A Dialectical Behaviour Therapy program was created for female offenders supervised by Wollongong Community Offender Services (COS). The cohort, nicknamed ‘Messy Women’ by case managers, had been difficult to engage in established offender programs or interventions, creating high levels of distress and frustration. Consultations with specialist psychologists indicated that these female offenders would likely meet the diagnostic criteria for Borderline Personality Disorder (BPD) and as such they could respond well to DBT. Following these consultations, the COS District Office, in partnership with the University of Wollongong Northfields Clinic, developed a modified DBT program and trialled its use for this particular client group over a ten month period from October 2010. This case study outlines (1) why a new approach was required with this client group, (2) the reasons for using DBT and the modifications that were made to the basic DBT approach for this client group, (3) the issues and challenges which arose during the delivery of the program in a community correctional setting and (4) the results of an initial evaluation of the program’s effectiveness. The results suggest that the DBT approach was well-received by both the female offenders and the COS staff and that it has had success in reducing some of the difficult behaviours characteristic of the client group. The program also appears effective in the management of these ‘messy women’ within a community corrections context in Australia.
PART I: CONTEXTS

Who are the ‘messy women’ and can we devise a better way to work with them?

In 2007 Corrective Services NSW (CSNSW) staff at the Community Offender Services (COS) District Office in Wollongong, New South Wales, undertook a needs analysis in order to determine if there was a better way to address the needs of their difficult-to-work-with female offenders. The impetus for this analysis was a challenge made by Bob Tsapsilis—then program manager for St John of God hospital in Burwood, NSW—who asked District Office staff who they thought were the most difficult and challenging clients to supervise in the community. Probation and Parole Officers (PPO) unanimously identified a group of high needs clients who they grouped under the sobriquet ‘messy women’. These clients were very difficult to supervise, were hard to place or retain in standard offender programs and often did not meet the criteria for on-referral to community based mental health services. Experienced PPOs expressed intense frustration at the difficulties of working with this group of women. They asserted that, while they had exerted a lot of effort to assist the women address their critical issues, they later felt manipulated or ineffectual.

PPOs identified the following characteristics as common to these ‘messy women’:

- have been in co-dependent, abusive relationships
- had their children removed from their care by Department of Community Services’ intervention
- had their first pregnancy (primagravida) at an early age
- have been repeat victims or perpetrators of domestic abuse
- were sexually abused when they were young
- are manipulative, though often in genuine crisis
- have problems with finances
- have difficulties with getting transport for legal appointments
- lack positive social support
- had interrupted education
- lack education and employment skills
- have negative associates and links with criminal networks
- have a pattern of unsatisfactory relationships
- have low self-esteem
- have mental health disorders especially anxiety and depression
- have poor organisational skills
- do not follow-through even when appearing motivated
- have been dependent on Centre link benefits
- have a history of conflict with government agencies
- poor attendance in programs
- have high rates of re-offence
- have had repeated unsuccessful interventions
- display aggression, uncontrolled weeping, attention seeking behaviour
- are demanding of staff time.

When presented with the above list, Tsapsilis suggested the characteristics of the ‘messy women’ fit a diagnosis of Borderline Personality Disorder (BPD) and advised that the Dialectic Behaviour Treatment (DBT) program may assist staff to manage this complex group.

The American Psychiatric Association’s (1994, p.710) Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) describes people with Borderline Personality Disorder as having a pervasive pattern of unstable and intense interpersonal relationships, poor self-image, affective instability and marked impulsivity beginning in early adulthood and present in a variety of contexts, as indicated by five (or more) of the following characteristics:

1. frantic efforts to avoid real or imagined abandonment. Note: Does not include suicidal or self-mutilating behaviour covered in Criterion 5.

2. a pattern of unstable and intense interpersonal relationships characterized by alternating between extremes of idealization and devaluation

3. identity disturbance: markedly and persistently unstable self-image or sense of self
4. impulsivity in at least two areas that are potentially self-damaging (e.g. spending, sex, substance abuse, reckless driving, binge eating). Note: Does not include suicidal or self-mutilating behaviour covered in Criterion 5.

