FORUM

on Corrections Research

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Featured issues

"What Works" in Corrections

Offender assessment

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Program evaluation

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FORUM on Corrections Research

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Articles should be written in plain language. Complicated research and statistical terms should be avoided. However, if they are unavoidable, a clear explanation of the meaning of the term should be provided. FORUM reaches about 6,000 individuals in more than 35 countries, including academics, the public, journalists, corrections staff (from front-line staff to senior managers) and members of the judiciary. Our goal is to present reliable research to a **lay audience**.

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Ideally, articles should be 1,000 to 1,500 words in length (six double-spaced pages). Feature articles must be no longer than 2,000 words.

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A Compendium on "What Works" in Offender Programming

by ***Larry Motiuk*** *and* ***Ralph C. Serin***[1]
Research Branch, Correctional Service of Canada

In Canada, the number of provincial/territorial prison admissions increased by 22.5% between 1990-91 and 1992-93 from 207,946 to 245,746. Similarly, federal admissions increased 21.4% between 1990-91 and 1993-94 (peaking one year later than provinces/ territories) from 4,646 to 5,642. The increase in admissions contributed in large measure to the rapid growth of the Canadian federal/provincial/territorial prison population in the early 1990s. Moreover, the total actual-in prison population rose by 16% between 1990-91 and 1994-95 from 29,224 to 33,882.[2]

Because of this growth in the prison population, the Federal/ Provincial/Territorial Ministers Responsible for Justice asked Deputy Ministers and Heads of Corrections to identify options to deal effectively with growing prison populations. A paper entitled 'Corrections Population Growth' was subsequently developed and presented to the Ministers in May 1996. An additional recommendation made in the First Report on Progress[3] *was "sharing research findings on offender program effectiveness". This recommendation inspired the formation of an expert advisory group to design and develop a 'Compendium on "What Works" in Offender Programming.' This article provides the background and framework for this work. Other articles in this issue of FORUM on Corrections Research give a synopsis of selected chapters from the Compendium.*

Background

The Correctional Service of Canada (CSC) was requested by the Federal, Provincial and Territorial (F/P/T) Heads of Corrections to convene an advisory group of international experts on effective correctional programming and develop a framework for a compendium on "what works" in offender programming. Subsequently, the Research Branch of CSC was approached to undertake a comprehensive review of the literature on effective correctional programs and evaluation methods. Accordingly, a leadership role was taken in assembling an expert advisory group, designing a compendium framework, compiling relevant program information and surveying best practices across the various jurisdictions in Canada.

The Expert Advisory Group

To create an expert advisory group, CSC identified and contracted with a number of well-known researchers/evaluators in the field of effective correctional programming. From Canada, there was Don Andrews (Carleton University), Paul Gendreau (University of New Brunswick), Alan Leschied (University of Western Ontario), and Joseph Couture (Athabaska University). From the United Kingdom, there was James McGuire (University of Liverpool). From Germany, Freidrich Losel (Universtat Erlangen-Nurnberg) and from the United States, Douglas Lipton (National Development and Research Institute). In conjunction with CSC Research Branch staff, these individuals comprised the expert advisory group tasked with drafting a framework for a compendium on "what works" in offender programming.

The Framework

For the expert advisory group, potential impacts of the compendium were seen as the following: meeting the needs of multiple users, from practitioners to administrators; sharing best practices among various jurisdictions; providing reasonable measures of evaluating program effectiveness, and, where possible, making recommendations regarding specific tools or instruments to assist staff in this regard; developing innovations in correctional programming; conducting ongoing research into program effectiveness; and enabling different jurisdictions to embrace technology transfer.

In March 1998, a second meeting of the advisory group was held to finalise the compendium framework that had arose from earlier discussions. At this meeting, some new members joined the advisory group. They included Jim Bonta (Department of the Solicitor General), Nicola Epprecht (Research Branch, CSC), and Kelley Blanchette (Research Branch, CSC). Following that meeting, the framework for a compendium on "what works" in offender programming was finalised and presented to the F/P/T Heads of Corrections for approval in May 1998. Consequently, the task of compiling a five part *'Compendium 2000 on Effective Correctional Programming'* was approved to move forward. While a massive research undertaking ensued, the sheer magnitude of it is beyond the scope of this article. However, an overview of the basic content of the two volumes is provided here.

Volume 1	Part 1.	Contributing to Effective Correctional Programs
	Part 2.	Correctional Programs/Intervention
	Part 3.	Evaluation
Volume 2	Part 4.	Inventory of Correctional Programs
	Part 5.	Best Practices

Part 1 — *Contributing to Effective Correctional Programs* — In addition to introducing the initiative and purpose of *Compendium 2000*, Part 1 includes a chapter outlining various definitions of correctional programs by James McGuire (University of Liverpool). Then there is a summarised version of the contribution by Paul Gendreau with Claire Goggin (University of New Brunswick), Francis Cullen (University of Cincinnati), and Don Andrews (Carleton University) that situates correctional programs within the context of criminal justice sanctions, including alternatives to incarceration. In this issue of FORUM, Jim Bonta (Department of the Solicitor General) provides a synopsis of his chapter on offender assessment. There is also a feature article on treatment responsivity by Sharon Kennedy (Ottawa Parole, CSC) and another on treatment resistance by Denise Preston (Research Branch, CSC). Other chapters in Part 1, not presented here, encompass principles of effective correctional programs, obstacles to effective correctional programs, implementation and staff issues.

Part 2 — *Correctional Programs/Intervention* — This part of *Compendium 2000* is organized to provide up-to-date overviews of the treatment literature for specific program areas. The content areas were selected for their relationship to criminality, such that when the appropriate intervention is applied to meet the need it might reasonably be expected to reduce re-offending behaviour. In this issue of FORUM on Corrections Research, Dennis Stevens (University of Massachusetts) discusses education programming. Christa Gillis (Research Branch, CSC) concentrates on offender employment. Alan Leschied (University of Western Ontario) details the program factors contributing to effectiveness for institutionalised and non-institutionalised young offenders. Bill Marshall (Queen's University) and Sharon Williams (Regional Treatment Centre — Ontario, CSC) explore the assessment and treatment of sex offenders. Ralph Serin and Denise Preston (Research Branch, CSC) investigate programming for violent offenders. Lynn Stewart (Programs Branch, CSC) and Rob Rowe (Carleton University) examine the problems of self-regulation among adult offenders. Other chapters in Part 2, not covered here, include programs for familial and intimacy violence, mentally disordered offenders, Aboriginal offenders, female offenders, and substance abusers.

Part 3 — *Evaluation* — This section of *Compendium 2000* provides evaluation guidelines for criminal justice policy makers, correctional administrators and program staff. For example, Gerry Gaes (United States Federal Bureau of Prisons) provides guidelines for asking the right questions and communicating results and Shelley Brown (Research Branch, CSC) examines cost effective correctional treatment. Part 3 of *Compendium 2000* also has chapters that look at a variety of other measurement issues.

Part 4 — *Inventory of Correctional Programs* — Using a standard protocol, the Research Branch surveyed the F/P/T jurisdictions regarding their correctional programs. The purpose of the survey was to provide an up-to-date inventory of all programs, both institutional and community-based, with an emphasis on effective programming. The survey incorporated program descriptions; development and evaluation; assessments of treatment need; and where applicable, outcome and/or financial data. This information can be used to determine the status of certain types of programs in different jurisdictions, to facilitate information exchange, and to assist in treatment planning for offenders throughout their involvement with the criminal justice system. As of April 2000, over 700 surveys from eleven (11) jurisdictions have been received.

Part 5 — *Best Practices* — Again, using a standard protocol, the F/P/T jurisdictions were invited to submit specific programs that they wished to highlight as a best practice. As of April 2000, 132 programs were nominated by their jurisdictions as a best practice.

The Deliverable

Compendium 2000 on Effective Correctional Programming provides a comprehensive and critical appraisal of the empirical literature in the field of corrections and behaviour change. More importantly, it provides new knowledge on program effectiveness, an overview of existing programs in Canadian correctional jurisdictions, and guidelines for evaluating operations and policy in the area of correctional programs. ■

[1] 340 Laurier Avenue West, Ottawa, Ontario, K1A 0P9.

[2] Statistics Canada. (1996). *Adult Correctional Services in Canada 1994-95*. Ottawa: Canadian Centre for Justice Statistics.

[3] Corrections Population Growth. (1997). First Report on Progress for Federal/ Provincial/Territorial Ministers Responsible for Justice. Fredericton, New Brunswick.

Defining correctional programs

by ***James McGuire***[1]
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Using interventions in forms that may be described as programs is not new, and there are examples of this kind of work dating back to the 1940s. The research indicates that the true era of development in this sphere commenced about in 1975. This article examines what correctional staff and researchers mean when they talk about a program. This is not as straightforward as it sounds, and it is difficult to arrive at a single, clear-cut, unassailable definition of correctional programs that will firmly demarcate them from other forms of activity conducted with individuals sentenced by criminal courts.

First, it will be helpful to set this in a broader context. Correctional programs as we currently observe them being implemented whether in institutional or community settings have a common primary objective. The desired changes may include imparting knowledge, acquisition of skills, or improved health. But in criminal justice services, this usually hinges upon the concept of *correction*: the adjustment of behaviour from a pattern that is criminal or anti-social to one that is more law-abiding or pro-social.

Correctional programming has numerous points of contact and degrees of overlap with other types of intervention that have the essential aim of engendering individual change on the basis of personal choice. This includes *education*, that focuses on helping individuals acquire knowledge and information. It includes *training*, which is designed to help people acquire manual or cognitive skills for application in the workplace. It also includes *therapy*, that is intended for alleviation of emotional distress and amelioration of symptoms of mental disorder. All of these processes also instil new modes of thinking and problem-solving that are transferable across situations, and often also new perceptions of and attitudes to the self. Thinking more broadly and considering how this would be viewed in a non Western cultural context, there are also similarities to processes of *healing*. Each of these domains is virtually impossible to define in any simple, satisfactory and mutually exclusive way.

Recently, in the wake of large-scale reviews of the effectiveness of psychological therapies, there has been a trend towards standardisation and *manualisation* of the procedures to be followed.[2] This is partly to allow systematic testing of interventions in carefully controlled research trials. But it is also designed to allow other practitioners to emulate the 'best practices' identified in such work. In addition, for those types of problems that are experienced by many clients, it has proved possible to develop *empirically supported treatments* the ingredients of which can be described in detail in accompanying therapist manuals. Over the last quarter of a century, a similar idea has progressively become implanted in correctional services, and today holds a position of some prominence.

Types and levels of interventions

The concept of *program* is now widely discussed in correctional settings, but evidently still means different things to different people. To refine the concept slightly, a useful starting point is to examine different approaches to crime prevention and to the intervention efforts that might be planned and delivered within each. For this purpose we can borrow a familiar distinction, made by Tolan, Guerra and Hammond,[3] between *primary, secondary* and *tertiary* crime prevention strategies.

Primary prevention consists of two different types of strategies. *Situational prevention* is designed to limit crime opportunities, sometimes by increased security measures, police patrols, video surveillance, target hardening, or the re-design of environments in residential or retail zones. Interventions of this type are sometimes referred to as programs; for example, neighbourhood watch programs. *Developmental prevention* entails provision of services to families and children in environments, such as socio-economically deprived neighbourhoods, with the aim of reducing long term difficulties including delinquency but also school dropout, mental health problems and substance abuse. Such developmental prevention programs have shown to be potentially highly effective; and in some instances, such as the *Perry Preschool Project*, have also been shown to be highly cost-effective over long-term follow-up intervals.

Secondary prevention is focused on known at-risk groups. This includes for example individuals who are identified as pre-delinquents, who are playing

truant from school, have conduct disorders, or are residents of child-care facilities. In some cases there may be evidence of development of delinquent or anti-social tendencies and efforts are directed towards averting subsequent involvement in juvenile offending. In other circumstances prevention may be broadly aimed at averting gang involvement or drug use in the school population as a whole.

Tertiary prevention is addressed to adjudicated offenders, those already convicted of crimes, with the objective of reducing rates of recidivism. This is the domain of correctional services and the subject-matter of the present article. Note however that correctional services need not be exclusively focused on tertiary prevention; for example youth justice teams may be engaged in some multi-agency programs with a secondary prevention focus.

Basic concept and definitions

To an extent, the way a correctional program is defined depends in part on what we consider to be the overall function of society's correctional efforts. This raises rather daunting philosophical questions, concerning the nature of justice or social order, which are beyond the scope of this article, but the fact that these issues are inter-dependent should be constantly borne in mind.

On scanning the literature it is possible to discover that the word 'program' is used in at least three separate though inter-related ways.

Definition one

The types of interventions known as *programs* may be employed at any of the levels mentioned above (primary, secondary, or tertiary), but for present purposes discussion will be limited to the tertiary, in which most correctional service agencies usually operate. Within this context, the typical program is a circumscribed set of activities, with an appointed objective, and consisting of a number of elements that are mutually inter-connected. In its first, strictest terms, a correctional program can be defined at its core as a planned sequence of learning opportunities delivered to adjudicated offenders with the general objective of reducing their subsequent criminal recidivism. From a behavioural perspective, it is intrinsic to this that a *constructional* approach is adopted. This entails the reduction of undesirable behaviour through the application of positive reinforcement procedures and repertoire-building techniques.

