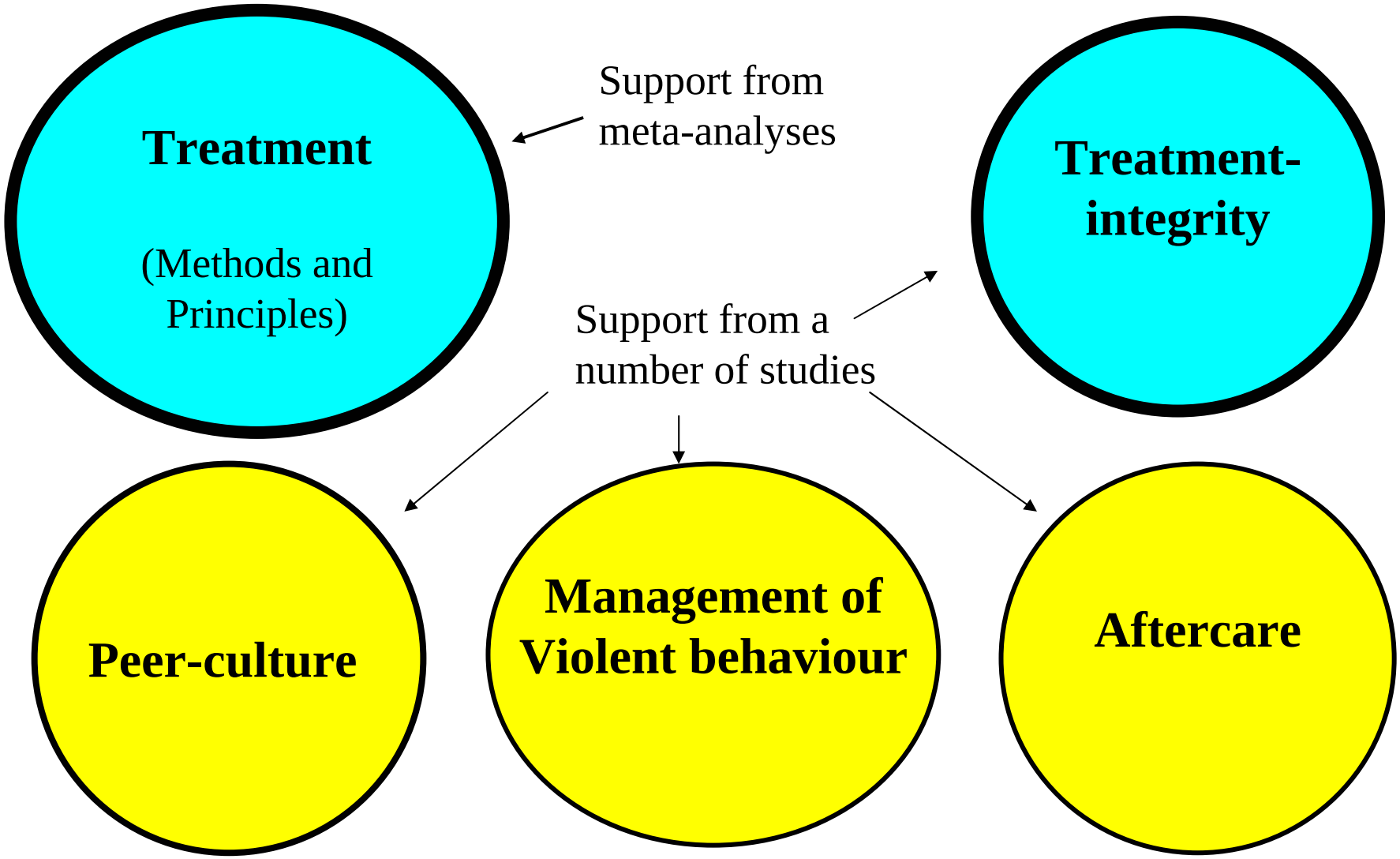
- Focus on vague emotional and personal complaints that have not been linked with criminal or antisocial behaviour.
- Increasing self-esteem (without reductions in antiosocial thinking and associations)
- Talking cures.
- Vague unstructured rehabilitation programs.

Effects of residential treatment seems to depend on several factors

- No single treatment approach alone is sufficient to give long-term effects on antisocial behaviour.

- Based on the research several important topics may be identified. Among these are:
  - Treatment,
  - treatment integrity/fidelity,
  - peer culture,
  - management of violent behaviour,
  - aftercare.

Important topics in residential treatment of antisocial behaviour.



Perhaps the Most Important Results From the Research Is the Formulation Of:

Principles of effective treatment

Andrews, Zinger, Hoge, Bonta, Gendrau og Cullen (1990).

(Later supported by several meta-analysis).

Principles of Effective Treatment

Risk Principle: Intensity of the intervention should correspond with level of recidivism risk.

Need Principle: Targets of interventions should be known risk factors (criminogenic needs).

Responsivity principle: The intervention should be matched to the individual learning style.

- **The Risk-principle identify who should get intensive treatment.**

- **The Principle of need focus on what should be treated/changed (intermediate objective).**

- **The Responsivity-principle focus on how the treatment should be performed (methods).**

1. Risk Principle

- Intensive interventions are more effective for youth with high risk for antisocial behaviour than for youth with low risk.

- Such interventions gives little or no effect (even negative) for youth with low risk for antisocial behaviour.