5. recurrent suicidal behaviour, gestures, threats or self-mutilating behaviour

6. affective instability due to a marked reactivity of mood (e.g. intense episodic dysphoria, irritability or anxiety usually lasting a few hours and only rarely more than a few days)

7. chronic feelings of emptiness

8. inappropriate, intense anger or difficulty controlling anger (e.g. frequent displays of temper, constant anger, recurrent physical fights)

9. transient, stress-related paranoid ideation or severe dissociative symptoms.

**Overview of Dialectical Behaviour Therapy**

Dialectical behaviour therapy was originally developed by Marsha Linehan to treat people with borderline personality disorder. DBT combines standard cognitive-behavioural techniques for emotion regulation and reality-testing with concepts of distress tolerance, acceptance, and mindful awareness largely derived from Buddhist meditative practice (Linehan 1993).

Linehan’s (1993) DBT program is structured in such a way that participants are taught to develop skills across four main themes:

- **Core Mindfulness Skills** – These skills are the ‘vehicles for balancing the “emotion mind” and “reasonable mind” to achieve a “wise mind”. [...] The “mindfulness what skills” include learning to observe, to describe and to participate. [...] The “mindfulness how skills” have to do with how one attends, describes and participates’ (Linehan 1993, p.63-64).

- **Interpersonal Effectiveness Skills** – ‘This [module’s] goal is to teach clients how to apply specific interpersonal problem-solving, social and assertiveness skills to modify aversive environments and to obtain their goals in interpersonal encounters’ (Linehan 1993, p.70).

- **Emotion Regulation Skills** – The aim of this module is ‘to understand one’s emotions, reduce emotional vulnerability and decrease emotional suffering’ (Linehan 1993, p.86).

- **Distress Tolerance Skills** – This module is concerned with developing ‘skills for tolerating and surviving crises [and] skills for accepting life as it is in the moment’ (Linehan 1993, p.97).

DBT emphasises four areas “that have not received as much attention in traditional cognitive-behavioural applications:

- the emphasis on acceptance and validation of behaviour as it is in the moment
- the emphasis on treating therapy-interfering behaviours of both client and therapist
- the emphasis on therapeutic relationships as essential to the treatment
- the emphasis on dialectic processes” (Linehan 1993, p.5).

Chris Allan, Director of Northfields Clinic, University of Wollongong, agreed with Tsapsilis that DBT may be an appropriate and potentially successful program approach to working with this group of offenders.

By early 2008, COS district office management had decided to investigate establishing an office based DBT program. The University of Wollongong offered to support the initiative by providing a clinical psychologist to co-facilitate the program, clinical supervision and basic evaluation tools and a partnership was established.
Would DBT work for our clients?

Anticipated Challenges

In 2008-09 several meetings were held to examine the potential challenges involved in running a DBT program in a community corrections setting. A cursory review of the literature revealed that there were no studies that demonstrated whether the use of a DBT approach would work for this particular client group: that is, community supervised female clients who may have significant BPD traits complicated by co-morbid issues likely to include anti-social personality traits, anxiety disorder and substance abuse.

Several potential challenges to the successful implementation of DBT in a community corrections setting were identified in relation to:

1. **Best Practice.** DBT group therapy practitioners have developed best practice frameworks that recognise the need for intensive long term support of participants and facilitators, while also establishing firm boundaries around attendance. The elements of this approach include: (a) firm entry/attendance rules; (b) group matching; (c) clinical assessment prior to commencement; (d) concurrent one-to-one therapy; (e) clinical supervision of facilitators; and (f) recommended two years of group work. The partners recognised that these elements were crucial to the sustainability and effectiveness of such a program. But they were also aware that the DBT program that they planned to run would be unable to match all the elements of a ‘best practice’ approach.

2. **Identifying Participants.** In a dynamic government service setting that targets offending behaviour, how would COS district staff be able to identify which clients might have BPD and could be appropriate for the DBT program? Even psychologists and psychiatrists are rarely able to confidently diagnose BPD in clinical settings when working with self-motivated private clients. Clearly correctional staff would find it quite challenging to correctly diagnose BPD among forensic clients who typically have an array of co-morbidity issues such as alcohol and drug dependence, psychiatric disorders (e.g. schizophrenia and bi-polar disorders), cognitive impairment and post traumatic distress disorder. Could an offender’s suitability for the DBT program be based on an educated guess? What if an offender was wrongly assessed as having BPD and considered suitable for the DBT program? Would this misdiagnosis cause harm to the participant?