In its first, strictest terms, a correctional program can be defined at its core as a planned sequence of learning opportunities delivered to adjudicated offenders with the general objective of reducing their subsequent criminal recidivism.

This definition implies that a program has a specified objective and it should be possible for this to be clearly stated by its designers, users, evaluators and preferably also its participants. There may be intermediate objectives that in practice are only distantly connected to the goal of reducing recidivism; but the nature of any such linkage should be explained in supporting program documentation. There should be a planned sequence of activities; this might be called a curriculum: a series of sessions or a timetable. It is the physical representation of what is involved in trying to operationalize the program's objectives. The program should have internal coherence, in the sense that the activities that are planned can be shown to be justifiable for achieving the objectives. This should hold both *theoretically* (there is a sound model on which the design of the program is based) and *empirically* (there is evidence concerning its effectiveness, either as a totality or in terms of its components).

Definition two

In corrections the word *program* is also used in a second, broader and more flexible sense. For example, mentoring schemes for young offenders, or therapeutic communities for substance-abusing offenders are also referred to as programs. In the purer sense of definition one, the term is a misnomer. But it is possible to specify the objectives of both these processes and to define operationally what is intended to happen within them. Thus if the experiences which are to be arranged for participants can be adequately described, to the extent that other practitioners could adopt and replicate them, it is still accurate to use the word program as applicable to these interventions.

Activities such as mentoring, intensive supervision, or physical challenge do not however contain the detailed pre-planning or expectation of measured development that is a central feature of programs in definition one. Individual change may occur, but there is no explicit structure or designated sequence through which the participants progresses as is the case in, for example, a cognitive skills program.

This flexibility of nomenclature can lead to confusion. Mentoring may be an added element in a juvenile correctional service in which young offenders also participate in structured activities programs that would satisfy the first definition given above. That might similarly occur in the setting of a therapeutic community. Evidently, it is very difficult to delineate the outer limits of what is meant by a correctional program.

Definition three

Taking a far broader perspective, MacKenzie[4] has classified criminal justice interventions into six separate but overlapping groups, as follows.

- *Incapacitation*. Removing the offender's capacity to commit crimes, usually through detention (incarceration).
- *Deterrence*. Punitive sanctions which as a result of the infliction of pain or discomfort will deter individual offenders subjected to them (specific deterrence) or other potential offenders and members of the public-at-large (general deterrence). The primary means of accomplishing this is through restriction of liberty but additional sanctions may also be applied as in a correctional boot camp.
- *Rehabilitation*. Provision of treatment or allied forms of intervention designed to alter the thoughts, feelings or behaviour of individual offenders.
- *Community restraints*. This includes surveillance, supervision, or other methods of closely monitoring an individual's behaviour or sphere of activities such as to preclude engagement with crime opportunities.
- *Structure, discipline and challenge*. Physically (and sometimes mentally) demanding experiences designed to influence the individuals' attitudes in a positive way or to act as a deterrent against further criminality.
- *Combining rehabilitation and restraint*. An amalgamation of methods of treatment with methods of surveillance or limitation of liberty that will enforce compliance with requirements.

This constitutes, potentially, a third definition of the word "program". It may be important however to distinguish between the above aspects which are structures of the criminal justice system and that flow directly from judicial sentencing; and efforts made by other correctional agencies to introduce active change ingredients into the context set by this framework. While it is a widespread public expectation that the sentence of a court will in itself have an impact on offenders, there is little evidence to support this supposition. Examination of data concerning the differential impact of sentencing on recidivism, using official criminal statistics and making comparisons between predicted and actual rates of re-offending amongst large samples, shows that sentencing *per se* is largely irrelevant to outcome[5]. It is on this basis that Andrews has argued that the sentence can only ever be the starting condition for programmatic intervention.[6]

We might also question whether punishment and deterrence can be conceptualised as *programs*. From a layperson's standpoint, the *raison-d'être* of criminal justice is to punish offenders for their wrongdoing. Punishment is, metaphorically speaking, the correctional equivalent of cosmic background radiation in physics; pervasive and ever-present.

Perhaps the focal defining aspect of a program does not reside in the kinds of external, directly observable components described earlier. Rather, the pivotal feature could be the proposed *vehicle of change*. This is the mechanism within a program which it is presumed (or preferably, firmly demonstrated) will produce the difference in recidivism that is the program designer's and the agency's ultimate goal.

Varieties of offender programs

One of the recurrent difficulties of defining programs on the basis of available literature is that descriptions of them are often used in loose, overlapping, and sometimes incompatible ways. The same program can be conceptualised in different terms depending on which aspect of it is highlighted. In addition, reviewers of research (including meta-analysts) invariably develop their own classification or coding systems when grouping programs together to compare effect sizes. Thus, an interpersonal skills program could be defined straightforwardly by that label. But equally, it could be categorised the headings *skills-training, behavioural*, or *cognitive* depending on which aspect of it a reviewer perceived as most salient. Alternatively, as a function of its location in correctional services, it might instead be subsumed under some other title

Dimensions of variation in programs

Theoretical model. Programs differ according to the models of crime causation or of individual change on which they are based. Whilst the most successful programs to date involve applications of cognitive/social-learning models, many other approaches exist and have obtained modest and occasionally larger effect sizes.

Treatment targets (criminogenic needs). It is essential, if programs are to be effective in changing risk of future offending, that they are focused on aspects of individuals' functioning that have been shown to be linked to criminal acts. Programs vary in the number, range, and degree of inter-relatedness of such targets.

Dosage. Programs also vary simply in the numbers and duration of staff-client contacts; in their intensity over time; and in their overall time-scale of delivery. Following the risk principle it would be expected that there will be a correspondence between risk levels and assignment to different degrees of program intensity; but this relationship may not be linear.

Criminal justice setting. The most immediately obvious aspect of this is whether programs are delivered in institutions or in the community. Programs also vary in respect of the kind of agency within which they are run, the point during sentences when programming is carried out, and the amount of access to other services concurrently.

Sentencing context. The nature of the sentence imposed may have a direct influence on program delivery, as it will influence the amount of control in the hands of correctional staff, with potential consequences for the degree of participation by offenders.

Specificity. There are differences between programs in terms of the specificity of their objectives. Whereas some may have a very precise focus on a single problem area (e.g., anger management), others may have very broad objectives and a wide spectrum of treatment targets. Given the findings from large-scale reviews concerning their superior effectiveness, multi-modal programs, using a combination of targets and methods of working, are usually seen as more powerful agents of change.

Program portfolios. Within a single institution there may be a range of program opportunities. Correctional planning principles can then suggest the most appropriate array of programs for an inmate, moving for example from generic, broad-ranging and multi-modal programs to others with more specific treatment targets.

Programs also differ in other respects, for example whether they are designed for delivery on an individual or group basis. Both for reasons of economy and for the other advantages gained from joint activity and collaborative learning, a majority of extant programs are based on a group format.

Target population

Another important issue is that of who should participate in a program. In one sense that may seem obvious: the offender allocated to take part. However, it can be tentatively suggested that the more support individuals have from different aspects of their social environments, the likelier it is that they will achieve change. Some programs, therefore, include significant others as participants.

Safeguarding integrity

Regardless of precisely how programs are defined and their ingredients assembled together, certain issues are now seen as paramount in ensuring that they are properly delivered. Lipsey found marked differences in effectiveness between programs that were thoroughly monitored and those that were not.[7] Moncher and Prinz found that the integrity of delivery of a program has been shown to be vitally important in mental health settings.[8]

Thus, all commentators in this field now acknowledge that it is vital that programs be delivered as planned. Procedures need to be in place to monitor this process, and to furnish feedback to program managers or external consultants. The maintenance of program integrity is known to be dependent on appropriate training of staff, provision of adequate resources, good communication between designers, managers and tutors of programs, availability of supervision, and use of some means of measuring client level of participation and change over time.

Equally, many of these tasks will be facilitated if clearly presented manuals and other associated materials support the program itself. Both the program as a whole and its constituent sessions should have clearly stipulated objectives. This is a foundation for many other aspects of the work: unless staff involved in delivering a program can visualise the required contents of sessions, their mode of delivery is likely to deteriorate. During training, staff should practise delivery and have opportunities to be observed by trainers. There should in addition be a clearly defined set of staff competency criteria to be met by those delivering the program. All of these components are products of the core definition of the program and its objectives by its planners. Whatever the nature of a program, it is crucial that these aspects can be clearly defined, if other aspects of delivery are not to become confused and dysfunctional as a result.

Accreditation process

Informed by the steadily accumulating body of treatment-outcome research in work with offenders, correctional services, in several countries, are seeking to establish well-validated intervention programs together with methods of monitoring their application. The optimal route selected by a number of services is the development of procedures for *accreditation* of programs designed to reduce recidivism.

In addition to program accreditation, each location in correctional services (a prison, probation office, or other unit) must also satisfactorily meet criteria for *site accreditation*. This is part of a process of certifying program and treatment integrity at that site. Systems for collecting monitoring information must be in place, and the data so collected made available for an annual *site audit*. Audit reports are then scrutinised both by correctional agency staff and by members of the independent accreditation panel.

Program implementation and delivery

Several authors have provided valuable guidelines for sensibly directing this process. Reflecting on the general context of installing new programs in organisational settings, Bernfeld, Blase and Fixsen have advocated the adoption of a *multi-level systems perspective*.[9] This entails focusing on four separate but related levels of analysis: *client*; *program*; *organisation*; and *societal*. Programs should not be seen in isolation but as parts of an interactive, dynamic and evolving whole. Using different terminology but addressing essentially the same issues and problems, Harris and Smith have discussed how to implement programmatic developments in community-based correctional services.[10] More recently, Gendreau, Goggin and Smith have forwarded a set of systematised principles for guiding the total process of program implementation.[11] ■

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Compendium 2000 on Effective Correctional Programming

This issue of **FORUM** *is comprised of selected and summarized chapters drawn from the Federal/Provincial/Territorial Heads of Corrections, 'Compendium 2000 on Effective Correctional Programming',* ***Volume 1****, that will be published later this year.*

The effects of community sanctions and incarceration on recidivism

By ***Paul Gendreau*** *and* ***Claire Goggin***[1]
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Within recent years "get tough" strategies have become the latest panacea for dealing with offenders. This article quantitatively summarizes a substantial body of literature that assesses the effectiveness of two types of "get tough" programmes: community sanctions and incarceration. A brief history of the development of these initiatives is provided accompanied by a meta-analytic summary of the data.

Community sanctions

At one time, some of the services provided in probation and parole settings adhered to a dynamic rehabilitative model wherein it was gratifying to discover well-conceptualized programmes of sound therapeutic integrity.[4] Reductions in recidivism of 20%-60% were reported for some of these programmes.

What kinds of programmes were these? First, treatment staff conformed to the principles and techniques of the therapies they were employing. Secondly, staff were carefully monitored by the programme developers who themselves had excellent skills in behavioural treatment and their assessments, with ongoing training being frequently provided. Thirdly, offenders' individual differences relative to varying styles of service delivery were considered. Finally, the programmes were intense; contact between offenders and therapist was frequent and focussed on learning pro-social skills.

The following three programmes best illustrate the above. The first of these, by Walter and Mills,[5] was a behavioural employment programme for juvenile probationers utilizing a token economy, contingency contracting, and life skills interventions. The programme was admirable in that its treatment design intimately linked the courts with community-based employers who were trained as paraprofessional behaviour modifiers. The second example came from Andrews and Kiessling's[6] Canadian Volunteers in Corrections Programme which combined professionals with paraprofessionals in an adult probation supervision programme. The major features of the counselling and supervision practices were the use of authority, anti-criminal modelling and reinforcement, and problem-solving techniques. The quality of interpersonal relationships was also considered when pairing offenders with probation and parole officers. The theoretical importance of this study should not be understated as the treatment guidelines employed herein were instrumental to the continuing development of the principles of effective correctional treatment literature.[7]

Thirdly, there was a series of studies by Davidson, Robinson, and Seidman that featured an amalgam of behavioural techniques, relationships skills training, child advocacy, and matching of offenders and therapists.[8] As community psychologists, they were among the first researchers to be aware of the need to overcome system-based barriers in delivering effective interventions.

Just when it seemed, however, that progress was being made in the confirmation and promulgation of effective services for probation and parole, a counterrevolution began to evolve: the new epoch of punishment-based strategies.[9] The reasons why this new epoch gained favour is reviewed elsewhere.[10] With the exception of occasional reports of successful intervention programmes in probation and parole, distinct forms of "get tough" strategies known as intermediate sanctions began to proliferate in probation and parole settings. The term "intermediate" was derived from the notion that deterrence strategies based on excessive use of incarceration were too crude and expensive while regular probation (with or without treatment services), on the other hand, was too "soft". Interestingly, some proponents of intermediate sanctions asserted that probation could be even more punishing than prison.[11] The most common form of intermediate sanction was intensive supervision programming (ISP). As Billie J. Erwin so forcefully put it when referring to the Georgia ISP, considered by many to be a model for the United States: "...We are in the business of increasing the heat on probationers...satisfying the public's demand for just punishment...Criminals must be punished for their misdeeds".[12]

This new generation of ISPs quickly spread throughout the United States, and to a much lesser extent, within Canada. They turned up the heat by: greatly increasing contact between supervisors and offenders; confining offenders to their homes; enforcing curfews; submitting offenders to random drug testing; requiring offenders to pay restitution to victims; electronically monitoring offenders, and requiring offenders to pay for the privilege of being supervised. Most ISPs have employed arbitrary combinations of the above sanction types in varying degrees with the major emphasis for most being an increase in the frequency of offender-probation/parole contacts. Boot camps and quick/brief arrests or citations, often in response to spousal abuse offences, are other types of sanctions that may fall under the intermediate sanctions umbrella.