- Target group have to be chosen by measuring risk level with standardized instruments

Major Set of Risk Factors

- Antisocial/procriminal attitudes, values, beliefs and cognitive-emotional states

- Procriminal associates **and** isolation from anticriminal others

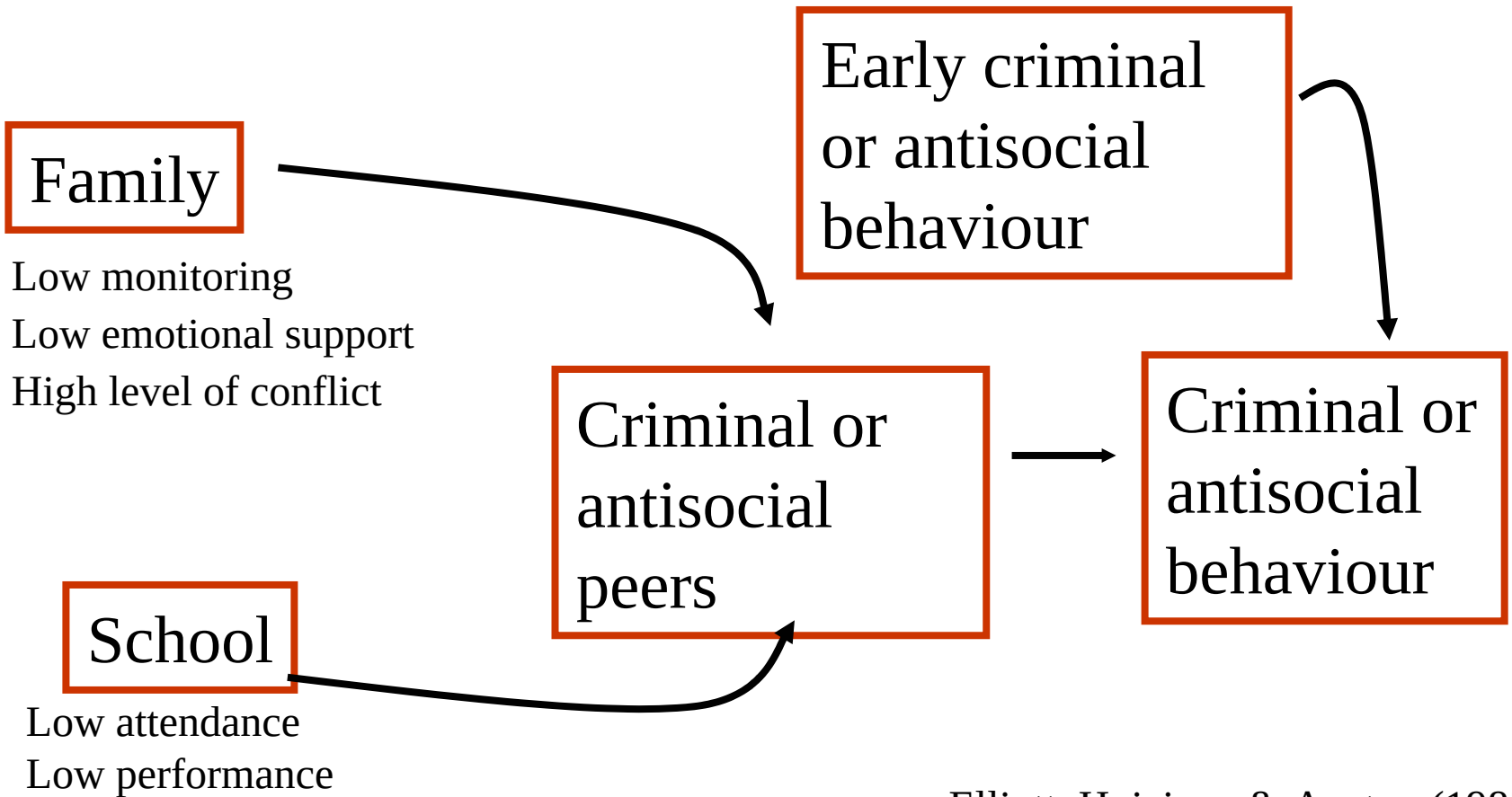
- Temperamental and personality factors conductive to criminal activity including:
  - -psychopathy
  - -weak socialization
  - -impulsivity
  - -restless/aggressive energy
  - -egocentrism
  - -below average verbal intelligence
  - -weak problem-solving/self-regulation skills

- A history of antisocial behavior:
  - -evident from a young age
  - -in a variety of settings
  - -involving a number and variety of different acts

- Familial factors that include criminality and a variety of psychological problems in family of origin including:
  - -low levels of affection, caring and cohesiveness
  - -poor parental supervision and discipline practices
  - -outright neglect and abuse

- Low levels of personal educational, vocational or financial achievement.

Empirical model (krim. & substans abuse.)



Elliott, Huizinga & Ageton (1985)

2. Need Principle

- Changes in risk factors for development and maintenance of antisocial behaviour are associated with changes in antisocial behaviour.

- Not all risk factors are modifiable. Those that are open to change (dynamic) are called **criminogenic needs** and are seen as promising targets for intervention.

- Criminogenic needs are characteristics of the individual youth, but also of the ecology of the youth; **the family, peers, school and neighbourhood**. Within each area the research have specified the needs that is associated with antisocial behaviour (Andrews and Bonta, 1998).

