

What Works and What Doesn't in Reducing Recidivism with Youthful Offenders: Understanding the Principles of Effective Intervention

By Edward J. Latessa

The Meaning of Evidence

In creating programs to reduce recidivism, evidence can mean several things. Edward Latessa makes a distinction between a lower form of evidence- anecdotes, opinions, testimonials, etc., and a higher form, for which successful programming is paramount. This evidence is empirical. It is the result of peer-reviewed research, tested data-sets, and controlled studies. Programs whose success is measurable and proven through this form merit the title "Evidence-based."

What the Evidence Tells Us

A large body of existing and ongoing research is telling us that correctional services and interventions can indeed be effective for reducing recidivism, however, not all programs are equally effective. The most effective are based on certain principles when intervening:

- **Risk (who needs intervention)**
- **Need (what should be targeted to reduce risk)**
- **Treatment (how we intervene)**
- **Fidelity (whether the program is implemented as designed)**

1. The Risk (who) Principle

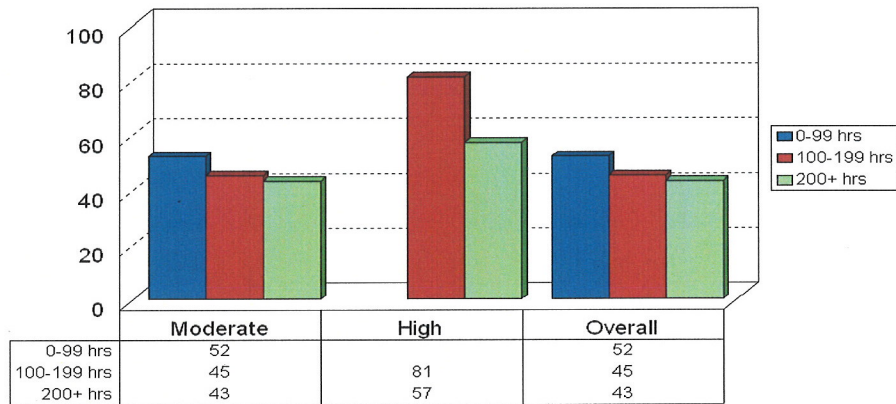
Effective programs are those that target those youth with higher probability of recidivism, and provide most intensive treatment to higher risk youth. However, it must also be taken into account that intensive treatment for lower risk youth can actually increase recidivism

Unfortunately, even with evidence-based programs, there will be those who fail. A typical cross-section of failure rates looks like this:

- If you have 100 high risk youth, about 60% will fail
- If you put them in a well designed, evidence-based program (for sufficient duration), you may reduce the failure rate to about 40%
- If you have 100 low risk youthful offenders, about 10% will fail
- If you put them in the same evidence-based program mentioned above, the failure rate will increase to 20%

A rule of thumb when providing treatment is 100 hours for those with moderate risk, and 200+ hours for those who are higher risk. This is because studies have shown 100 hours for high risk juveniles usually has no effect.

Recidivism Rates by Intensity and Risk Level



Studies have shown that when lower risk juveniles are placed in programs alongside those who are higher risk, they tend to learn more anti-social behavior from them. Also, when lower risk youth make friends with higher risk youth, pro-social networks like family, community, friends, and other supports are disrupted.

2. The Need (what) Principle

What are the problems we need to address? Certain behaviors, beliefs, and attitudes that juveniles display are warning signs for risky behavior now and in the future. Good programs thus need to identify these risk factors so we know exactly what we are treating and how to treat it. Studies have shown a juvenile is at risk when he or she has:

- Anti-social/pro-criminal attitudes, values, and beliefs
- Pro-criminal associates and isolation from anti-criminal individuals
- Temperamental and anti-social personality patterns conducive to criminal activity, like:

- Weak socialization with others growing up
- Impulsivity
- Adventurous behavior
- Restless/aggressive behavior
- Egocentrism (“I matter more than others”)
- A taste for risk
- Weak problem-solving skills
- Weak self-regulation/coping skills
- A history of anti-social behavior
- Familial factors, like:
 - Having family members who are criminals
 - Family members who have psychological problems
 - Members who show low levels of affection, caring and cohesiveness
 - Parents with poor supervision and discipline practices
 - And parents exhibiting outright neglect and/or abuse
- Low levels of personal, educational, vocational, or financial achievement
- Low levels of involvement in pro-social leisure activities
- Substance Abuse

3. The Treatment (how) Principle

The treatment principle requires that programs use a behavioral approach to target risk factors. There are several important attributes: focus on current risk factors, and use action oriented techniques that attempt to teach youth new ways to behave by practicing and reinforcing appropriate behavior. Two of the most effective interventions for juveniles are:

A. Family-Based Intervention

B. Cognitive Intervention

Both of these interventions rely on what’s called “behavioral” treatment. Behavioral treatments are those that see the behavior of the juvenile as the target for therapy. For example, both of the above techniques provide a structured environment for juveniles to learn social skills. As juveniles learn to practice these skills and behave in pro-social ways; mental, cognitive, emotional, familial, communal, and other forms of well-being tend to follow.