Besides serving an underlying retributive purpose and reducing prison overcrowding costs, an important expectation was that ISPs would effect pro-social conformity through the threat of punishment.[13]

How well are intermediate sanctions working? So far they appear to be "widening the net" by targeting low-risk offenders who would normally receive periods of regular probation. The data indicate that the use of intermediate sanctions can increase the number of technical violations and lead to higher rates of incarceration.[14] As to recidivism, we found little evidence of the effectiveness of intermediate sanctions among this sample of studies. These results are illustrated in Table 1. Of note, a positive correlation indicates that the sanction was associated with an increase in recidivism while a negative correlation means the sanction has suppressed or decreased recidivism. Within Category 1, ISPs, there were 47 comparisons of the recidivism rates of offenders in an ISP with those receiving regular probation. These comparisons involved 19,403 offenders with a mean treatment effect of .00, expressed as a phi coefficient (Φ), indicating no difference in percentage recidivism rates between the two groups. The recidivism rate for each of the ISP and comparison groups was 29%.

The confidence interval (CI) is a useful index of the likelihood that a given range of values will contain the "true" population parameter. In the case of ISPs, the CI about Φ is -.05 to .05, reflecting recidivism rates ranging from a 5 per cent reduction (Φ = -.05) to a 5 per cent increase (Φ = .05). Also of note, when a CI contains 0, one can infer a lack of significant treatment effects ($p>.05$).

The $z^{\pm}$ value is a weighted estimate of Φ. That is, each effect size is weighted by the inverse of its variance ($\sqrt{N - 3}$) thereby giving more emphasis to effect sizes generated with larger sample sizes. The $z^{\pm}$ for ISPs indicates that they were associated with a 6% increase in recidivism with an associated CI of .04 to .07.

Upon examining the mean Φ and $z^{\pm}$ values for each of the eight types of intermediate sanctions, one can see that 13 of the 16 CIs contain 0. Only in the case of restitution and fines was there any indication of a suppression of recidivism (i.e., CI did not include 0) but these results were criterion-dependent. A summary of the data from all of the eight categories produced mean effect sizes of .00 with a CI of -.02 to .03 for Φ, and .02 for $z^{\pm}$ with an associated CI of .01 to .03.

In fact, an examination of the effect sizes from intermediate sanctions that purported to provide a

Table 1

Mean Effect of Community Sanctions on Recidivism

Type of Sanction (k)	N	%E	%C	M Φ	CI Φ	$Z^{\pm}$	CI $z^{\pm}$
1. Intensive Supervision Programs (47)	19,403	29	29	.00	–.05 to .05	.06	.04 to .07
2. Arrest (24)	7,779	38	39	.01	–.05 to .04	.00	–.02 to .02
3. Fines (18)	7,162	41	45	–.04	–.08 to .00	–.04	–.06 to –.02
4. Restitution (17)	8,715	39	40	–.02	–.15 to –.01	.03	–.01 to .05
5. Boot Camp (13)	6,831	31	30	.00	–.05 to .08	.00	–.02 to .02
6. Scared Straight (12)	1,891	46	37	.07	–.05 to .18	.04	–.01 to .09
7. Drug Testing (3)	419	13	12	.05	–.12 to .12	.00	–.10 to .10
8. Electronic Monitoring (6)	1,414	6	4	.05	–.02 to .11	.03	–.02 to .08
9. Total (140)	53,614	33	33	.00	–.02 to .03	.02	–.01 to .03

Note. k = number of effect sizes per type of sanction; N = total sample size per type of treatment; %E = percentage recidivism for the group receiving the sanction; %C = percentage recidivism for the comparison group (regular probation); M Φ = mean phi per type of sanction; CI Φ = confidence interval about mean phi; $z^{\pm}$ = weighted estimation of phi per type of sanction; CI $z^{\pm}$ = confidence interval about $z^{\pm}$.

modicum of "treatment" — in each case the treatment was ill-defined and, therefore, impossible to assess as to quality — an interesting result was uncovered. The addition of a treatment component produced a 10% reduction in recidivism. On this evidence, one can tentatively conclude that the effectiveness of intermediate sanctions is mediated solely through the provision of treatment.

Incarceration

The view that the experience of prison in itself acts as a deterrent has a long history in criminal justice.[15] It is rooted in specific deterrence theory,[16] which predicts that individuals experiencing a more severe sanction are more likely to reduce their criminal activities in the future. Research strongly indicates that both the public and many policy-makers assume incarceration has powerful deterrent effects. Amongst academics, economists have taken the lead in support of the specific deterrence model.[17] They maintain that incarceration imposes direct and indirect costs on inmates (e.g., loss of income, stigmatization) such that, faced with the prospect of going to prison or after having experienced prison life, the rational individual would choose not to engage in further criminal activities.

What kind of data is used to support the hypothesis that prison time suppresses criminal behaviour? The most compelling evidence comes from some ecological studies where the results are based on rates or averages (aggregate data). An example of one of the most positive results came from a study by Fabelo[18] that reported a 30% increase in incarceration rates across 50 U.S. states, corresponding with a decrease of 5% in the crime rate for a five-year period. Fabelo's data has been interpreted as convincing evidence that prisons deter crime.

The addition of this body of evidence to the "what works" debate leads to the inescapable conclusion that, when it comes to reducing individual offender recidivism, the "only game in town" is appropriate cognitive-behavioural treatments which embody known principles of effective intervention.

To be fair to deterrence aficionados, we must acknowledge that there are a number of caveats about the potency of prison in this regard. These include the following: deterrent effects are more likely to be found among lower risk offenders, harsher prison living conditions, and aggregate data which tend to wildly inflate results in favour of deterrence.[19]

To return to the original question as to whether longer periods of incarceration are associated with reductions in recidivism, we examined two sets of data that addressed the above-noted caveats and provide the most exacting assessment of the issue to date. We located 222 comparisons of groups of offenders ($\underline{n}$ = 68,248) who spent more (an average of 30 months) versus less (an average of 17 months) time in prison. The groups were similar on approximately 1 to 5 risk factors. As seen in Table 2, offenders who did more time had slight increases in recidivism of 3% regardless of whether the effect sizes were unweighted ($\underline{\Phi}$) or weighted ($\underline{z}^{+}$).

The second sample involved 103 comparisons of 267,804 offenders who were either sent to prison for brief periods (only 18% of effect sizes had length of incarceration noted) or received a community-based sanction. Once again, the results from Table 2 indicate no deterrent effect. Using $\underline{\Phi}$ as a measure of outcome, we see an increase

Table 2

Mean phi ($\underline{\Phi}$) and mean weighted phi ($\underline{z}^{+}$) for More vs. Less and Incarceration vs. Community sanctions

Type of Sanction ($\underline{k}$)	$\underline{N}$	$\underline{M}\,\underline{\Phi}$ ($\underline{SD}$)	$\underline{CI}_{\Phi}$	$\underline{Z}^{+}$	$\underline{CI}_{\underline{z}+}$
1. More vs. Less (222)[a]	68,248	.03(.11)	.02 to .05	.03	.02 to .04
2. Incarceration vs. Community (103)[b]	267,804	.07(.12)	.05 to .09	.00	.00 to .00
3. Total (325)	336,052	.04(.12)	.03 to .06	.02	.02 to .02

Note: $\underline{k}$ = number of effect sizes per type of sanction; $\underline{N}$ = total sample size per type of sanction; $\underline{M}\,\underline{\Phi}$($\underline{SD}$) = mean phi and standard deviation per type of sanction; $\underline{CI}_{\Phi}$ = confidence interval about mean phi; $\underline{z}^{+}$ = weighted estimation of $\underline{\Phi}$ per type of sanction; $CI_{\underline{z}+}$ = confidence about $\underline{z}^{+}$.

[a] More vs. Less — mean prison time in months ($\underline{k}$ = 190): More = 30.0 mths, Less = 12.9 mths, Difference = 17.2 mths.

[b] Incarceration vs. Community — mean prison time in months ($\underline{k}$ = 19): 10.5 mths.

in recidivism of 7% but no effect (0%) when effect size is weighted by sample size.

Clearly, the prison as deterrent hypothesis is not supported. The opposite conclusion, and one that is widely endorsed in some correctional circles, is that prisons do increase recidivism, in other words act as "schools for crime". This is problematic in our view. The studies in this data base are sufficient information to adequately assess this question. Moreover, the design strength of many of the comparison groups leaves much be desired, albeit we found no correlation between quality of design and effect size (Φ). While this is the "best" available evidence with which to assess the enthusiastic claims of prison deterrence supporters, the only really satisfactory answer to this particular question is for prison authorities to periodically assess incarcerates on a comprehensive list of dynamic risk factors and correlate time served and changes in risk while incarcerated with future recidivism. This will prove, by far, to be the most sensitive analysis. Regrettably, evaluations of this type have rarely been reported in the corrections literature.

In summary, the addition of this body of evidence to the "what works" debate leads to the inescapable conclusion that, when it comes to reducing individual offender recidivism, the "only game in town" is appropriate cognitive-behavioural treatments which embody known principles of effective intervention.[20] ■

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Offender Assessment: General issues and considerations

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There are few activities in corrections as important as the assessment of offenders. An accurate assessment facilitates the fair, efficient and ethical classification of offenders. We are currently seeing a convergence in thinking about offender assessment that bridges the traditional concerns of safety, security and offender rehabilitation.

This article presents an overview of what we know about offender risk assessment. Our understanding of criminal behaviour influences our approach to offender assessments. Most theories of criminal behaviour can be grouped into three broad perspectives of criminal conduct, and each of these perspectives suggests different approaches to offender assessment. These three perspectives are: Sociological, Psychopathological, and General Personality and Social Psychological. This article presents evidence which leads to the conclusion that the General Personality and Social Psychological perspective encompass factors (dynamic) which best predict criminal behaviour.

Sociological perspectives

The sociological perspectives proposes that social, political and economic factors are responsible for crime. For example, poverty, lack of employment and educational opportunities, and systemic bias toward minority groups cause frustrations and motivations to engage in crime. These perspectives, in one form or another, say that society *creates* crime. That is, society is largely responsible for crime and the solution to crime rests in altering the social, political and economic situations of society's members.

Psychopathological perspectives

Within the psychopathological perspective, people commit criminal acts because there is something psychologically or emotionally wrong with them. Individuals disobey the laws and norms of society because of a neurosis, or they are following the commands of internal voices. They may have too much testosterone that drives them to commit sexual crimes or they have a neurological disorder that results in uncontrolled, violent behaviour. For the psychopathological theories, it does not matter if one is poor or not, from an ethnic minority or a politically powerless group.

General personality and social psychological perspectives

The general personality and social psychological perspectives emphasise the learning of attitudes, emotions and behaviours that lead to criminal conduct. The focus is the individual (like the psychopathological theories) but it is the learning experiences of the person that account for crime. It is not so much that the offender is "sick", but that the offender was exposed to situations that rewarded and encouraged antisocial behaviour. For example, a child who grows up in a home where the parent(s) allow aggressive and hostile behaviour, model antisocial attitudes and fail to direct the child in prosocial activities (e.g., school) and appropriate friendships, learns antisocial behaviour.

Each of the three perspectives directs our attention to different factors for understanding criminal behaviour. As a consequence, they suggest what should be assessed when dealing with offenders. Table 1 illustrates how the various perspectives forward certain variables as candidates for assessment.

Table 1

The Relationship Between Theory and Offender Assessment

Theoretical Perspective	Example Characteristics Assessed
Sociological	Social status (e.g., age, gender)
	Race and ethnicity
	Financial status
Psychopathological	Psychological discomfort (e.g., anxiety)
	Self-esteem
	Bizarre thoughts
General Personality & Social Psychological	Peer support for behaviour
	Employment instability
	Antisocial attitudes
	Antisocial personality
	Substance abuse
	Antisocial behavioural history
	High crime neighbourhood

What theory should be chosen to direct offender assessment activities? An evaluation of the evidence in support of a theoretical position is the key for selection among competing theories. A simple and straightforward way of evaluating a theoretical perspective is to see if the factors identified by theory are actually related to criminal behaviour. For example, are financial earnings, ethnicity, "nervousness", and having criminal friends associated with an individual's criminal conduct? The research finds that the variables derived from a General Personality and Social Psychological perspective are better predictors of criminal behaviour than the variables suggested by the other theories.