Promising targets for intervention

- Changing Antisocial Attitudes
- Changing/Managing Antisocial Feelings
- Reducing Antisocial Peer Associations
- Promoting Identification/Association & Anticriminal Role Models
- Promoting Familial Affection/Communication
- Promoting Familial Monitoring and Supervision

- Increasing Self Control, Self Management & Problem Solving Skills
- Replacing the Skills of Lying, Stealing and Aggression with More Prosocial Alternatives
- Reducing Chemical Dependencies & Substance Abuse
- Shifting the Density of the Personal, Interpersonal & Other Rewards & Costs for Criminal & Noncriminal Activities in Familial, Academic, Vocational, Recreational & Other Behavioral Settings, So That the Noncriminal Alternatives are Favoured

Less promising targets for intervention

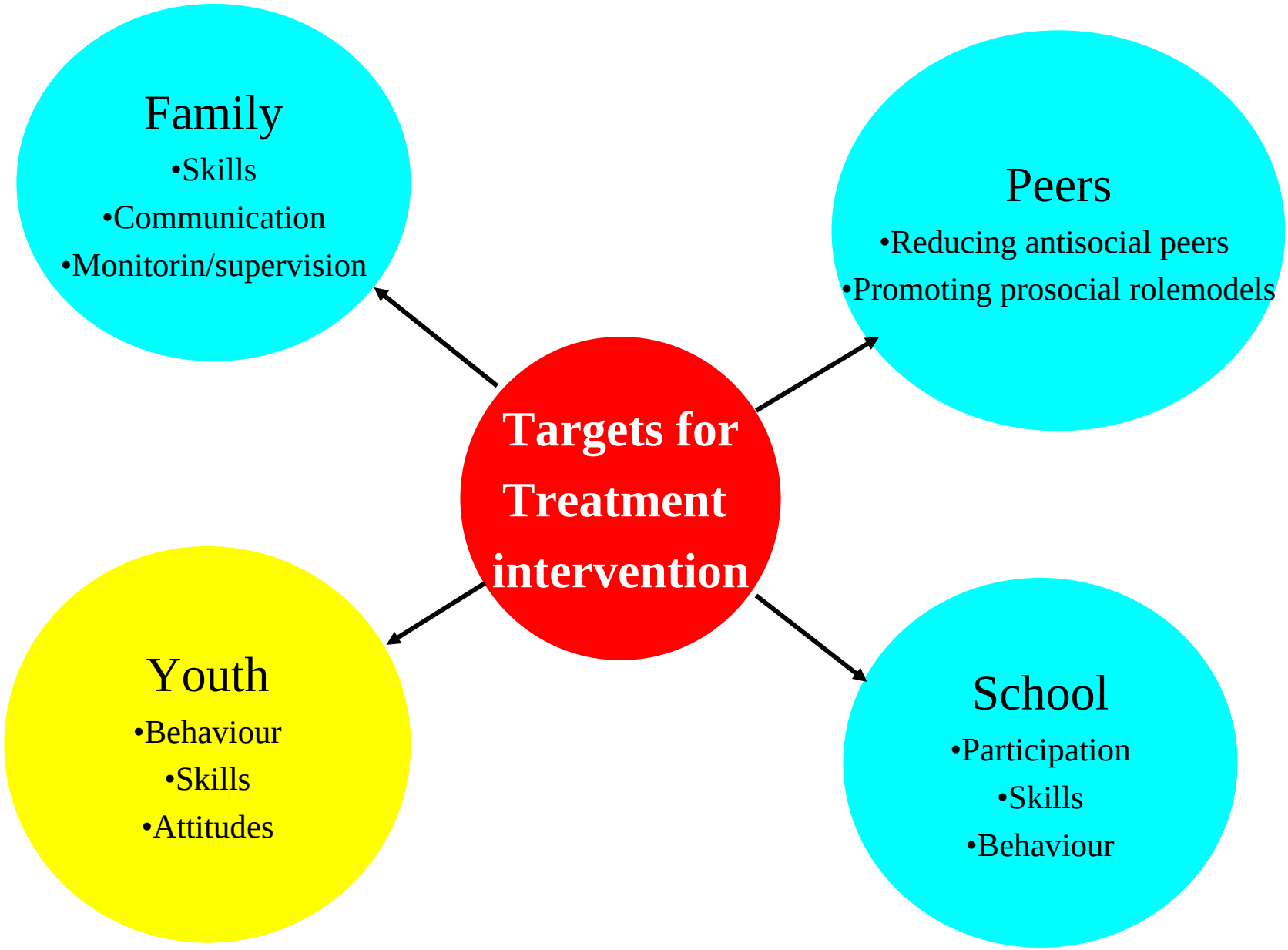
- Increasing Self-Esteem (Without Simultaneous Reductions In Antisocial Thinking, Feeling & Peer Associations)
- Focusing On Vague Emotional/Personal Complaints That Have Not Been Linked With Criminal Conduct
- Increasing The Cohesiveness of Antisocial Peer Groups

- Improving Neighbourhood-Wide Living Conditions Without Touching the Criminogenic Needs of Higher-Risk Individuals & Families

- Showing respect For Antisocial Thinking On The Grounds That The Values of One Culture Are as Equally Valued As The Values of Another Culture

- Increasing Conventional Ambition In The Areas of School, & Work Without Concrete Assistance In Realizing These Ambitions

- Attempting to Turn the Client Into a **“Better Person”** When the Standards For Being a **“Better Person”** Do Not Link With Recidivism


Family
•Skills
•Communication
•Monitorin/supervision
Peers
•Reducing antisocial peers
•Promoting prosocial rolemodels
Targets for Treatment intervention
Youth
•Behaviour
•Skills
•Attitudes
School
•Participation
•Skills
•Behaviour

3. Responsivity Principle

- Certain personality and cognitive-behavioural characteristics of the offender influence how responsive he/she is to types of treatment.

- Styles and mode of treatment should be matched to the learning style and skills of the antisocial youth.

- General responsivity (antisocial youth as a group) is differentiated from specific responsivity (individual youth).