3. **Responsivity vs. Criminogenic Needs.** CSNSW has for many years worked towards focusing its intervention strategies and group programs towards directly addressing the criminogenic needs of its clients. In such a paradigm, a personality disorder would be classified as a responsivity factor and therefore be less of a priority when it came to allocating resources. Although a strong belief was held by those involved in the partnership that successful engagement of the target group in DBT would reduce the participants’ involvement in the legal system, no research could be found that supported or refuted such a belief.

Visions for establishing a state-wide research-based program were floated in the meetings. Suggestions were made to have: (1) thorough pre-group assessments; (2) a ‘treatment as usual’ group being ‘blind-selected’; (3) psychologists being available by phone for participants seven days a week; and (4) strict rules on program attendance. But as the scale and complexity of program delivery increased, those involved in the partnership realised that it would be very difficult to run the program with all these requirements.

In terms of program content and delivery, Allan advocated taking the simplest and most targeted approach. The DBT program would be simplified by the facilitators to match the participants’ capacity. There would be one session, once a week at COS. While it would be ideal if the participants had individual psychological support, the partners agreed that this would not be necessary. It was agreed that it would be
ideal if all of the clients had been formally diagnosed with BPD prior to commencing the program. However, rather than waiting for a formal diagnosis, each client would be interviewed by one, or both, of the facilitators to determine whether they showed significant symptoms of BPD and as such could be appropriately referred to the DBT program.

In addition, a student psychologist on placement at the Wollongong COS District Office administered two tests – the Depression Anxiety Stress Scale 21 (DASS21) and the Personality Assessment Inventory – Borderline Features (PAI – BOR) - at approximately Week 4 of the program. The DASS21 measures the severity of a number of symptoms related to depression and anxiety, while the PAI-BOR is a measure of BPD features. Both tests are self-reported; that is, they consist of questions answered independently by participants. Data from the PAI-BOR indicated that all of the participants demonstrated features of BPD, suggesting that the initial clinical interviews had resulted in the selection of appropriate participants for the group.

**Program Partnership Arrangements**

In 2009, Northfields Clinic, based in the psychology department at University of Wollongong, formally entered into a partnership with Wollongong COS to establish a DBT program for female offenders. It was agreed that Northfields would identify therapists who would deliver the program with a COS co-facilitator. These therapists would be clinical psychologists undertaking doctoral work with the University. Northfields would provide supervision and training for COS co-facilitators and assist CSNSW to formulate a set of guidelines to help establish programs targeting personality disorders in other CSNSW sites. On 17 May 2010, the Commissioner of CSNSW approved the business case the partnership had prepared.

CSNSW provided Northfields Clinic with $15,000 to assist in covering the costs of providing a clinical psychologist to jointly facilitate the DBT program at Wollongong COS District Office over the initial ten months of the program (2010-11). All additional costs involved in establishing and maintaining this program have been borne by each of the program partners. Northfields estimated the cash value of its investment in the program as around $10,000.

**Training and Supervision Arrangements**

The DBT program was co-facilitated by a doctoral candidate in Psychology at the University of Wollongong, and a Unit Leader at Wollongong COS District Office. The COS facilitator was provided with DBT program specific training by the psychologists from Northfields. In addition, Northfields provided BPD awareness training for COS staff in 2008. Further training was conducted in 2010 by a Behaviour Management Specialist from CSNSW. COS staff were invited to attend annual conferences held by the University of Wollongong on the subject of personality disorders. The Northfields Clinic Director agreed to provide clinical supervision to both facilitators on a fortnightly basis during the pilot program.

**PART II: IMPLEMENTATION**

**Adapting DBT to a community corrections setting**

The partnership between Wollongong COS and Northfields raised the issue of how to combine correctional services with community based psychological therapy. Wollongong COS often employs individuals from community agencies to co-facilitate internal CSNSW offender programs. However, the partnership with Northfields was the first time at Wollongong COS that an external agency would have joint responsibility with COS for planning, developing and delivering a program within the COS environment. It was necessary to develop clear operating principles and a framework which would capitalise on the benefits of the partnership and pull together the organisational cultures of the two different agencies.