Technical challenges of offender assessment

There are two general approaches to making decisions about the future criminal behaviour of offenders (i.e., recidivism). One approach, often referred to as the clinical method, uses subjective and professional judgements to assess the variables deemed important by theory. The other approach is more objective and leaves less room for subjective interpretation. This second approach is referred to as the structured, actuarial method because it involves statistical, evidence-based estimates of risk.

To illustrate the distinction in approaches, let us use the variable antisocial attitudes. Antisocial attitudes can be assessed in different ways. One can search for evidence of antisocial attitudes during a conversation with the offender (clinical method) or one can administer a paper-and-pencil test of antisocial attitudes (structured, actuarial). In the first case, professional skills and experience are required to elicit and note expressions of antisocial attitudes. The interviewer may vary the questions asked from offender to offender. The problem with this is that the way information is gathered may potentially influence responses and therefore, the reliability of the assessment of antisocial attitudes. In the administration of a paper-and-pencil test, the assessment is conducted in a standard manner. Offenders are asked exactly the same questions and their responses are recorded in the same way for everyone.

In the real world, both approaches are frequently used together. Studies comparing clinical and actuarial methods in the prediction of criminal behaviour, or any behaviour for that manner, usually show that assessments based upon the objective approach tend to be more accurate.[2] What do we mean by "more accurate"? In any prediction task, there are four possible outcomes. You can predict that something will happen, and it does. For example, a parole board may predict that an offender is dangerous and the offender actually goes on to commit a violent crime. Or, the board may predict that the offender is no risk to the public and it turns out that the offender makes a successful reintegration into society. You can make mistakes. For example, parole is denied to someone who, on follow-up, commits no new crimes or parole is granted to an offender who re-offends violently.

A problem occurs when people assign different importance to the types of predictions and errors. A prediction strategy that would minimise this type of error would be to predict that all offenders will commit another crime. But, at what cost? Studies suggest that there are large numbers of offenders who will not re-offend. For some, this is a minor problem ("saving one victim is enough"). For others (e.g., civil libertarians, financial managers) it represents a serious social and economic issue.

In general, it is best to think of predictive accuracy in terms of the overall proportions of correct predictions and errors. That is, we need to know how the numbers are distributed across all four possibilities to gain a true appreciation of our predictions. We must also accept the reality that no prediction instrument will be perfect. From our discussion of clinical and actuarial approaches to offender assessment, our starting point for improving predictive accuracy is to use actuarial methods in the measurement of offender characteristics and their situations.

Measuring theoretically relevant factors in an objective, actuarial manner, unfortunately, is not as easy as it sounds. Any measuring instrument will have some error associated with it. Even the trusty ruler that you had since grade school is not 100% accurate. When it comes to the assessment of human factors, the range of error is considerably greater than errors associated with mechanical instruments such as rulers, weigh scales, etc. This is one reason why we can never achieve perfect prediction.

One approach of limiting measurement error is to use different methods for assessing the same factor. Returning to the example of antisocial attitudes, we can measure this variable with a paper-and-pencil test *and* by way of a structured personal interview. Structured interviews are not open-ended clinical interviews. The structured interview involves an observable and clear method for asking questions and recording the answers. Furthermore, the results from structured interviews can be quantified and evaluated as to their validity.

By using more than one method of assessment, the problems associated with one method of assessment are counter-balanced by another method. For example, a potential problem with a paper-and-pencil measure is that one may not be certain that the offender understood the questions or if he/she was motivated to answer truthfully. In an interview approach, the interviewer can verify whether the questions are understood and gauge the offender's interest and motivation. Research has shown that when more than one method is used to assess a certain offender characteristic, the overall predictive accuracy improves significantly. These research findings are easily translated into practice and the best correctional practices are seen when we use multiple methods (e.g., questionnaires, interviews, direct behavioural observations).

Research has shown that when more than one method is used to assess a certain offender characteristic, the overall predictive accuracy improves significantly.

The objective, multi-method measurement of theoretically relevant factors is the first step in improving predictive accuracy. The second step to improving predictive accuracy is to combine the individual factors to form more comprehensive offender assessment measures. The combining of factors are usually done in one of two ways. The simplest, called the Burgess method, is to assign a score of 1 if the factor is present and 0 if the factor is absent. Thus, you can have a number of items/factors in a scale that are simply scored (0 or 1) and then summated to give an overall score. The other method uses advanced statistical techniques to assign different weights to the factors. The Level of Service Inventory — Revised is an example of an offender assessment instrument using the Burgess method and an example using the weighting method is the Wisconsin Risk-Needs scales. The research evidence however, does not favour one approach of assigning scores over the other.

If we apply multi-method assessments to the different domains or factors related to criminal behaviour and then combine these domains, the prediction estimates increase substantially. Previous research has demonstrated impressive evidence on how multi-method and multi-domain sampling can improve prediction.[3] Adult probationers were given an assessment battery that measured different domains and used different methods of measurement. They found that the correlation (r) for antisocial attitudes and recidivism was .46 when a paper-and-pencil measure was used and .63 when it was combined with a structured interview. When this information was combined with other domains (e.g., antisocial personality, criminal history, age), the correlation (Canonical correlation to be precise) increased to a value of .74.

Purposeful use of relevant factors

Risk assessment

Although risk assessment is obviously important for release and security decisions, it also has implications for treatment planning. Appropriate decisions concerning who to place into treatment are informed by offender risk. The risk principle is especially informative for clinicians and treatment staff who have been schooled and trained in therapeutic techniques that are suited to clients who are verbally skilled, reflective and socially skilled. Although the "talking" and relationship oriented therapies can be helpful to many people, they are not very effective with the typical offender client. Many offenders lack the verbal and thinking skills required by these counselling techniques. Consequently, when therapists practising relationship, verbal therapies meet failure with the offender client, they tend to blame the failure on the client's "resistance" and "lack of motivation" rather than the technique.

Some observers have long admonished correctional and forensic therapists for preferring to counsel the low risk young, attractive, verbal, intelligent and socially skilled (YAVIS) client rather than higher risk client who really needs the service. Low risk offenders are certainly more pleasant to counsel. Moreover, some of our ideas about criminals make it relatively easy to dismiss efforts for dealing with higher risk offenders ("he's a psychopath", "he's too hard core to change"). The research evidence however, suggests that it is the higher risk client that can benefit from treatment more so than the lower risk offender. Fortunately, the importance of targeting higher risk offenders is permeating throughout the field as more treatment effort is being directed to higher risk offenders.

Needs assessment

One of the important derivations from a general personality and social psychological perspective of criminal conduct is that many of the factors identified as important are dynamic or changeable. An individual can change their attitudes and friends, he/she can find or lose a job, stop taking drugs or begin to drink heavily, and so on. Even

antisocial personality features can be changed if we consider antisocial personality in a very broad sense rather than in the narrow sense of a diagnosis of psychopathy. This view of antisocial personality encourages attempts to change a constellation of dynamic offender attributes such as thrill seeking, impulsiveness and egocentrism.

For offender assessment, the theory highlights the importance of objectively and systematically assessing dynamic risk factors. Reviews of the literature show that dynamic risk factors predict recidivism as well as static risk factors.[4] More importantly, changes in dynamic risk factors have been associated with changes in recidivism.[5]

Dynamic risk factors are also referred to as criminogenic needs. Criminogenic needs are those offender needs that when changed are associated with changes in recidivism. The Need principle of effective rehabilitation calls for the targeting of criminogenic needs in treatment programs. From an assessment perspective, the measurement of criminogenic needs is highly important for directing treatment services and for the active supervision of offenders. The evidence is convincing that interventions that target criminogenic needs are associated with reductions in recidivism.[6] At present, there are intervention programs that are reasonably effective and assessment instruments that reliably document changes in dynamic risk factors. Some of the assessment instruments are quite specific to a particular criminogenic need (e.g., measures of substance abuse or antisocial attitudes) and other instruments provide more general assessments of offender risk and needs (e.g., the Level of Service Inventory — Revised).[7]

For offenders under community supervision, the monitoring of dynamic risk factors assumes an additional significance. Probation and parole officers need to be attentive to both improvement and deterioration in the offender's situation. Community supervisors easily note dramatic changes in the offender's situation. However, more subtle and gradual changes are not so easy to detect. Reliance on subjective, professional judgements of change is difficult to defend when objective, empirically based assessment measures are available. This is especially true when correctional staff can administer many of these measures after brief training. That is, psychologists and psychiatrists are not required to administer risk-need assessment instruments or many of the paper-and-pencil measures of criminogenic needs that are available.

Assessment of Responsivity Factors

How people learn from life's experiences depends, in part, on certain cognitive, personality and social-personal factors. These factors may, or may not be, offender risk factors or criminogenic needs. They do however, influence the individual's responsiveness to efforts to help them to change their attitudes, thoughts and behaviours. These responsivity factors play an important role in choosing the type and style of treatment that would be most effective in bringing about a change. A few illustrations of responsivity factors are helpful in understanding this concept.

Our first example is taken from the cognitive domain. Individuals vary in their thinking styles (e.g., concrete vs. abstract, impulsive vs. reflective) and general intelligence. In terms of risk, neither of these two factors are particularly strong risk factors. However, these cognitive factors are very important with respect to learning new thoughts and behaviours. They influence how an individual best profits from instruction and the ease of learning. Two offenders may be of equal risk to re-offend and have the same criminogenic needs but they can differ in their cognitive level and style. One may be more verbally skilled and quicker to grasp complex ideas while the other is less cognitively skilled. The goals of treatment are the same but how one reaches that goal will be influenced by the client's cognitive responsivity factors. For the more cognitively skilled client, a program that is highly verbal and that requires abstract reasoning skills may be effective. However, this same approach would present a serious challenge for the less cognitively sophisticated offender.

Another example is taken from the personality domain, the trait of anxiety. Once again, a responsivity factor without risk or criminogenic need qualities. Levels of anxiety are poor predictors of recidivism and decreases in anxiety are not associated with reductions in recidivism. Yet, the anxiety levels of offenders could impact on the choice of treatment. For example, an anger management program may work well in a group format consisting of relatively non anxious individuals. For clients who are extremely anxious in social situations however, the program would be more effective if delivered on an individual basis.

Some risk and criminogenic need factors may have responsivity characteristics. For example, offenders described as having an antisocial personality are not only higher risk offenders with many criminogenic

needs, but their lack of empathy and anxiety require an intervention approach that is highly structured. Their energetic and restless nature calls for a treatment style that is active and stimulating. Classroom discussions and quiet readings are not the preferred mode of intervention for these types of offenders.

Objective measures of antisocial personality are available with one of the best validated instruments being Hare's Psychopathy Checklist. Unfortunately, because the Psychopathy Checklist is often used to form a diagnosis of psychopathy, the instrument is not conducive to treatment planning. A diagnosis of psychopathy is often seen as a sign of untreatability. As a result, efforts to treat "psychopathic" offenders is minimal despite the fact that there is no convincing evidence that theoretically relevant interventions will not "work". In addition, there is no research exploring the role of psychopathy and/or antisocial personality as a responsivity factor.

Psychologists have been extremely successful in developing valid and reliable measures of other responsivity factors. There are many excellent measures of intelligence (e.g., the Wechsler IQ scale), anxiety (e.g., Spielberger's State-Trait Anxiety Inventory), and interpersonal maturity (e.g., Jesness I-Level). There, is however, a need to develop good measures of impulsiveness, empathy and self-control, to name a few. Clearly, there is much work to be done.

In addition to cognitive and personality characteristics, some personal and demographic characteristics may operate as responsivity factors. Two possible candidates are gender and ethnicity. Female offenders may respond better to a style of intervention that is more women centred. Aboriginal offenders may benefit from a program offered by native counsellors and elders. Although there is no need for assessment measures of personal and demographic characteristics, there is a need for research examining the most effective styles of treatment based on gender and ethnicity factors.

Conclusions

Research in offender assessment holds excitement and promise. Although our prediction instruments will never reach perfection there is still tremendous room to improve predictive accuracy. Research on the assessment of responsivity factors and risk-needs factors specific to certain offender groups (e.g., sex offenders) must become a greater priority. Nevertheless, the momentum exists for continued improvements toward a more effective and humane correctional system. ■

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Coming up in the September 2000 issue of *FORUM on Corrections Research*

The September 2000 issue of FORUM will focus on Lifers and Long-term Offenders.

Treatment responsivity: Reducing recidivism by enhancing treatment effectiveness

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One of the contemporary concerns in corrections is the risk management of offenders in the community. Thus, in many correctional agencies, treatment is currently viewed as an integral part of the risk management continuum, and therefore, treatment responsivity is a critical issue for correctional programs. The responsivity principle has been a largely neglected area of study, despite the fact that responsivity and other variables related to offender motivation are widely recognised as critical factors mediating the success of treatment.[2] It is postulated that treatment readiness and responsivity must be assessed and considered in treatment planning if the maximum effectiveness of supervision and treatment programs is to be realized and if we want to ensure the successful reintegration of the offender into the community.

This article addresses the concept of treatment responsivity and examines a number of responsivity assessment measures currently in use. The development of a new standardized assessment battery of offender responsivity is presented, and a number of responsivity-related factors are identified and discussed in terms of their potential impact on treatment outcome. The construct of treatment responsivity is placed in a context that underscores the importance of allocating offenders to programs in the most effective manner and of identifying factors that might mediate the effectiveness of treatment services.