Responsivity factors (Bonta -95)

General population:

- Anxiety
- Self-esteem
- Mental Illnes
- Age
- Gender
- Race/Ethnicity

More Common with offenders:

- Poor social skills
- Inadequate problem solving
- Concrete oriented thinking
- Poor verbal skills

General responsivity

- As a group antisocial youth are characterized by weak skills within several areas.

- The most effective treatment approach for antisocial youth as a group is based on cognitive behaviour theory and social learning theory.

  - Documented effects on antisocial behaviour in comparison with other treatment approaches.

  - Equips the youth with skills that are neccesary, but not sufficient for long-term effects on antisocial behaviour.

Garrett (1985):

Meta-analyses of treatment programmes in residential setting.

Included 111 studies which included 13000 youth.

- Found clear differences based on treatment content both for function in residential setting, and for behaviour problems after treatment.
- Focus on social and other skills, and use of cognitive behavioural programmes showed the best effects.
- Individual therapy, group-therapy and psychodynamic approaches showed no or negativ effect.

Izzo and Ross (1990):

Meta-analyses of 46 studies (residential and no-residential).

- Cognitive programmes (included social learning theory and behaviour modification) gave twice as large effect as no-cognitive programmes regarding violence, theft, etc. Effective techniques included training in problem solving, model learning, and skills training.

- Programmes which focused on punishment, medical models, or focus on explanations through poor parents etc., were less effective.

Andrews (1990):

- Cognitive / behavioural components and programmes gave significant better effects than other programmes.

- Effective treatment involved model learning, training in skills, tocen economy, cognitive restructuring, etc.

Ross (1980):

- Effective programmes included a cognitive component or technique that may influence on how the youth think (attitudes, etc.).

Antonowicz and Ross (1994):

- Behavioural programmes which not included a cognitive component were less effective in getting changes in behaviour.

Lipsey (1992, 1999):
Meta-analyses which included 83 residential studies with treatment of youth with serious behaviour problems.

- Effective approaches included skills training, training in control of aggression, tocen economy, cognitive reconstruction, and moral discussions.

Agression Replacement Training (ART)

- Promising program for reduction of antisocial behaviour

- The Program combines:
  - **Training in aggression control (ACT),**
  - **Social skills training**
  - **Moral discussion groups**
    (Goldstein och Glick, 1994).

EQUIP

- Multicomponent program that is used together with ”Positive Peer Culture” (PPC).
- PPC focus on involvement of the youth, and uses the peer culture active as part of the treatment.
- Social skills training is neccessary for development of a prosocial peer culture.

  (Similar with ART in combination with principles from PPC).

Izzo and Ross rapported that :

programmes with a clear theoretical foundation, regardeless of which, were 5 times more effective than those without such a fundation.

Are Programs based on CBT allways effective?

Cameron and Telfer (2004):

- An uncritical interpretation of the evidence for cognitive behavioral interventions without focus on other variables may result in wrong conclusions.

- The efficacy of cognitive-behavioral programs in group settings is dependent on attention to certain features. These include accurate assessment of the “risk”, “needs” and the “responsivity” of offenders, and there has to be strategic targeting of such risk and need factors for programs to succeed.

Spesific Responsivity

- Refers to the learning styles of individual youth.

- Factors that might be taken into acount are:

  - lack of motivation to participate in the program,
  - feelings of anxiety or depression,
  - neuropsychological deficits stemming from early childhood experiences, and other .....

  which may influence on the possibilities to change the behaviour and the criminogenic needs.

Treatment integrity/fidelity

- No treatment approach is effective if the actual practice is not in agreement with the underlying theoretical principles and intentions.

- Programs that monitor the treatment integrity produce better outcomes than those that do not.

How Can Effectiveness be Sustained Over Time?

What Could Go Wrong?
Threats to Integrity

- **PROGRAMME DRIFT**
- **PROGRAMME REVERSAL**
- **PROGRAMME NONCOMPLIANCE**

Hollin (1995)

PROGRAMME DRIFT

- **The focus of the treatment gradually moves over time, as practitioners and managers change, so that eventually the treatment no longer addresses the original aims and objectives**

PROGRAMME REVERSAL

- **“Turf Wars” where behaviours incompatible with the aims of the programme are modelled and reinforced in other parts of the organisation.**

  Eks: If the treatment consists of training in aggression control, while parts of the staff beliefs that the best help for aggression is to express it.

PROGRAMME NONCOMPLIANCE

- **Staff make decisions to change the programme, say by altering the number of sessions, introduction new targets for change, using different treatment methods, changing the admission criteria, and not recording monitoring information**

Maintaining Integrity :

- The programme have to be based on a **specific theoretical treatment orientation**

- **There must be no important differences between staffs regarding theory on problem behaviour or attitudes towards the treatment.**

- **The staffs need to have traning in methods** to ensure integrity. Training gives better possibility to understand the treatment and to perform the treatment as planned.

Maintaining Integrity

- System to collate monitoring information
- Feedback system to managers and practitioners on the quality of implementation
- Use of treatment audit

One conclution is that effective interventions, regardless of setting, have some common:

Antisocial behaviour is understood as linked with characteristics of the youth **and** his/her family, peer group, and school. Interventions should focus on changing these.