'Messy Women': A case study of the adaptation of Dialectical Behaviour Therapy for a group of difficult to engage offenders
The DBT program delivered to COS clients did not depart significantly from the content of Linehan’s program. However, to accommodate the fact that some of the participants had developmental disabilities, attention problems, literacy issues and education deficits, some of the more conceptual materials were omitted and some exercises were modified to make these more relevant to the participants’ experiences. More significantly, the program’s structure was changed to suit the unique demands of the community corrections environment. For example, a ‘rolling entry’ system was introduced to allow offenders who had just been released into the community to join the program midstream and to allow participants to exit, if they chose to do so, when their orders ended.

It was anticipated that COS clients would balk at the idea of a 32-week program and a modular structure was therefore adopted. Each of the four topics was delivered in a four-week module. In accordance with Linehan’s model, the four modules were then repeated with the complete DBT program delivered in a total of 32 weeks. A new intake of participants was introduced every eight weeks, after delivery of two modules. The clients were asked to commit initially to one four-week module which most participants found reasonable. Facilitators hoped that participants would engage well and would be motivated to participate in further modules.

Also considered in developing the program were strategies to address the difficulties experienced by staff in supervising high-needs female offenders, which was the initial impetus behind the project. Some of the issues which made supervision so difficult were identified as follows: client resistance, unreliability and a high level of mistrust. The partners aspired to create an ethos for the DBT program which could set it apart from interventions that had not been successful with this client group.

**The Question of the Criminogenic**

Offender programs or interventions in CSNSW are typically overtly linked to offending behaviour in that they are either offence-specific (e.g. the Sober Driver Program or the Domestic Abuse Program) or directed towards specific criminogenic issues (e.g. anger management or substance abuse).

The piloted DBT program did not seek to modify Linehan’s DBT model to target offending behaviour in accordance with standard CSNSW practice. Rather, the vision underpinning the program was that it would help participants to develop skills that could improve their lives. At the same time, it became apparent that the issues which made the lives of the participants most difficult were precisely the issues that had brought them into contact with the criminal justice system and resulted in their repeated ‘failures’ under supervision. Their distress, their efforts to avoid overwhelming emotions, the ever-present threat of abandonment, and their unstable identities were all intensely bound up with their substance abuse, violent behaviour and impulsivity. It was assumed that ‘improving participants’ lives’, although not specifically an offence-related goal could be precisely the way to address these clients’ offending behaviour.

The broader CSNSW approach does recognise problems of responsivity, factoring them into the case planning process and often addressing them in short preparatory programs or through individual treatment options. CSNSW also acknowledges that criminogenic and responsivity issues are not mutually exclusive and that the issues which lead to offending are often the same issues which can affect a person’s response to supervision and intervention. In essence, then, the approach adopted for the COS DBT program was consistent with the broad CSNSW framework, although it perhaps shifted the emphasis typical of program-style intervention.

**The Question of Voluntary Participation in Programs**

The issue of voluntary participation in programs clearly differentiates the CSNSW context from the therapeutic work conducted by community based agencies such as Northfields. Clients of CSNSW are, of course, mandated to be under the supervision of COS staff as part of their participation...
sentence. Implicit in the supervision process is the understanding that those who fail to abide by the conditions of their sentences are likely to be punished.

This is not to say that interventions conducted in this context cannot be fruitful. There is a significant amount of research (e.g. Benfield, Farrington & Leschied, 2001; McGuire, 2002; Trotter, 2006; Rooney, 2009; Sheehan, McIvor & Trotter, 2011) addressing the issue of working effectively with mandated clients and these ideas underpin much of the work done in CSNSW. Even at an anecdotal level, many clients who are initially resistant eventually report that they have benefitted from the programs they have been directed to undertake.