Four general principles of classification

The research of Andrews and colleagues outlines the four general principles of classification for purposes of effective correctional programming.[3] These principles are based on their detailed analysis of programs that showed above-average success in reducing recidivism.

The risk principle states that the intensity of the treatment intervention should be matched to the risk level of the offender. This is because research has demonstrated that higher risk cases tend to respond better to intensive and extensive service, while low risk cases respond better to minimal or no intervention. Rehabilitation programs should, therefore, be reserved for higher risk offenders in order to achieve the greatest reductions in recidivism. The reality is that low risk offenders usually do well without intensive treatment.

The need principle distinguishes between criminogenic and non-criminogenic needs. The former are dynamic risk factors,[4] which, if changed, reduce the likelihood of criminal conduct. In contrast, such non-criminogenic needs as anxiety and self-esteem may be appropriate targets when working on responsivity issues; however, such needs would be inappropriate targets for risk reduction, as their resolution would not have a significant impact on recidivism.

The responsivity principle states that styles and modes of treatment service must be closely matched to the preferred learning style and abilities of the offender.[5] Treatment effectiveness depends on matching types of treatment and therapists to types of clients.

The professional discretion principle states that, having reviewed risk, need and responsivity considerations as they apply to a particular offender, there is a need for professional judgement. In some cases, then, the application of professional judgement will (and should) override recommendations based on numerical scores alone, thereby improving the final offender assessment on programming strategies.

Definition and model of treatment responsivity

The responsivity principle

Three components of responsivity include matching the treatment approach with the learning style of the offender, the characteristics of the offender with those of the counsellor, and the skills of the counsellor with the type of program conducted. Offenders differ significantly, not only in their level of motivation to participate in treatment, but also in terms of their responsivity to various styles or modes of intervention. According to the responsivity principle, these factors impact directly on the effectiveness of correctional treatment and, ultimately, on recidivism.

If the responsivity principle is not adhered to, treatment programs can fail, not because they do not have therapeutic integrity or competent therapists, but rather because offender responsivity related barriers, such as cognitive/intellectual deficits, were not addressed. This last factor, for example, could prevent the offender from understanding the content of the program. Consequently, various offender

characteristics must be considered when assigning offenders to treatment programs.

Internal responsivity factors

We can consider responsivity factors as individual factors that interfere with or facilitate learning. They can be broken down into internal and external responsivity factors. The assessment of individuals factors is the first step in helping us develop the best strategies as to how to best address an offender's criminogenic needs. This, in turn, can ensure that offenders derive the maximum therapeutic benefit from treatment.

Internal factors refer to individual offender characteristics such as: motivation, personality characteristics, cognitive and intellectual deficits, and demographic variables.[6]

Specific internal responsivity factors are represented in most settings. Consideration of gender issues, ethnicity, age, social background, and life experiences may prove to be important for some types of treatment because they contribute to the engagement of offenders into treatment and the development of therapeutic alliance.[7] For instance, recent research[8] indicates that female offenders score significantly lower than male offenders on measures of self-esteem and self-efficacy.

An offender's level of intellectual functioning is an important responsivity consideration. According to Fabiano, Porporino and Robinson, cognitive skills programs are more effective with offenders of average to high-average intelligence and are less effective with offenders of below-average intelligence.[9]

Similarly, age may be viewed as a responsivity factor. Certainly, the "average" young offender would present different challenges to the effective delivery of a treatment than would be the case for an "average" adult offender. Age, in and of itself however, does not provide the necessary degree of precision required when the assessment of responsivity is the issue. It is important, for instance, to have adequate information on the individual's level of maturity, as this will effect how the individual views the need for change, how he or she relates to others, etc.

Using gender and maturity level to provide the context, then, it is easy to imagine how ignoring responsivity factors can result in the inaccurate assessment of an individual's treatment motivation or readiness, and how this may seriously impede an offender's compliance with treatment.

Motivation as a dynamic variable

Motivation may be operationally defined as "the probability that a person will enter into, continue, and adhere to a specific strategy".[10] In this context, motivation is dynamic and, therefore, at least some responsibility falls to the therapist to motivate the offender. The counsellor must strive to create effective motivational choices in order to increase the probability that offenders will respond favourably to correctional programming. This includes enhancing offender motivation and dealing with resistant clients after the pre-treatment assessment of treatment readiness.

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External responsivity factors

Correctional counsellor/worker characteristics

External factors refer to counsellor characteristics (i.e., some counsellors may work better with certain types of offenders) and setting characteristics (i.e., institution versus community, individual versus group). Regardless of the therapeutic orientation or the characteristics of the client group, a client is more apt to engage in treatment and treatment is more likely to be effective if a good therapeutic alliance is created.[11]

Unfortunately, there is little systematic research on the quality of the therapeutic alliance and the interaction effects of counsellor and offender characteristics in the field of correctional treatment. This is a much needed area of research, as it has often been found that a group of counsellors working in a common setting and offering the same treatment approach can produce dramatic differences in terms of client attrition and successful outcome. Counsellor attitudes and competence that do not match the aims and content of a program may lower treatment integrity and reduce its effectiveness.

Appropriate role modelling is also a critical aspect of the counsellor offender relationship. According to Andrews and Bonta,[12] effective workers are able to establish high quality relationships with the client, approve of the client's anti-criminal expressions (reinforcement), and disapprove of the client's

pro-criminal expressions (punishment), while, at the same time, demonstrating anti-criminal alternatives (modelling).

Setting characteristics/modes of program delivery

Some research has suggested that appropriate treatment programs delivered in the community produce two to three times greater reductions in recidivism than appropriate treatment programs delivered in prison.[13] With institutional and treatment programs in community correctional centres, offenders typically show up for treatment as a much more captive audience. In the community or outpatient settings, the no shows rate is higher, presumably because the client has more freedom to choose. It is important to understand that external factors, in isolation, may not impact on responsivity, but rather those staff characteristics or setting characteristics interact with offender characteristics to affect responsivity, either positively or negatively.

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Responsivity assessment measures

Although responsivity is clearly identified as the third principle of effective correctional treatment, there is a paucity of standardised assessment measures in existence. The need for a systematic and comprehensive assessment of responsivity and its related constructs (i.e., motivation and treatment readiness) is essential for the successful planning, implementation and delivery of appropriate and effective treatment programs. This is especially true when reintegrating offenders into the community. In order to make sound release decisions and enhance the protection of the public by effectively managing the risk that offenders pose; we would want to be able to assess their treatability (level of motivation and responsivity to treatment) prior to releasing them into the community.

The Client Management Classification (CMC) is a widely used responsivity tool in corrections. This instrument was developed as part of the Wisconsin Risk and Needs Assessment system, and became part of the National Institute of Corrections Model Probation and Parole Project.[14] The Client Management Classification differentiates five offender profiles and prescribes detailed supervision guidelines for each profile. It also facilitates case planning. By identifying offender characteristics and recommending supervision strategies, the CMC represents an attempt to match offenders and staff based on responsivity characteristics.

The Jesness Personality Inventory is another instrument that can help identify offenders' "personality" traits.[15] This instrument is the second most widely used personality inventory in juvenile court clinics in the United States. The Jesness was designed specifically for use with juvenile delinquent populations both male and female, ages 8-18. Similar to the Client Management Classification, the Jesness Personality Inventory helps identify offender personality characteristics that can be an obstacle to treatment.

The Level of Service Inventory-Ontario Revision (LSI-OR)[16] is the first risk assessment instrument to incorporate a section on "special responsivity considerations". In this section the instrument measures motivation as a barrier, denial/minimization, interpersonal anxiety, cultural issues, low intelligence and communication barriers.

A model for assessment of treatment responsivity

Prochaska and his colleagues have conducted important research on the process of psychotherapy change, in the areas of substance abuse, criminality, and a variety of high-risk health behaviors.[17] These researchers believed that individuals vary in terms of their stage of readiness for change and, as such, different therapeutic approaches/techniques need to be applied. To ensure their intervention is sensitive to clients' level of readiness, Prochaska developed and validated a self-report measure, the University of Rhode Island Change Assessment (URICA), on various samples. According to this model, individuals in the process of change move through a series of stages prior to changing their problematic behaviour. The five stages of change that have been identified are: precontemplation, contemplation, preparation/determination, action, and maintenance.

In the precontemplation stage, the individual is not considering the possibility of change and does not think he/she has a problem. Individuals in this stage typically perceive that they are being coerced into treatment to satisfy someone else's need. If the offender does not participate in treatment then there is little probability that recidivism can be reduced or that the risk level of the offender can be managed effectively.

The contemplation stage is characterized by ambivalence; in other words, individuals may simultaneously, or in rapid alternation, consider and reject reasons to change. At this stage individuals are aware that a problem exists, but are not ready to commit to therapy.

The preparation/determination stage is characterised by a combination of intention and behavioural criteria. Individuals at this stage may report that they have made some small behavioural changes.

Individuals in the action stage have made a commitment to change and are engaging in actions to bring about change; in other words, they are actively doing things to change or modify their behaviour, experiences, or environment in order to overcome their problems. At this stage they are typically involved in therapy or counselling.

Individuals in the maintenance stage are working hard to sustain the significant behavioural changes they have made and are actively working to prevent minor slips or major relapses. The maintenance stage is not static, but rather dynamic particularly when the individual is exposed to high-risk situations. The problem is not that offenders do not change, but rather that they do not maintain the changes.

Although the assessment work of Prochaska and his colleagues is evolving, it provides a starting point for our work on the development of a multi-method assessment strategy of treatment readiness and responsivity with offenders.[18] Its application to correctional intervention with a wide population of offenders, representing a range of offence types and settings, may well provide the conceptual focus that has been lacking.

Recent developments

A theoretically-based, multi-method assessment protocol for treatment readiness, responsivity and gain was developed in conjunction with the Research Branch of the Correctional Service of Canada in order to contribute to the broader literature on effective correctional programming. The intent was to pilot an assessment battery that could be administered in conjunction with a range of correctional program. Accordingly, the protocol was developed for generic application rather than for a particular type of treatment program. This was the first step in developing a systematic protocol for the assessment of treatment responsivity in the context of a risk/need management framework.[19]

The second step is now completed and an interview-based assessment protocol for treatment readiness, responsivity and gain was developed.[20] A set of guidelines for counsellors' ratings and a more explicit scoring scheme was establish to maximise reliability. Plans are also underway to develop a training package, to implement the revised protocol with a wide range of correctional programs and to begin to collect data on the assessment protocol.

Treatment participation

Despite the obvious importance of measuring progress in treatment this has been an often-neglected aspect of assessment. It is important for staff to measure knowledge of program content, skills acquisition, individual and group disclosure, offender confidence, transfer and generalisation of skills to real life situations, insight, attendance, participation, performance and therapeutic alliance.

Of course, the true effects of responsivity and other (motivational) factors on treatment can only be determined by examining recidivism rates over extended periods of time. If offenders who both acknowledge responsibility for their crimes and attend and actively participate in therapy, have lowered recidivism rates compared to those who do not, then the motivational (responsivity) variables have demonstrated meaning beyond treatment gains measured during, or immediately upon completion of treatment.

Conclusion

The principle of responsivity, which includes the appropriate matching of offenders to programs and staff, and the identification of factors that might mediate the effectiveness of treatment services, has not been given the attention it deserves. Offenders are not all alike, nor are all staff, settings, or treatment programs. The matching of offenders to treatment, counsellors to offenders, and counsellors to the treatment groups that best match their skills, can improve the effectiveness of correctional intervention. Responsivity should therefore be an important consideration in risk management and risk reduction. Failure to appropriately assess and consider responsivity factors may not only undermine treatment gains and waste treatment resources, but also may also decrease public safety.

Best practices with regard to responsivity starts with good assessment. Knowing an offender's motivation level, cognitive ability, personality traits, and maturity is essential to good case planning. Following assessment, a good case plan takes into account factors related to the treatment settings, the treatment program options and staff characteristics. Finally, understanding the skills and interests of staff should also become part of the case planning process, and will allow for more effective matching of offenders and counsellors. ■

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Treatment resistance in corrections

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Treatment resistance, while ubiquitous, has a negative impact on treatment outcome, in terms of poorer compliance regarding attendance and performance and reduced treatment gains. Given that the primary outcome anticipated from correctional intervention is the protection of the public, efforts to reduce treatment resistance are paramount.

This article discusses sources of resistance, presents strategies to reduce resistance,[2] and describes treatment engagement strategies employed in a specific Correctional Service of Canada intervention, the Persistently Violent Offender treatment program.[3]

Reasons for resistance

Resistance can stem from the following five sources: the client, the treatment or techniques employed, the environment, the clinician, and the client-clinician relationship.

Client variables

Scores of client variables have been related to resistance. They can be classified into the following subgroups:

- disorder;
- personality;
- behavioural;
- client fears; and
- client self-serving.

Disorder variables — The very nature of certain disorders often predisposes clients to be resistant to treatment efforts. Most often, this is related to how the disorder affects clients' abilities to trust. These disorders include borderline, anti-social, narcissistic, and paranoid personality disorders, psychopathy, schizophrenia, organic or neurological disorders, intellectual deficits, and substance abuse.