Special for effective residential treatment:

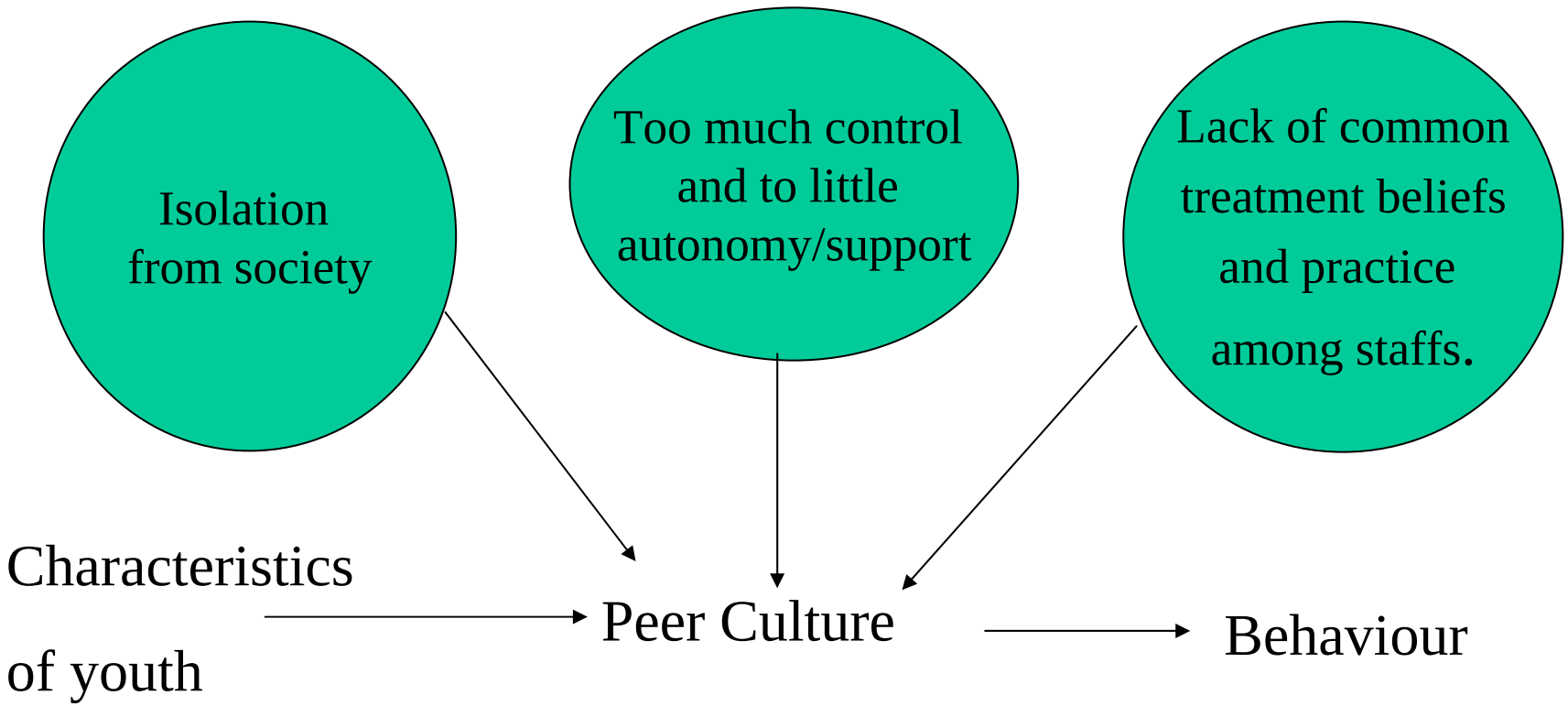
1. Are able to moderate the influence of the peer culture
2. Are able to manage violent behaviour
3. Are able to transfer behaviour changes to the society

Peer culture

- Influence of antisocial peers and antisocial youth culture is important risk factors.

- In residential settings an unintended consequence might be that the group might contribute to the development and maintenance of antisocial behaviour.

Main risk factors that influence the culture seems to be:



Autonomy and control

(Scholte and Van der Ploeg, 2000; Gold and Osgood, 1992)

- Involvement of youth in decissions (within limits of security and aceptable behaviour) may support a prosocial culture.

- Too much adult domination and authority control may result in negative sub-cultures which stands against the treatment.

- **Balance between control-autonomy and structure-support (firm but fair) seems to be important for the development of a prosocial peer culture, and for growth in social competence.**

Staff structure and culture

(Brown, Bullock, Hobson and Little, 1998)

- ➔ Structure of the residential home determines the staff culture
- ➔ The staff culture determines the youth culture
- ➔ The youth culture determines the outcome for the residential home and for the youth

If beliefs about treatment are

- ➔shared by the staff,
- ➔in agreement with the goals of the treatment, and
- ➔are reflected in daily practice towards the youth,

this may result in a strong and goal-focused staff which influences the peer culture in a positive direction.

➔ Different beliefs and attitudes about treatment makes a fragmented staff culture and peer culture, and to a negative development for the youths.

Aftercare

Function and behaviour in residential setting is not predictive for function after leaving.

Function after leaving seems more related to the quality of the ecology of the youth in society, than to the function before leaving.

Aftercare

Cass og Nelson (1998):
Study of data for 7000 youth who left residential treatment during 1997.

- Tendence to offer the same model of aftercare for all
- Those who received most intensive aftercare, where those who most often was arrested.
- Youth that did not receive any aftercare, was among those who got least arrested.

The study concluded with:

- The best aftercare focused on the family, the school, the peers, and the youth.

- The best aftercare was differenciated based on the needs of the youth, and focused on risk factors for the single youth.

Characteristics of Effective Residential Treatment

- Residential treatment should target high-risk offenders. The risk level has to be assessed.

- The targets for interventions should be known dynamic risk factors. The criminogenic needs within the youth, the family, the peer relations, and the school have to be assessed.