A. Family-Based Intervention

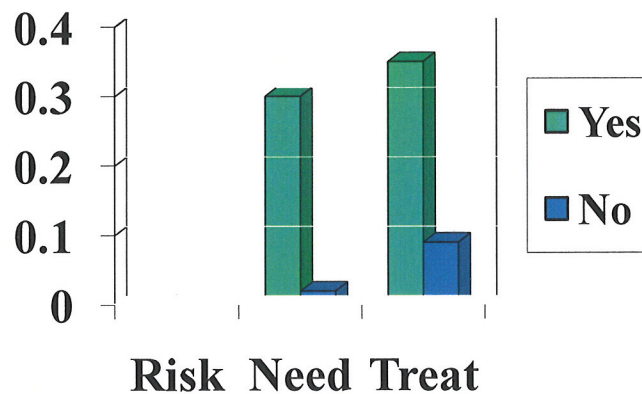
These interventions train family members in appropriate relational techniques, though different programs approach this goal in different ways. Four such programs have been identified and proven through evidence to be successful in reducing recidivism:

- Functional Family Therapy
- Multi-Systemic Therapy
- Teaching Family Model
- Strengthening Families Program

After 38 primary studies and 53 effects tests, the average reduction in recidivism between these programs was an astounding 21%, though variability was broad (-0.17 - +0.83)

Dowden & Andrews, 2003

Mean Effect Sizes: Whether or not the family intervention adheres to the principles



B. Cognitive Intervention

Cognitive interventions are treatments that wish to change juvenile behavior by influencing thinking patterns in positive, healthy directions. If unhealthy, destructive thinking patterns can be reoriented this way, then positive behavioral outcomes may follow, and chances for the juvenile's success will increase. This type of intervention carries with it a number of assumptions:

- That thinking affects behavior
- That anti-social, distorted, unproductive, and irrational thinking can lead to anti-social, distorted, unproductive, and irrational behavior
- Thinking can be influenced
- And that we can change how we feel and behave by changing how we think

58 peer-reviewed studies, featuring 19 random samples, 23 matched samples, and 16 convenience samples, found that cognitive-behavioral therapy reduced recidivism by 25% on average, but the most effective configurations found reductions of more than 50%.

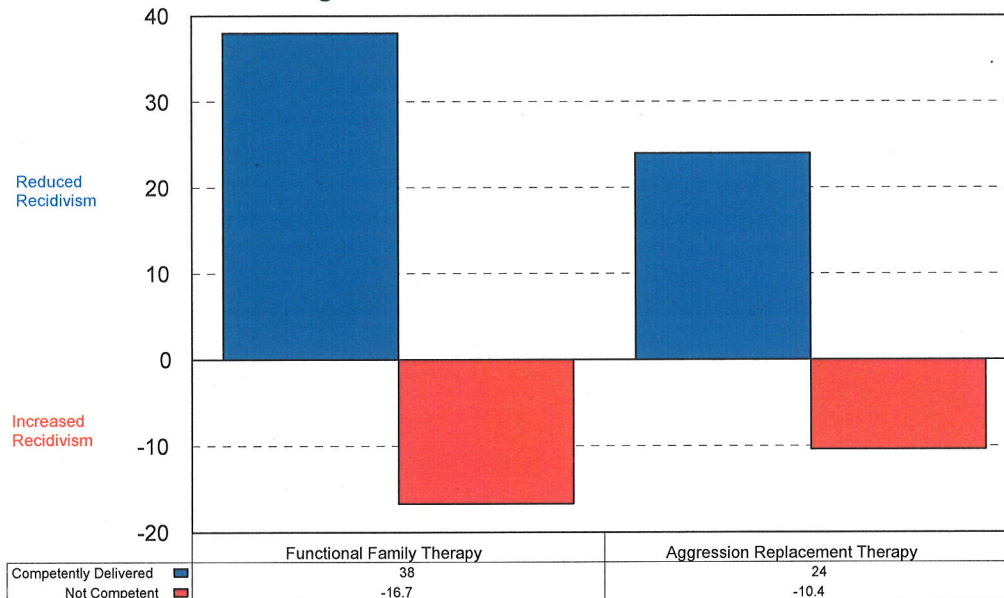
Effects were stronger if...

- There were 2 or more sessions per week (Treatment)
- Implementation was monitored (Fidelity)
- There was a higher proportion of juveniles completing treatment (Responsivity)
- The offenders being treated were higher-risk... (Risk)
- Cognitive-behavioral therapy was combined with other services (Need)

4. The Fidelity (how well) Principle

Finally, the most reliable programs use evidence to evaluate their success. Evidence-based programs like those featured here assure their validity by internal and external quality assurance.

Effects of Quality Programs Delivery for Evidenced Based Programs for Youth Offenders



Source: Outcome Evaluation of Washington State's Research-Based Programs for Juvenile Offenders. January 2004. Washington State Institute for Public Policy.

What Doesn't Work with Juvenile Offenders?

1. Programs that cannot maintain fidelity
2. Programs that do not target the problems underlying criminal behavior
3. Drug education and prevention programs focused on fear and other emotional appeals
4. Shaming offenders
5. Non-directive, client centered approach
6. Expressive therapy (art therapy, poetry/writing therapy, etc.)
7. Talking cures
8. Self-help or self-esteem programs
9. Vague, unstructured rehabilitation programs
10. Treatment plans using the medical model (regarding juvenile behavior as a disease)
11. Programs that claim to "punish smarter" (boot camps, scared-straight programs)

References

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