Personality variables — Clients who are hostile, defensive, demanding, and rebellious are resistant to intervention. So are those who reject authority, have an extreme sense of entitlement, and an excessive need for control. Finally, those with an eternal locus of control, such that they deny, minimize, or externalize blame are also resistant to intervention.

Behavioural variables — Numerous client behaviours contribute to resistance. These include lack of motivation to change and failure to see personal problems as serious. These also include various skills deficits, anger, aggression, and violence, and being suicidal.

Client fears variables — A variety of client fears are related to resistance. Some reflect a lack of understanding of the nature of therapy while some serve a self-protective function. For example, clients may fear a lack of confidentiality in the therapeutic relationship. Or, they may feel hopeless about their ability to change.

Client self-serving variables — Clients may be resistant for various self-serving reasons. For example, they may experience secondary gains from the dysfunctional behaviour that is being targeted in treatment. Or, they may have other hidden agendas to justify continuing to behave the way they do.

Treatment variables

Various treatment variables can have an impact on resistance. Most obviously, a poor match between type of treatment or treatment techniques and clients does not bode well for behaviour change. For example, verbal therapies, abstract concepts, and written homework would likely lead to resistance on the part of low functioning, illiterate, inarticulate clients. Group size can also affect client resistance and treatment outcome.

Treatments of shorter duration tend to result in less client resistance and, although there is no significant difference in the amount of resistance encountered by various types of therapies, behavioural therapies seem to engender slightly less resistance than others.

Environment variables

Cultural disparities between clients and clinicians can have a negative impact on resistance as can clinicians' failure to understand culturally-defined client behaviours. Low socio-economic status can also have a negative effect on client resistance, primarily due to lowered client expectations of their need for and ability to change. As well, poor social support systems can serve to maintain client resistance. The setting in which treatment is

provided can also engender client resistance. This is particularly true if the setting is a negative one or if clients are institutionalized and possibly attending treatment involuntarily.

Clinician variables

There has been little systematic research looking at the impact of clinician qualities on the therapeutic process and client resistance. Lack of research notwithstanding, several clinician qualities have been suggested to contribute to client resistance. These can be divided into the following two sets.

The first set of clinician qualities contributing to resistance is independent of the existence of client resistance. That is, in such cases, clients may or may not demonstrate resistance, but clinicians may erroneously conclude that they are due to their own cognitive or perceptual distortions.

The second set of clinician qualities has a negative impact on client resistance. In these cases, client resistance is evident, but clinicians respond in ways that exacerbate the situation. A confrontational approach is one example while providing little guidance or feedback to clients is another.

Client-clinician relationship

In some respects, it is difficult to separate the client-clinician relationship variables from client variables and clinician variables as, ultimately, both sets of factors have their impact on the client-clinician relationship. Nevertheless this relationship, hereafter referred to as the therapeutic alliance, and variables affecting it are considered separately because of the importance of the therapeutic alliance to client resistance and therapeutic outcome.

Clinical researchers have written extensively about therapeutic alliance. They have noted that therapeutic alliance is likely to be the most important factor related to compliance with treatment. It accounts for most of the variance in treatment outcome, and is the strongest predictor of outcome in brief dynamic and client-centred therapies.[4]

The development of a therapeutic alliance is contingent upon both client and clinician variables. Related to clients, therapeutic alliance depends upon clients' commitment to treatment, working capacity, and ability to establish healthy interpersonal relationships.

Related to clinicians, therapeutic alliance depends upon qualities such as competence, empathy, sincerity, and acceptance of clients. It also depends upon the degree to which clinicians can motivate clients and the type and quality of communication with clients. Also important are negative clinician attributes such as highly moralistic and judgmental attitudes toward clients, clinician interpersonal or relationship problems, erroneous clinician perceptions of clients as resistant, and counter-transference issues.

Strategies to reduce resistance

Clinicians should select intervention strategies only after careful analysis of the form of resistance clients are demonstrating. Due to the sheer number of combinations this level of analysis can potentially yield, it is impossible to prescribe specific techniques for every possible manifestation of resistance. Often, it will be necessary to employ several techniques, either concurrently or successively. In all cases, however, two things should be kept in mind. First, the ultimate goal of the selected strategy is to reduce resistance, enhance motivation, and facilitate treatment gains. Second, it is important to work with rather than against resistance.

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Strategies for reducing client-related resistance

Given the relationship of resistance to dropout rates, it is important to effectively address it early on. One possibility is to provide treatment priming or pre-therapy sessions prior to the commencement of a particular course of treatment. This could be provided on an individual or group basis.

If priming sessions are not a possibility, resistance will have to be addressed early in treatment. It is best not to address resistance directly in the first session as that should be a non-threatening opportunity for clients and clinicians to formulate initial, hopefully positive, impressions of each other.

When resistance is ongoing, as in repeated statements challenging clinician credibility or program integrity, therapists have several options as to how to address it, either individually or in-group sessions. They can attempt to respond specifically to the content of what clients are saying. While this may be helpful in certain circumstances, it can also exacerbate the situation as clients may then resist

what the clinician has said. They can respond to the process of the challenge, either by labelling the comments as resistance and using this as a forum for discussion or making observations such as "I have noticed when we discuss X, you do Y" and then ask clients for explanation.

Finally, if resistance is ongoing and repeated attempts have failed to reduce it, it may be necessary to terminate clients from treatment. This is particularly true if the ongoing resistance is interfering with the progress of other clients. Termination from treatment should be carefully considered, however, as it may create other unforseen problems.

Strategies for reducing treatment-related resistance

Clients should be actively involved in developing their treatment plan, setting treatment goals, and selecting treatment techniques to achieve their goals. Plans, goals, and techniques imposed by clinicians will likely engender client resistance with the end result of limiting treatment outcome. The agreed-upon goals must be reasonable, attainable, and pro-social and clinicians should provide regular feedback concerning clients' attempts to achieve their goals.

Strategies for reducing environment-related resistance

Some environmental factors, such as cultural background and socio-economic status, are beyond the control of clients and clinicians. Clinicians should ask clients directly about the impact of their cultural background on their beliefs, attitudes, and behaviours and they should take these factors into consideration in treatment planning. With respect to socio-economic status, clinicians should strive to encourage clients about their potential for and ability to change. As with cultural factors, they should take socio-economic status into account in treatment planning.

Resistance due to the setting in which treatment is offered may have to be addressed similarly to cultural and socio-economic factors. That is, in many cases clients and clinicians may not be able to control where treatment is delivered. This is particularly true if treatment is delivered in an institutional setting. Where possible, selecting the best possible location to foster a therapeutic atmosphere within the institutional setting can be helpful. So can reminding clients that, despite the negative atmosphere, they can maintain a positive attitude and change their behaviour for the better.

Strategies for reducing clinician-related resistance

It is incumbent on clinicians to determine their contribution to client resistance and to modify their behaviour accordingly.[5] In addition to accurately assessing client resistance and skillfully employing the strategies above, the following qualities seem essential. Clinicians should be perceptive, sensitive, empathic, friendly, and trustworthy. They should also be flexible and tolerant. They should demonstrate acceptance of clients, despite their behaviour, good communication skills, and a sense of humour. They should be supportive of and encouraging to client, at all times emphasizing client readiness and willingness to make behaviour changes. This is consistent with motivational interviewing techniques suggested by Miller and Rollnick.[6] They should use self-disclosure carefully as the utility of clinician self-disclosure depends on the type of therapy, the purpose of the self-disclosure, the particular client, and the amount that is disclosed. They should minimize their use of confrontational approaches as these only serve to increase resistance and attrition rates. As well, aggressive confrontation exemplifies clinicians taking responsibility for bringing about behaviour change in clients.[7]

Finally, clinicians should critically evaluate the source of any counter-transference reactions they may have to clients. For example, in the event that they feel anger toward clients, they should try to discern whether or not their anger stems from provocative client behaviours or from their own frustration with recalcitrant clients. After having identified the source of their counter-transference reactions, clinicians must then manage them appropriately.

Strategies for reducing client-clinician relationship resistance

Just as ensuring a good match between clients and treatment is important to reduce treatment-related resistance, so too is ensuring a good match between clients and clinicians. This entails consideration of factors such as cultural background and sensitivity, gender, personality, and interpersonal style.

Clinicians should attempt to maintain an empathic and consistently positive attitude towards resistant clients and must establish and maintain clear professional roles and boundaries from the outset. This is distinct from clinicians making a deep personal commitment to clients as is often implied in client-centred therapies.

Forensic populations and settings

While many of the issues and suggestions likely apply to forensic populations, some issues are particularly germane while other additional ones must be considered.

Just as resistance was identified as ubiquitous and predictable in all forms of psychotherapy, it is

inevitable with forensic populations. Numerous client-related reasons for resistance were identified; forensic clients demonstrate most, if not all of these factors simultaneously and in greater severity than non-forensic clients. That is, the majority of forensic clients are diagnosed with one or more disorders that seriously impair their ability to effectively engage in treatment, demonstrate hostile, defensive, and aggressive personalities, skills deficits, lack of motivation, a number of fears and insecurities, and numerous self-serving behaviours. Moreover, forensic populations tend to be less motivated for treatment, more resistant or non-compliant while in treatment, have higher attrition rates, demonstrate fewer positive behavioural changes while in treatment, and, possibly, demonstrate higher recidivism rates after participating in treatment.[8]

In addition to the strategies suggested for non-specific client populations, clinicians working with forensic populations must take the clients' legal dilemmas into account. For example, forensic clients may appear resistant when they are actually trying to protect themselves from further legal consequences.

Andrews and Bonta[9] state that correctional treatment should be delivered to higher risk offenders, target criminogenic needs, be based upon cognitive-behavioural or social learning theories as opposed to non-directive, insight-oriented, or evocative approaches, and take into consideration the principles of risk, need, and responsivity. Relating to the process of treatment, they specify several clinician and therapy variables such as the relationship and contingency principles. The relationship principle presents that a positive therapeutic alliance between clinicians and offenders has the potential to facilitate learning. The contingency principle holds that clinicians must, as part of their relationship with offenders, set and enforce agreed upon limits to physical and emotional intimacy as well as clear anti-criminal contingencies. The latter includes effective reinforcement for pro-social behaviour and effective disapproval for anti-social behaviour.

This indicates, then, that the development of a therapeutic alliance or a positive interpersonal relationship between clinicians and clients is of primary importance with both non-forensic and forensic populations. This may not be the case, however, for psychopaths.[10]

Persistently Violent Offender Treatment Program

The Persistently Violent Offender Treatment Program is a demonstration project developed and funded by the Research Branch of the Correctional Service of Canada. It is a multi-year, multi-site non-residential treatment program currently offered in two medium-security institutions in Canada. The program targets persistently violent offenders, defined as those having at least three convictions for violent (non-sexual) offences. It is based upon a social problem-solving theoretical framework and is delivered according to cognitive-behavioural principles. It involves 16 weeks of half-time participation.[11]

Given the population in question, most are treatment-resistant. For this reason, the first section of the program is a motivational module designed to facilitate participant interaction, commitment, and trust. The module begins with two weeks of individual therapy as a form of priming. This allows clients and clinicians a non-threatening opportunity to begin to get to know each other. Clinicians can address any concerns clients may have and to begin to explore clients' goals for the treatment program. At all times, clinicians are respectful, empathic, and supportive.

The motivational module also includes one week of group sessions. During this week, violence is rarely discussed. Instead, clients and clinicians generate group rules, discuss obstacles to treatment such as on-going substance use, impulsivity, and aggressive beliefs and how to minimize their impact on treatment outcome, and complete a cost-benefit analysis of program completion. In all of these exercises, the short-term and long-term positive and negative impact of various behaviours on clients and others are considered.

The second and third sections of the program are the problem-definition and skills-building modules, respectively. While specific resistance-reducing strategies have not been incorporated into these modules as they have been in the motivational module, other factors facilitate the reduction of resistance. On occasion, a peer tutor is hired to serve as a positive role model for resistant clients. As well, clinicians encourage the use of problem-solving and conflict resolution skills in each group such that clients feel more empowered and take more ownership over how the group progresses.

Finally, clinicians selected for the program are screened for personal suitability factors. Preferably, they are competent, confident, sensitive individuals who ascribe to a "firm but fair" approach in dealing with offenders. The perception of self-confidence is particularly important with this population of offenders as they have a tendency to prey upon staff that appear to be lacking in confidence. They must have a strong sense of their professional identities and boundaries and be intrinsically motivated. They must also work together co-operatively and

supportively, to model appropriate behaviours to clients, to reduce potential manipulation by clients, and to sustain each other through inevitable difficulties.

Measurement of motivation in the Persistent Violent Offender program

Clients who participate in the Persistently Violent Offender treatment program complete a comprehensive assessment battery before and after the treatment program.[12] Self-report measures of responsivity and motivation for treatment are included in the assessment battery. Given the lack of correlation between offender self-reports of motivation and behaviour change and outcome, clinicians also complete weekly behavioural ratings of client motivation and behaviour change, as indicated by attendance, participation, behaviour, and attitude. Future analyses will examine the correlation between the two methods of assessment and the relationship of each one to treatment outcome.