Still, given the specific issues faced by the target group in the pilot program, the project partners felt that the COS DBT program should seek to minimise the degree to which the anxieties and ‘acting out’ of these clients would be exacerbated by their presence in a corrections context. It was felt that the program’s ethos should be founded on the concepts of voluntary participation, commitment, ownership and choice. Of course, the partners recognised that such notions of choice are complex in the context of the corrective services environment, and this was acknowledged in the development of the DBT program. Nonetheless, within the obvious limitations of this environment, strategies were adopted to make the notion of choice as meaningful as possible.

For example, the process of assessing and selecting participants was designed with this aim in mind. A substantial portion of the initial clinical interview was devoted to motivational work, assessing the client’s level of commitment to the group and identifying possible barriers to her participation. The referred clients were advised that they were not required to participate in the program and would not be in breach of their orders if they chose not to join. However, the co-facilitators asked clients to commit to attending at least one four-week module, after which they could revisit the process and consider their options.

As this suggests, a degree of flexibility relatively unusual in CSNSW programs was built into the program. If participants were not committed to the group, they were able to leave without penalty (albeit with the understanding that their supervising officer may then direct them to undertake an alternative intervention). Similarly, if a participant missed three sessions in a row she would be withdrawn from the program, but could return at the next intake without sanction or penalty.

Finally, people were permitted to continue to attend the program once their orders had expired, which is not permissible in any other COS program. Interestingly, although participants were positive about the idea of this latter possibility, no one actually took advantage of it. Nonetheless, the option was made overtly available as part of the unique ‘feels’ of this group.

The Question of Safety

The ethos developed for the DBT program was also designed to promote an environment in which clients would feel safe enough to work with the overwhelming emotional and personality issues at the heart of the difficulties they experienced in their own lives and in their responses to COS supervision.

Many of the group members held long-standing and entrenched negative beliefs and assumptions about how they were viewed and treated, believing, for example, that everyone judged them and no-one cared about their problems. The mistrust, guardedness, hostility and reactivity which tended to characterise all of their relationships were perhaps particularly pronounced in their interactions with agents of authority, including the PPOs supervising them. Many of the group members also had very low opinions of psychologists and repeatedly expressed negative views about them. Significant effort was required to earn the trust of the participants and ensure that they felt safe in the group. In this context, remaining genuine and non-punitive in interactions with group members was vitally important, even if it would have been easier to use the opposite approach at times to enforce certain issues.
The principles which underpinned the COS DBT program were aimed at creating a 'sanctuary' where participants could feel safe and could trust what was happening in the room. It was anticipated that at least some of the participants might perceive this as a space different in some respects to the one they generally saw themselves as occupying in Corrective Services.

**PART III: CHALLENGES IN IMPLEMENTING THE PROGRAM**

Given the target population and the novelty of applying DBT to this specific group, it was anticipated that significant challenges would arise during implementation of the program, despite the strategies adopted to foreground safety and wellbeing rather than offence-specific treatment. Numerous challenges arose during the course of the program and various strategies were adopted to manage them as effectively as possible. Overall, the challenges did not overshadow the ability of the facilitators to deliver the program, and nor did they undermine the positive outcomes reported by group members.

**Client-related challenges**

One of the inherent challenges in making the group non-compulsory was that group members who were not committed were likely to demonstrate this in their attending behaviour. And indeed, erratic attendance patterns did occur and were disruptive to the delivery of the program, making it difficult to establish consistency and to work through the program material at an adequate rate.

Attendance was treated as an important issue by referring to it explicitly when establishing the group frame and by enforcing consequences (for example, withdrawal upon missing three sessions). Barriers to consistent attendance, which included medical issues, depression, and conflict with partners and other family members, were explored. Various forms of motivational interviewing and identification of values and goals were used in order to reinforce the importance of attending the different modules.

Despite these strategies, some clients eventually stopped attending the program, another development which not entirely unexpected. Nonetheless, it was felt that, if participation in the group had been mandated and missed sessions had been treated as breaches, the atmosphere, the level of safety, and the level of willingness to participate would have been far less positive. There was an explicit aim to engender a sense of safety and respect, and to position group members’ wellbeing (rather than their offending behaviour) as paramount. As well, it was recognised that, as with any intervention, clients need to be at an appropriate 'stage of change' in order for them to genuinely engage in any intervention process.