- Cognitive behavioural methods should be used to change the behaviour and to help to develop appropriate skills.

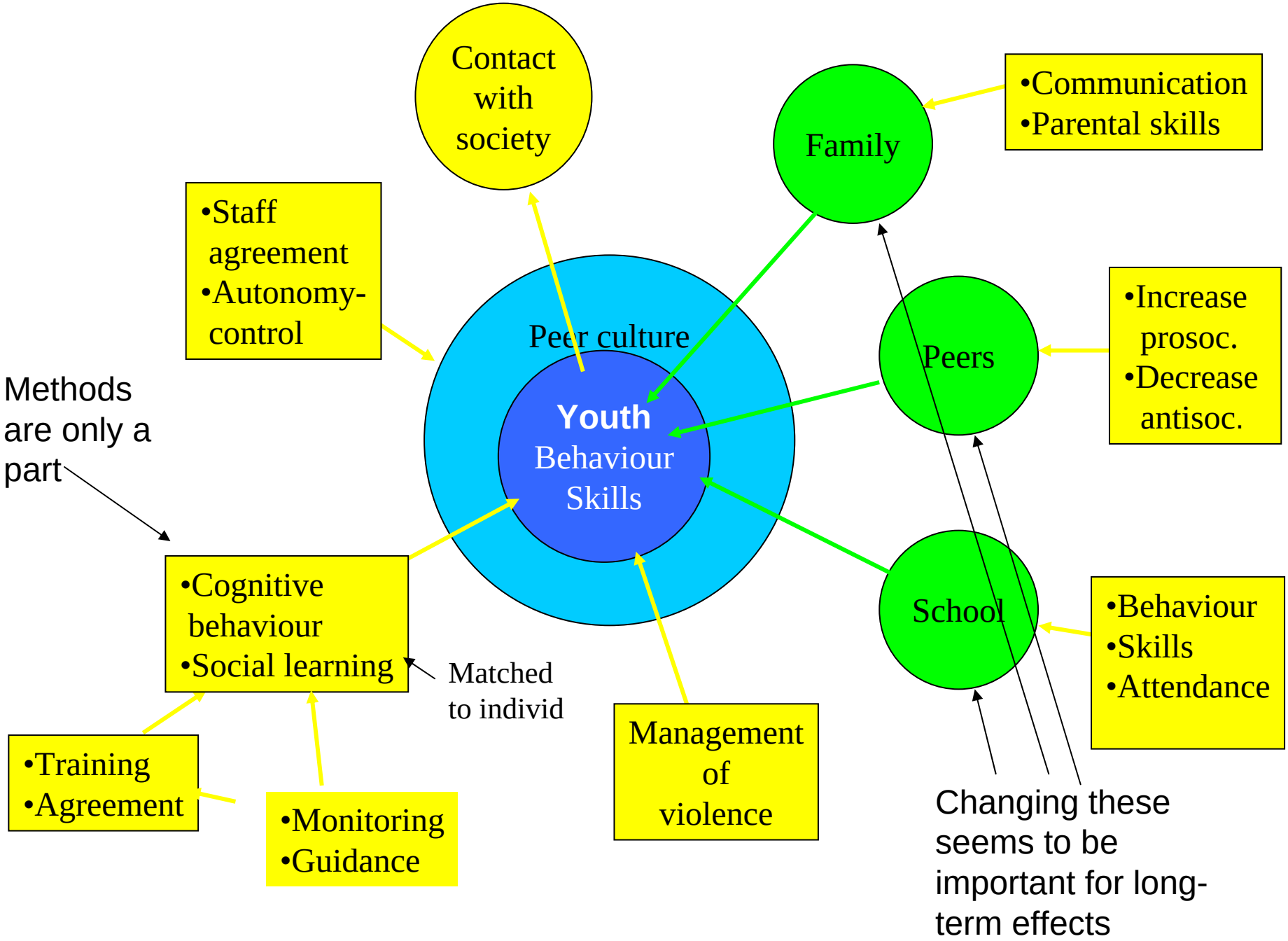
- There should be a focus on individual differences. Responsivity factors should be assessed.

- The treatment climate has to be balanced between autonomy/support and control/structure (firm but fair).

- The staff need competence in how to prevent and manage violent behaviour in a constructive way.

- There has to be an aftercare integrated into the treatment process, with focus on the criminogenic needs.

- There has to be systems to monitor the treatment integrity/fidelity.


Contact with society
Family
•Communication
•Parental skills
•Staff agreement
•Autonomy-control
Peer culture
Youth
Behaviour
Skills
Peers
•Increase prosoc.
•Decrease antisoc.
Methods are only a part
•Cognitive behaviour
•Social learning
Matched to individ
School
•Behaviour
•Skills
•Attendance
•Training
•Agreement
•Monitoring
•Guidance
Management of violence
Changing these seems to be important for long-term effects

Organizing the treatment

- The risk for negative influence from antisocial peers implies that the period of time used in residential setting should be as short as possibly.