Conclusion

Given the number of reasons for and forms of treatment resistance, it is impossible to prescribe exactly what to do with any client in any given situation. Careful analysis by clinicians is a prerequisite to employing the most efficacious means to reduce treatment resistance. These efforts are essential given that treatment outcome is contingent upon the reduction of treatment resistance and that the primary anticipated treatment outcome of correctional interventions is the protection of public safety. ■

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Education programming for offenders

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Controlling crime through education may be an effective and economical method of reducing recidivism rates. Phrased differently, education may be one means of improving reintegration potential of offenders. This articles examines education as one method of preparing an offender to step back into his or her community with a renewed sense of self image, pride through the accomplishment, and a plan to stay clear from one of the stimulators of criminal activity — unemployment.

Context

Offenders admitted into the custody of the Correctional Service of Canada typically rank among Canada's most poorly educated citizens. Nearly two out of three offenders (64%) have not completed their high school diploma, of whom 30% have not even completed grade eight. In 1993/94, 70% of newly admitted offenders tested below the Grade-8 literacy equivalency while more than four in five new inmates (86%) scored below Grade-10.[2]

The research indicates that the concept of incarceration as a form of punishment does not necessarily deter criminal activity on the street or in prison.[3] Returning uneducated individuals to the community could represent a further threat to public safety and may enhance recidivism rates. Sending individuals back to their respective communities through education provides a better understanding of society as a whole.

Education programs

Currently, educational and vocational programs are available at most correctional institutions in Canada. Educational programs consist of Adult Basic Education — (Grade 1 to 10), Secondary Education, Vocational, College, and University level programs. Prisoners generally pay for their own post-secondary education, unless it can be demonstrated that the education addresses a specific criminogenic need. Through vocational programs such as plumbing, welding and small engines repair, prisoners are provided with job related skills training relevant to employment opportunities available in the institutions and in the communities.

One of the most recognized programs is CORCAN. Through its five business lines — Agribusiness, Construction, Manufacturing, Services and Textiles — CORCAN provides offenders with work experiences and training which replicates private sector work environments as closely as possible. CORCAN programs are in place in 32 institutions across Canada, creating the equivalent of 2,000 full time trainee positions.

The mission of correctional education

The role of correctional education is to:

- function as an agent of change for both the prisoner and the system;
- maintain its integrity in terms of its basic commitment to freedom of inquiry; and
- study, evaluate, and respond to all variables in the individual, the system, and society that are to be benefited by the educational concerns with process, product, and social reform.[4]

We add that the role of correctional academic education could:

- relieve boredom of dead-head prison time;
- give student-prisoners a better understanding of society;
- give non custody professionals an opportunity to monitor correctional operations;
- keep offenders busy with positive pursuits;
- give prisoners an opportunity to experience values of a law abiding individual (teachers); and
- alter behaviour preventing costly reincarceration.

The controversy

Does correctional education reduce recidivism rates? Some authors argue that there is no conclusive evidence correlating correction education to reduced recidivism while others go further and suggest that little can alter criminally violent behaviour. For example, Martinson[5] argues that with few and isolated exceptions, rehabilitation efforts of advanced education that have been reported so far (1947-1967) have had no appreciable effect on reduced recidivism. Martinson's influence in corrections has frequently been associated with the

shift from a treatment/rehabilitation orientation in corrections to a just deserts/justice orientation.

Opponents to correctional education argue that criminal tendencies learned on the outside cannot be "unlearned" on the inside, and, they add, offenders gave up their rights to amenities such as education when they took away the rights of others.[6]

On the other side of the controversy, a total of 97 articles published between 1969 and 1993 were abstracted by researchers who examined the relationship between correctional education and recidivism levels.[7] The results reveal "solid support for a positive relationship between correctional education and [lower] recidivism." In the 97 articles, 83 (85%) reported documented evidence of recidivism control through correctional education, while only 14 (15%) reported a negative relationship between correctional education and reduced recidivism.

Additionally, one study examined the recidivism data of 60 released prisoners for a three-year period in the United States.[8] According to this study, each participant had earned an associate and/or a bachelor's degrees while incarcerated in a high custody North Carolina prison. When the data were pooled with data from other States, it appeared that earning a degree while incarcerated significantly reduced recidivism rates for both male and female offenders. Specifically, of the 60 North Carolina released prisoners, 5% (3, all males with associate's degrees) were returned to prison for criminally violent offences in the 36 months following their release. Women and male offenders who earned four-year degrees were not reincarcerated during the three-year period after their release, and, all but one of these individuals found employment relating to their degree. Also, the income of the degree-earning students was greater than their income prior to incarceration if employed, but most of them were unemployed at the time of their arrest and subsequent conviction. These findings are congruent with a study that shows individuals who received higher education while incarcerated have a significantly better rate of employment (60-75%) than those who do not participate in college programs (40%).[9]

Education is the cornerstone of a progressive society and an efficient agent for social change.

Encouraging education

One method to encourage education in the penitentiary is to have part (or all) of the educational process delivered inside prison and part (or all) of the educational process delivered outside of prison, thus program consistency is equally important. A student can take the same module or program at many locations throughout Canada. The advantages of having offenders engaged in an educational pursuit is that correctional supervision is shared through teachers and other students while meeting educational objectives and ultimately reducing recidivism levels.

Methods of delivery

Modules should include different methods of educational delivery in classrooms conducted by qualified educators, merged with a delivery system via computers, distance learning methods, and/or telecommunication programs. Distant learning methods work well but require full time qualified educators to be part of that system. In fact, those instructors should be the primary focus of the system. However, technology teaching must be part of the curriculum so students can compete for challenging jobs.

Assessment

As educational programs get underway, assessment methods should be in place to determine the effectiveness of those programs. That is, the utility of non-traditional forms of assessment is an important issue. Stecher, Rahn, Ruby, Alt, and Robyn[10] suggest a focus of program definition, implementation, and administration; the quality and feasibility of the assessment; and the potential usefulness of the assessment approach for educators.

Conclusions

Offering individuals under correctional supervision, a student-centred educational program, provides an avenue for those offenders who want change, an opportunity to advance themselves.

An interesting guide about educational reform comes from Tyack and Cuban[11] who suggest the following:

1. No master plans for the fixing of all problems will be accepted. We cannot leap into a perfect educational system, but must work to make things better bit by bit.
2. Involve teachers, parents, and administrators in the process of reform and make sure that the "answers" are to questions that are being asked by those involved.
3. Move in small steps. ■

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Reconceptualizing offender employment

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Offender employment has played a pivotal role in corrections since the introduction of institutions,[2] although the purpose of employment has changed with prevailing correctional ideologies.[3] Even though employment is an important rehabilitative tool, little is known about the factors and processes that contribute to employment stability among offenders.[4] Recent meta-analyses[5] provide empirical verification of employment as a moderate risk factor for recidivism among offenders. This finding reiterates the importance of enhancing our understanding of the employment construct in order to provide effective assessment and to assist in the reduction of this need through appropriately directed intervention strategies. This article describes current employment measurement techniques and proposes modified measurement strategies. It also describes a theoretical framework for the exploration of community employment stability, and provides recommendations regarding directions for future employment intervention with offenders.

Assessment of employment needs

Employment is a prevalent need among incarcerated Canadian offenders, with approximately 75% of offenders (76% of men, and 74% women) identified with employment needs at the time of entry to a federal institution.[6] Moreover, offenders have indicated that they perceive employment deficits as contributing to their criminal behaviour.[7]

Although employment deficits are firmly entrenched as a moderate predictor of recidivism,[8] the impact on recidivism may be underestimated due to oversimplified definition and measurement of the construct. Employment risk factors have traditionally been assessed in a dichotomous manner (i.e., presence/absence of employment deficits), thereby potentially reducing their predictive ability. In addition, many items are historical in nature, limiting the utility of this information for directing current interventions.

The Offender Intake Assessment (OIA) process,[9] used to evaluate offenders' criminogenic needs upon entry to federal correctional institutions, incorporates employment as one of the major seven offender need areas in the Dynamic Factors Identification and Analysis (DFIA). The employment domain in the DFIA is more comprehensive in its assessment of static and dynamic employment risk factors. It is therefore useful not only in predicting an individual's risk for recidivism but also for guiding the level of employment intervention required to decrease an individual's risk for recidivism, in accordance with the risk principle. Moreover, items from the DFIA employment domain may be used to suggest specific areas requiring attention, consistent with the need principle.[10]

The advent of dynamic risk assessment tools such as the DFIA has contributed not only to our ability to more effectively appraise offender needs and competencies, but also to our ability to track change in employment needs as a function of treatment participation. Nonetheless, there is a need to progress toward improved dynamic assessment of competencies, attitudes, values, beliefs and satisfaction with employment, as proposed by Gendreau and colleagues.[11] Gendreau advocated the enhancement of dynamic assessment within the DFIA, using a compilation of scales such as those proposed in Gillis.[12] In accordance with the principles of effective classification,[13] dynamic assessment would contribute to better understanding of an offender's criminogenic needs and employment competencies and strengths, consequently increasing the potential to prioritize offender employment needs and to guide effective intervention strategies. Furthermore, a dynamic assessment strategy in relation to offender employment needs would allow for reassessment to track change in employment needs as a function of training. An amalgamation of static and dynamic risk and needs assessment protocols would most effectively appraise competencies that potentially contribute to safe reintegration, in addition to evaluating factors that place the individual at risk for future involvement in crime. Such an approach is consistent with Correctional Service of Canada's *Correctional Strategy*, which advocates prioritizing offender criminogenic needs and providing correctional intervention on the basis of effective needs identification.

Employment as treatment

Just as employment assessment has often been conducted using a dichotomous approach to the identification of employment needs (i.e., absence/presence of needs), program evaluations have typically used an approach that likewise limits the utility of the information provided. Numerous researchers attempting to review the employment literature have noted these methodological weaknesses.[14] For instance, many evaluations of employment intervention strategies have defined the independent variable in a dichotomous manner (i.e., participated/did not participate in employment program). Such an approach precludes examination of integral factors such as quality of participation, length of time in the program, and reasons for attrition. Additionally, many program evaluations fail to report important information pertaining to offender employment needs and competencies prior to program participation. Moreover, the issue of comorbidity in offender needs, such as the combination of employment and substance abuse needs, is important to consider for its potential impact on work performance and treatment gain. Ryan[15] summarized many of the methodological flaws that inhibit our ability to formulate conclusive evidence on the impact of employment training on offenders, including: "problems in research methodology and program development, including comparability of experimental and control groups, selection of participants, tracking of ex-offenders, differentiation between structural and subcultural variables, and definition of job retention". A comprehensive evaluation of employment program effectiveness must therefore consider a variety of factors that may moderate the impact of the program on the criterion of interest (e.g., job attainment and retention, successful community performance).

In assessing the impact of employment training on offenders, one must be cognizant of the aforementioned limitations. To date, findings have been equivocal, with some studies reporting positive effects of employment on recidivism, and others reporting limited or no effects. Pearson and Lipton[16] aptly summarize the state of the employment literature, based on results from their meta-analytic review of educational and vocational programs: "Although some types of educational and vocational programs appear *promising* in terms of reducing recidivism, due to a lack of studies using high-quality research methods we are unable to conclude that they have been *verified* effective in reducing recidivism."

In light of meta-analytic findings on the overall treatment literature,[17] theorizing regarding treatment efficacy has progressed from the question "Does treatment work" for, as Lipsey contends, it is no longer a question of *whether* intervention is effective in reducing recidivism.[18] We know that treatment "works" and we must use the information derived from research to develop effective intervention strategies for offenders who manifest employment needs.

As a subset of overall risk, employment offers real potential for change among offenders with its focus on combining concrete skills-based training with the development and enhancement of generic employability skills, transferable to community employment settings. The provision of such intervention is consistent with a perspective that offenders have the capacity to change and that society is best protected through the reformation of offenders.

In evaluating program effectiveness, it is important to keep in mind that many evaluations have used recidivism as the sole criterion of program effectiveness. These studies, therefore, do not account for more intermediate outcomes that one would anticipate as resulting from employment programs, namely, increase in specific and generic skills, and employment status upon release. Understandably, these factors are often excluded due to the difficulty in monitoring long-term, and even short-term, outcomes associated with community adjustment.

Theoretical model

The need for an integrated theoretical perspective on employment cannot be disputed. Before effective programs can be developed, one first requires an understanding of the various factors and processes that combine to influence not only reintegration potential, but also employment stability in the community.

As previously mentioned, many studies to date have explored employment primarily in relation to recidivism, an approach which neglects important proximal outcomes. Exploration of intermediate targets is crucial for several reasons. First, many employment programs promote the development of job specific skills, but often, community employment opportunities are not consistent with those offered in the institution. Use of recidivism as the sole criterion of program effectiveness ignores other important potential gains from employment participation,

including job attainment, job retention, and increased prosocial orientation. Safe community reintegration, however, is the ultimate objective of the provision of programs to offenders, and should be included in a comprehensive theoretical perspective on employment.