Another challenge was keeping group members focused, participating and 'present' while in the room. Some clients treated the program as an opportunity to be part of a social support group and were less interested in learning the skills offered as part of the program content. Program delivery was affected by the disruptive behaviours of some participants, such as not turning off mobile phones, not paying attention while the facilitator was talking, and venting openly about personal experiences unrelated to the topic being discussed. Hence it was a challenge to 'hook' the participants and to keep them in the program long enough so they could realise that the skills they had been taught could help to improve their situations.

The DBT program required participants to complete take-home tasks and practise the skills they had learnt. This was another major challenge and group members were quick to offer excuses for not doing the tasks, most of which revolved around the general theme that their chaotic lives prevented them from practising any of the skills outside the group room. Participants were not acquiring the skills that they would have developed if they were able to practise these daily. This in turn hampered the facilitators’ ability to work through the course material at a reasonable pace.
The energy and passion of the facilitators had a positive impact on group members’ level of motivation and commitment. However, some form of crisis would frequently arise for group members and take priority over their level of interest and commitment to the group. The focus on experiential exercises and in-session skills practice (a hallmark of DBT) helped group members to remain ‘present’ and see the benefits for themselves. The emphasis on the idea of ‘seeing what works for you’ and infusing work around values, in order to build a perspective as to why participants should learn these skills, also helped facilitate commitment and motivation.

Standard techniques to manage group dynamics were effective, which was somewhat surprising given the cohort. Anticipated challenges regarding group members failing to get along with one another did not arise and there were no problems with aggressive or disrespectful behaviour, which had been anticipated given the nature of the target group. On the contrary, group members worked to achieve a sense of safety and group cohesion. They were generally polite and cooperative with one another, and welcoming of new group members. When this observation was shared with participants, they said they felt safe, respected and understood in the group and therefore did not feel a need to be aggressive or defensive.

**Facilitator-related challenges**

A significant challenge for the facilitators was the tension between process and content. The program participants were women who typically had crisis-ridden lives, difficulties with regulating their emotions, limited resources, housing problems, poor impulse-control, and numerous mental health issues. As a result, there was a tension between trying to get through the material and ensuring that adequate empathy and validation were conveyed to the women regarding the personal experiences that were brought up during the program.

The facilitators were also anxious about how to manage the often extreme and overwhelming emotions that group members brought into the room. One of the characteristic behaviours of this client group is to avoid or seek to escape their emotions when possible, and so encouraging them to engage in emotional exposure could at times fill the room with a combustible mixture of emotions and counter transference reactions.

Initially, the facilitators struggled with the intensity of emotions. They were wary of engaging in any emotional processing that could inadvertently lead clients to decompensate, yet they felt the clients needed this in order to harness the skills in more meaningful ways. However, once the facilitators acknowledged their own anxiety and it had been addressed in supervision, they were able to ‘sit with’ this anxiety and use it to model effective emotional exposure and processing with the clients. Following this there were substantial shifts in group cohesion, understanding of material, and general commitment to the program, and there were also important shifts in individual behaviour.

Clinical supervision was crucial to addressing facilitator-related challenges. Having a clinical psychologist experienced in providing supervision to professionals who work with people with personality disorders was invaluable in helping the facilitators contain their emotional reactions and work through frustrations, concerns, and anxieties. Supervision allowed the facilitators to continually work towards achieving a healthy balance of process and content, and model healthy ways of responding to emotions. As a result, an interesting paradox formed in that, as sessions became more intense and there was more room for exposure to powerful emotions, group members reported feeling safer and program content was covered more effectively and meaningfully.

Another important factor in these positive developments was the rapport developed between the program facilitators and their similar attitudes regarding important elements of the group. Having a psychologist and a COS staff member co-facilitate the group provided opportunities for different professional viewpoints and skills to merge. Treating group members with respect, ensuring they felt safe to
share, being genuine, and using humour were all the things that facilitated a good working atmosphere, and helped to provide a strong foundation for addressing many of the challenges that arose.

PART IV: OUTCOMES

The data collected over the duration of the program was primarily qualitative and anecdotal. The sample size was small but there is adequate information to suggest that a committed program focus on treating personality disorders can improve supervision outcomes for high needs female offenders in a community corrections setting.