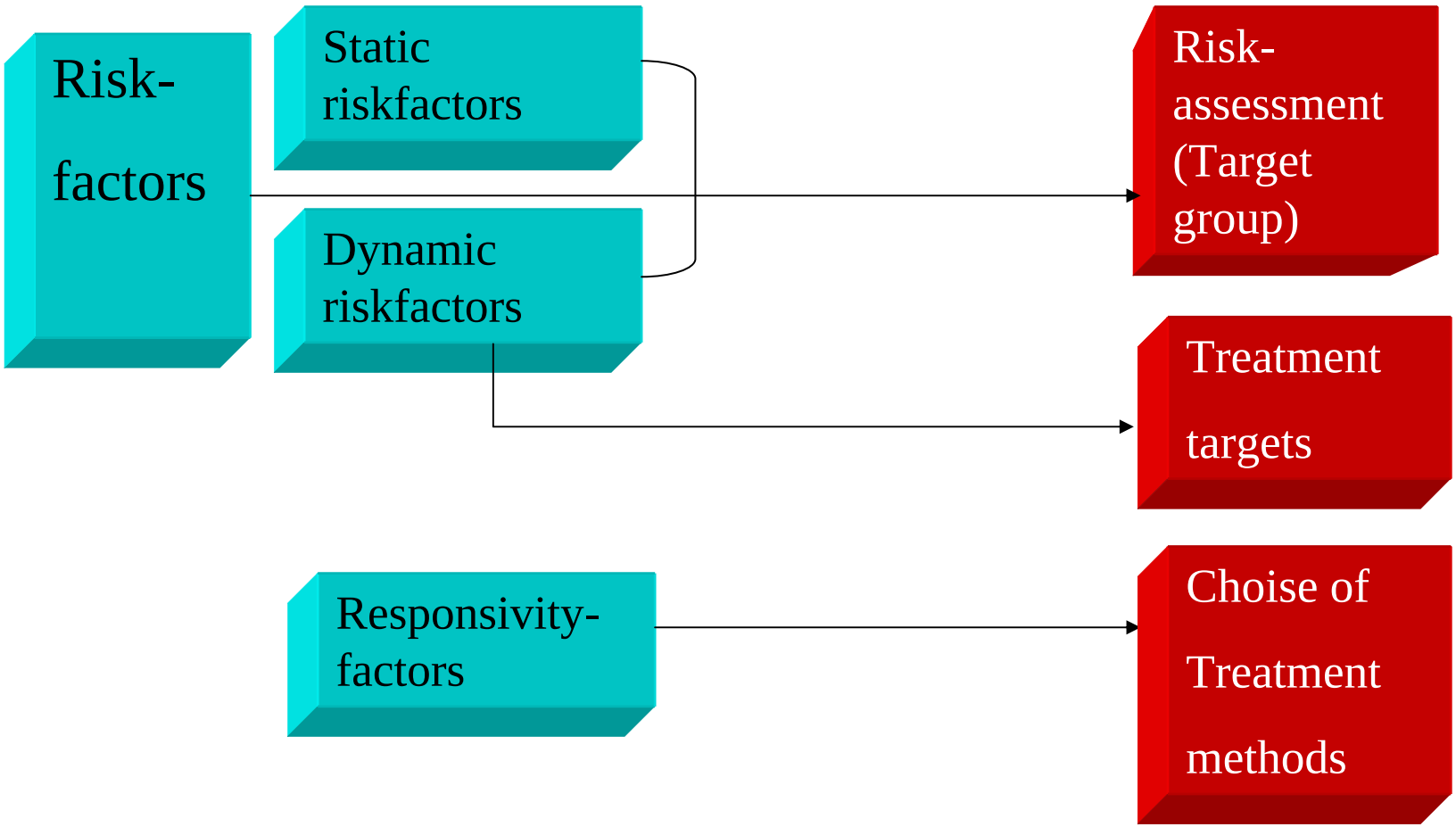
- The goal of the treatment in residential setting should not be complete changes in behaviour and criminogenic needs, but to equip the youth with neccesary skills to profit from home-based treatment interventions.

- Treatment that take place in residential setting should be seen as a time-limited part of the total treatment process. The aftercare is equally important.

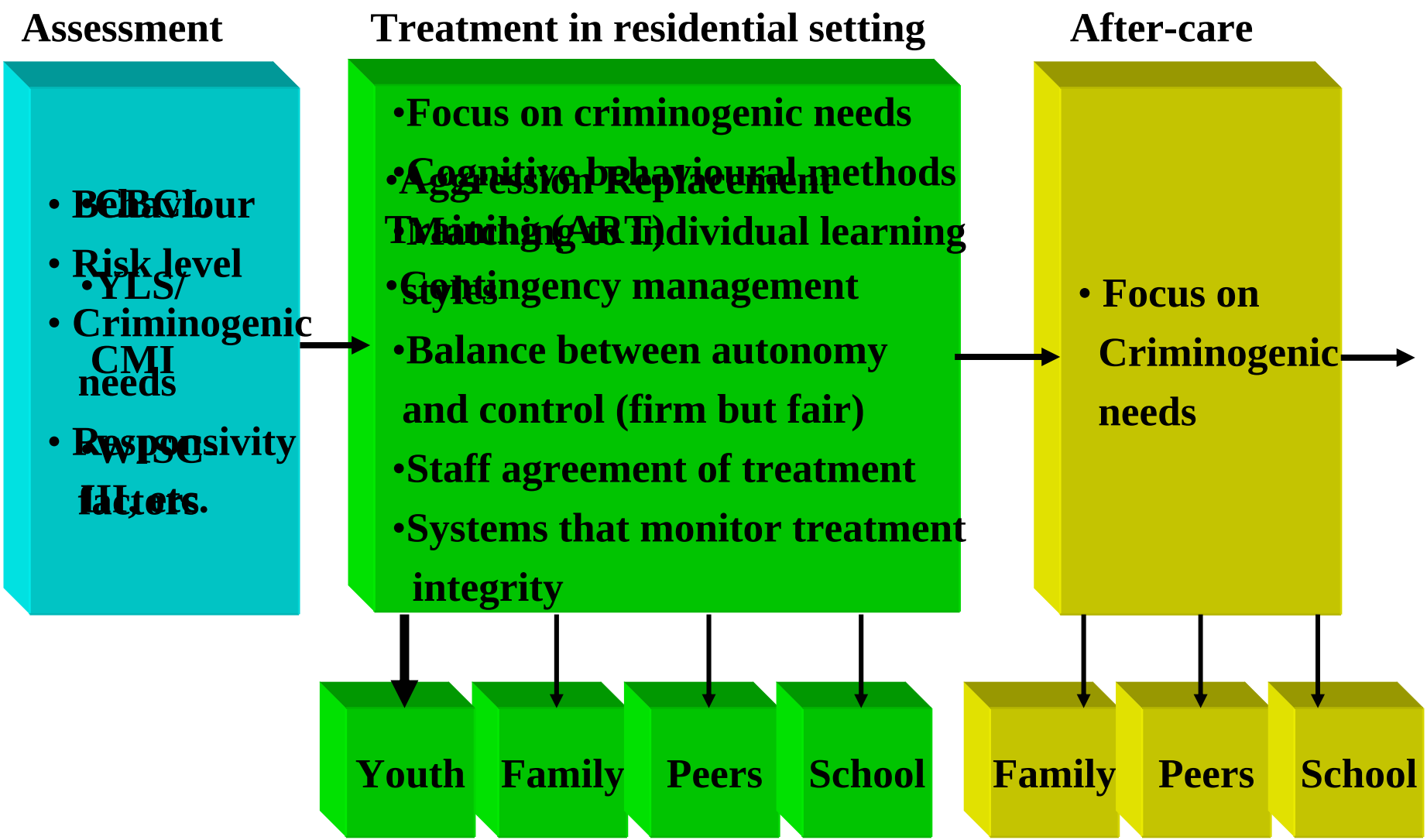
Implementing of the Residential Treatment Model

- Assessment
- Residential Treatment (duration of 6 months)
- Aftercare (duration of 3-4 months)

Assessment


Risk-
factors
Static
riskfactors
Dynamic
riskfactors
Risk-
assessment
(Target
group)
Treatment
targets
Responsivity-
factors
Choise of
Treatment
methods

Treatment process in three stages



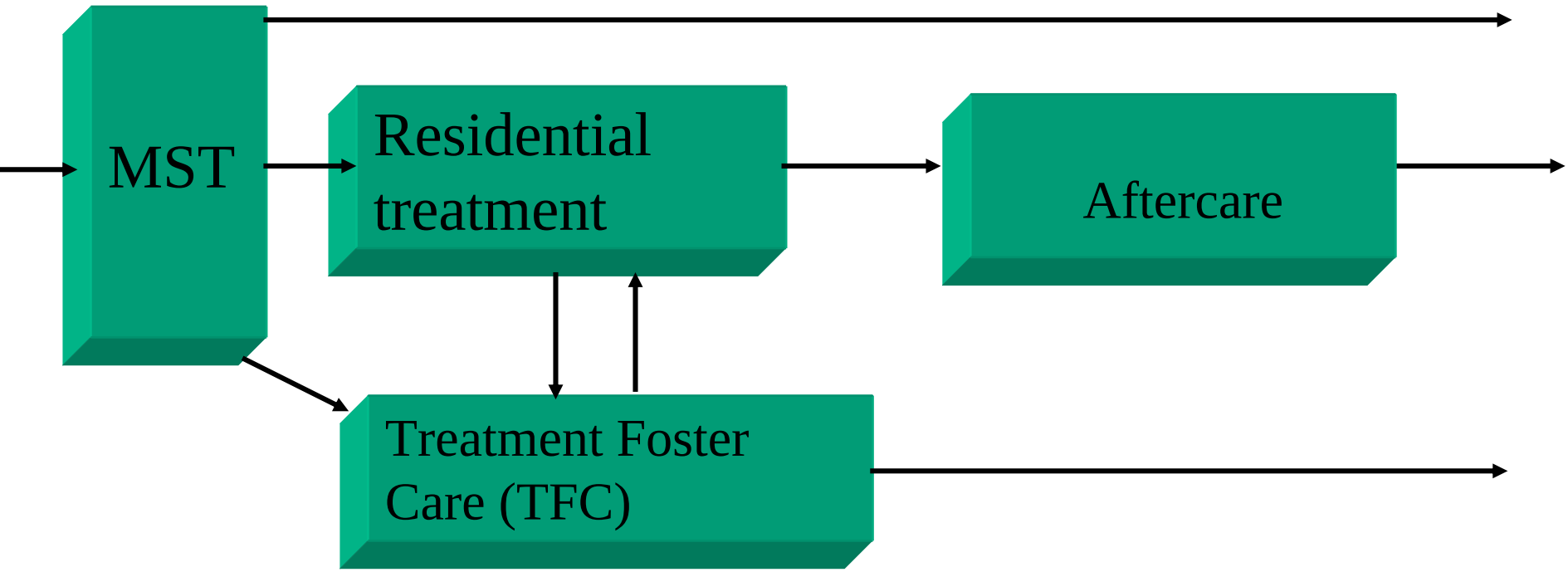
RESIDENTIAL TREATMENT AS A PART OF THE TREATMENT SYSTEM

- Treatment of antisocial behaviour is demanding, and it is difficult to make an effective residential program last over time.

- Interventions outside residential setting should be preferred whenever possibly.

- Residential treatment plays an important role for those who are not eligible for home-based interventions, or for whom it does not work.

Residential treatment based on these principles may have an important role combined with other treatment interventions



They are all different ways of doing the same in different settings, and they are all based on the same understanding of problem behaviour.