The following sources of information were used to assess the outcomes of the pilot project:

- PPOs who were supervising clients participating in the program were asked to fill out a questionnaire at around Week 16 of the program. They were asked to identify whether they had noticed any changes in the participants’ behaviour.
- Informal feedback was obtained from PPOs over the course of the program regarding their discussions with clients about the program and the general progress of participants.
- Co-facilitators observed the participants’ behaviour over the course of the program.
- Co-facilitators solicited feedback from program participants at various points during the program. Some participants gave feedback without any prodding.

Data on reoffending was sourced from departmental records.

On the basis of the available information, the following observations can be made about the outcomes of the DBT program:

1. A total of 16 people started the group at some point over the 32 weeks, each attending at least one session. Of these:
   - seven clients completed at least four modules;
   - one completed three modules only
   - one completed two modules only
   - three completed one module only
   - four did not complete even one module (these clients attended only one to two sessions before dropping out).

This was a higher completion rate than anticipated and it was noted that the people who did complete the program had not previously engaged successfully with intervention.

2. Of the nine people who completed at least two modules, only one was charged with a new offence during the course of the program. This person had previously been convicted of a violent offence and the new offence was a driving matter which may be regarded as a reduction in the severity of offending. Clearly more research data would be needed to establish whether the DBT program had an impact on the recidivism rates of those who completed the program. Nonetheless, it is interesting to note that several of these clients had had past patterns of frequent offending but were not charged with any offences during the course of the program.

3. Staff members were asked to comment on the changes in the women who completed substantial portions (that is, at least two modules) of the program. Staff identified the following marked improvements: there was a reduction in anger and aggression in clients’ presentation; their dealings with government agencies (Centrelink, Community Services, and Housing) were more effective; they had more stable relationships; and they experienced fewer crisis situations. Six participants reported forming new positive relationships, ending abusive relationships or stabilising previously chaotic relationships.

4. At a general level, the facilitators observed that participants became more open to the ideas being presented and more willing to volunteer information as the group coalesced and bonded. They noticed that interactions between group members were respectful and
supportive, reflecting the approach they had sought to model.

5. Of those people who completed at least two modules of the program, a very high commitment to program participation was noted. This was evidenced by the fact that participants would attend despite having to deal with a range of personal issues such as illness, child care demands, emotional difficulties, Court matters, financial limitations and family problems. Feedback from participants indicated that their strong commitment to the program was due to the ongoing motivational work of the co-facilitators as well as to the environment created within the group.

6. Several people made significant positive life decisions, joined new social groups and undertook education. When their achievements were discussed with them, they attributed their improved quality of life in part to their participation in the group.

7. Feedback from clients indicated that they regarded the group as providing an environment of safety and support which they saw as positive for their self-esteem. They commented that they did not feel judged or likened to ‘criminals’ in the group, which they described as a rare experience for them. They also indicated that participation in the group had significantly changed their previous negative perceptions of both psychologists and Corrective Services staff. This feedback suggested that the principles on which the program had been built had a significant impact on participants’ response to the group, to the program content and more generally, to the supervision process.

**CONCLUSION**

If the outcomes can be summarised in terms of the objectives of the program, it is possible to say that there have been some improvements in the quality of the participants’ lives and that this has improved the ability of COS staff to supervise effectively this group of clients. The program has clearly demonstrated that a partnership between a university-based organisation and a community corrections office can be effective in delivering a long term program for complex forensic clients. The COS-Northfields partnership offers many exciting possibilities for work with vulnerable high-needs female offenders across CSNSW. In 2010, the NSW Government established the University of Wollongong as the NSW ‘Centre of Excellence for research into the treatment for personality disorders’. The partnership between Northfields and CSNSW could provide significant benefits to forensic clients.

Clearly, there are some aspects of the program which could be improved, especially in relation to developing strategies that would encourage program attendance and completion. Given the specific issues facing this client group, future research should go beyond investigating recidivism measures and include exploring questions around participants’ contact with other services, entering or remaining in abusive relationships and the quality of relationships with children, partners, family and friends.
REFERENCES


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