A theoretical model was recently formulated to assist in the prediction of employment stability.[19] Revised from a theoretical model to predict criminal behaviour,[20] the model adopts a social learning/social cognition perspective in its amalgamation of the theoretical perspective proposed by Andrews and Bonta[21] and by Ajzen.[22] Furthermore, the model incorporates the risk factors most predictive of recidivism.

The Personal Interpersonal Community-Reinforcement perspective (PIC-R)[23] was formulated to account for inhibitory and facilitatory factors related to criminal offending. The theory employs a social learning perspective in its specification of the interrelationships between: (a) personally-mediated events, comprised primarily of the individual's attitudes, values and beliefs, and personality, which in turn, impact upon personally-mediated control (e.g., self regulation and cognitive functioning); (b) interpersonally-mediated control, consisting of the influence of others (i.e., associates/social support) via modelling, expressed approval, etc.; and (c) automatic rewards, which typically gain their rewarding properties through previous experience. These proximal factors, in interaction with more distal contextual elements (such as neighbourhood), influence the manner in which the individual perceives the costs/rewards for criminal behaviour.[24] For the present study, this model was modified to predict employment stability for offenders on conditional release by incorporating relevant work attitudes and beliefs.

The pre-test data collection phase for this research on employment stability was completed in September 1999, and post-test data collection in March 2000. Initially, the research explores factors that contribute to employment stability. Ultimately, the study will be extended to evaluate the impact of employment stability on long-term community reintegration. Thus, this research will explore proximal and more distal outcomes potentially related to attaining and maintaining employment in the community.

The current community-based employment research will also contribute to the development of a brief employment checklist comprised of factors that are most strongly linked to community success. This list of protective factors, coupled with known employment risk factors, will assist parole officers in tracking important employment factors among offenders who manifest employment needs.

Furthermore, rather than pure reliance on the assessment of static employment deficits among offenders, this research strategy involves exploration of dynamic employment factors. Accompanying the evolution of employment assessment strategies is the potential for renewed effort to target employment strengths and competencies that will assist offenders in their community adjustment.

Innovations and future directions

It can safely be asserted that there is a resurgence of interest in employment as an important factor in the safe reintegration of offenders. However, the systematic study of employment as a risk and need factor is still in its infancy. Although we know employment is important in contributing to outcomes for offenders, we are in the preliminary stage of understanding the processes and factors that are important to employment success and community reintegration.

This parallels the status of risk and needs assessment in corrections. Our knowledge of risk is good, but our understanding and ability to effectively intervene to decrease criminogenic needs is constantly evolving as our knowledge base increases. Employment, as a subset of offender needs, constitutes an important area of study. Once an enhanced understanding of the mechanisms and processes associated with employment stability is attained, this information may be used to guide the development of intervention strategies, both at the institutional and community level. Moreover, once this level of understanding has been achieved, subsequent intervention efforts should focus on responsivity issues (including gender, ethnicity, and motivation, and different learning styles), which have received relatively little exploration to date in the correctional literature.

There is reason to adopt an optimistic outlook that current research and endeavors to intervene with offenders with employment needs will yield valuable information for the development of a comprehensive and systematic employment strategy. ■

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Informing young offender policy in current research: What the future holds

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Knowledge of the general literature of risk is critical in the development of broad-based strategies to assess criminogenic potential in adolescents. Following from the risk principle of case classification,[2] knowledge and measurement of risk can assist in more effective case planning and selection of appropriate targets for service. According to Hoge and Andrews,[3] the assessor must make meaningful assumptions about the general level of risk to guide the intensity of intervention, and specific statements of areas of risk to provide relevance in case planning and targeting for appropriate treatment to take place.

Promising programs

During the past decade, meta-analytic reviews of the young offender treatment literature have contributed significantly to the appreciation that the "nothing works" debate is now over in youth corrections. Current discussions now emphasize the issues of what works and for whom and how to translate existing knowledge of successful programs to other jurisdictions.

Findings from the meta-analyses

Meta-analysis statistically compares the types of treatments that are offered, to whom they are directed and with what outcomes. The number and quality of the studies that are included in the review only limit the meaningfulness of meta-analysis. Fortunately, there is now an adequate quantity of qualitative studies to make interpretations of the treatment literature in youth justice with confidence.

In two separate analyses Lipsey suggested that the overall effect size linking treatment with reductions in re-offending lie between 20 to 40% as contrasted with no treatment comparison groups, and only slightly less when compared to groups receiving some type of "usual service".[4] Stronger effect sizes were found in his studies in the following variables; higher risk cases, longer duration of treatment and behavioural-oriented multimodal treatment with a stronger emphasis on "sociological" than psychological orientation of service delivery.

Institutional Versus Non-Institutional Placement for Treatment. Lipsey and Wilson's subsequent review distinguished placement of treatment, residential versus community, in differentiating characteristics of effective programs. This is a critical differentiation since much of the debate regarding effective youth justice policies centres on the importance of incarceration as a relevant factor in community safety. Table 1 summarizes factors relevant for effective programs in institutional and non-institutional placements.

Table 1

Program factors contributing to effectiveness for institutionalized and non-institutionalized young offenders

Institutional-Based Components	Non-Institutional-Based Components
Interpersonal Skills	Interpersonal Skills
Teaching Family Model	Individual/Group Programs
Multiple Services	Multiple Services
Behavioural Programs	Restitution/Probation
Individual/Group Programs	Employment/Academic Programs

Effect sizes accounting for total program outcome across both institutional and non-institutional programs suggested that the three factors comprising the highest ranking were; interpersonal skills training, individual counselling and behavioural programs. The second grouping of lesser, yet significant contribution were the two program factors consisting of multimodal services and restitution for youths on probation.

The work of Andrews et al.[5] was consistent with the findings of Lipsey. However Andrews' work provides more specificity in regards to appropriate targeting for intervention — known as the risk principle — and increasing sophistication regarding style and type of intervention, namely the importance of cognitive-behavioural oriented interventions. On a broader level, Andrews' work outlined characteristics of promising programs as:

- Employment of systematic assessment that emphasizes factors relevant to criminality;
- Possess therapeutic integrity;
- Attend to relapse prevention;
- Target appropriately;
- Employ appropriate styles of service.

Andrews and Gendreau[6] have developed the *Correctional Program Asessment Inventory* which

assess the extent to which the principles of effective service within a particular program may be present *based on the empirical outcomes from the meta-analysis.*

Despite the encouraging findings, Losel[7] has set forth a cautionary note. While underscoring many of the principle findings from Lipsey and Andrews, his conclusions are perhaps a bit more tentative, and worthy of comment. Losel suggests that while the links to effective intervention are clearly in the positive direction, they remain small relative to the proportion of variance accounted for by error or by factors not accounted for in the evaluations. He cites the need for research to address the following:

- Differential effects of offender characteristics
- Moderator variables such as psychopathy that seem to influence the extent of favourable outcomes
- The lack of replication of documented, effective programs

Specific interventions and service delivery issues

Community-based intervention

Two meta-analyses[8] have suggested that effect sizes linked to more effective outcomes were characteristic of programs delivered in the community as contrasted to those delivered in residence. Henggeler[9] suggests that in part this is accounted for by the type and quality of interactions adolescents experience with the social influences that surround them. To be effective, programs need to be in a position to influence those *social* factors that may in turn be interacting with a particular youth's competencies (e.g. problem-solving skills, beliefs and attitudes). Hence, particular attention is now being paid to interventions that influence the systems that are consistent with the major predictors of delinquency risk, namely, families, peers and schools.

Multi-systemic Therapy

Multi-systemic Therapy (MST) refers to the consistent application of principles that reflect what is known in the young offender literature. While some reviewers may suggest that MST does not represent "anything new under the sun", it is in the method of service delivery that MST has shown itself to be effective with high-risk youth. Consistent with the risk principle of case classification, MST attempts to influence the major criminogenic risk factors through the application of appropriate strategies in a multi-determined, multi-modal fashion.

In addition to reflecting the knowledge-base in the offender literature, MST has been evaluated with a series of randomized clinical trials that have included appropriate follow-up periods.[10]

While MST reflects interventions that have shown themselves to be effective, it is in the method of service delivery *within a specified set of principles* that MST distinguishes itself. The nine principles against which MST adherence is measured consist of the following:

- *The primary purpose of assessment is to understand the "fit" between the identified problems and their broader context.*
- *Therapeutic contacts should emphasize the positive and should use systemic strengths as levers for change.*
- *Interventions should be designed to promote responsible behaviours and decrease irresponsible behaviour among family members.*
- *Interventions should be present-focused and action-oriented, targeting specific and well-defined problems.*
- *Interventions should target sequences of behaviours within or between multiple systems that maintain the identified problems.*
- *Interventions should be developmentally appropriate and fit the developmental needs of the youth.*
- *Interventions should be designed to require daily or weekly effort by family members.*
- *Intervention efficacy is evaluated continuously from multiple perspectives with providers assuming accountability for overcoming barriers to successful outcomes.*
- *Interventions should be designed to promote treatment generalizations and long-term maintenance of therapeutic change by empowering care givers to address family members' needs across multiple systemic contexts.*

Finally, MST may ultimately prove it's worth to juvenile justice and children's mental health systems due to the development of a variety of dissemination manuals and training approaches. One such dissemination effort is taking place in Ontario, where a four year randomized clinical trial is now into its second year of implementation, and it consists of four participating sites in a variety of settings with therapists and supervisors who have participated in an intensive training. This trial is being rigorously evaluated.[11]

Cognitive-behavioural interventions

Cognitive-behavioural treatment (CBT) with young offenders has received considerable attention. This can be attributed to at least three influences: the general literature regarding effective interventions with children and adolescents has been supportive of CBT; risk factors regarding attitudes, beliefs and values have shown themselves to be strongly related to anti-social behaviour; and recent meta-analyses

have shown CBT to be the treatment of choice related to effectiveness over and above the traditional influences of psychodynamic, medical and behavioural interventions.

Interest in CBT has been based as well on the general theoretical assumptions about the *social-psychological* understanding of the etiological research on the development of delinquency. This body of theoretical work suggests that the interaction of the individual with systems that can influence attitudes and subsequent behaviour may improve the explanatory value of the studies on prediction and assessment. Hence, the importance of understanding how children/adolescents mediate their experience may not only assist in explaining the behaviour, but may also contribute meaningfully in how to alter behavioural outcomes.

Andrews et al. discuss the important aspect of *clinical relevance* in decision-making when important case management decisions arise.[12] Clinically relevant decisions can be considered as those that link the decision to correctly priorize or target certain behaviours/systems for change with the particular risk profile of the individual. Given the importance placed on attitudes from the prediction literature with young offenders, targeting cognitions would seem to make considerable sense as an important focus for service providers.

Not only has CBT made inroads in the promotion of effective intervention with children/adolescents generally, but numerous programs now exist to train workers in the youth corrections field in both residential and community contexts.

Directed interventions toward violent, substance abusing and sex offending youths

Programs Targeting Violent Youths

Unlike the stability of the construct of antisocial behaviour, violence or aggression in youth is considered a more complex and variable event. Indeed, misconceptions in the belief that childhood/adolescent aggression is a unitary construct may well be one of the main impediments to developing effective solutions. While readers will be familiar with the literature on genetic and biological bases of violence with youths, current research emphasizes the importance of violence as a *learned* behaviour. As such, learning can take place in response to a child/youth feeling overwhelmed and out of control, where the role of aggression may be to reassert control. Violence can also be vicariously learned as a result of experiencing the rewards that are perceived to be associated with exercising power through others.

Social skills training and anti-bullying programs have also become popular, particularly in light of encouraging findings.[13] They suggest that strategies targeting aggressive children — anti-bullying — can bring about meaningful reductions *not only in those children who receive the program, but in general levels of aggression within the schools which employed the program.*

Programs have also been developed to target safe and secure practices that are delivered within the juvenile justice system. Such factors as the availability of social skills programs, "dawn to dusk" programming, training that emphasizes the development of conflict resolution skills, classification for purposes of identifying perpetrators and likely victims of violence are components of safer practices within detention.

Programs Targeting Substance Abusing Youths

Substance use stands alone as a major risk factor for chronic/persistent young offenders. It is also highly related to peer associates in the context of affiliation with peers who endorse antisocial values as opposed to prosocial values. Hence, to be effective, programs need to be tailored to the developmental significance of the behaviour. Substance abuse programs need also to be intensive and include strategies such as: monitoring, being system-based (situated within the family and peer group) and include a relapse prevention component that is planned in a way to capitalize on changes that take place within the formal structure of the intervention.

Programs Targeting Sex Offending Youths

Interest in adolescent sex offending has not been well developed from a research perspective and no doubt represents one of those areas that will require a great deal more emphasis both for purposes of improving assessment and treatment.

Appropriate selection of treatment will follow from an understanding of the type/nature/duration of the offending pattern. Treatment strategies typically include a combination of cognitive interventions, anger management, social skills training, alcohol and substance abuse programs, victim empathy and age appropriate development of socially acceptable sexual behaviour.

Restorative Justice Programs

Revisions to Canada's youth justice legislation are providing considerable impetus for the development of alternatives to the traditional court system. This trend in Canada is keeping pace with similar initiatives in Western Europe, Australia and New Zealand.[14] The development of such alternatives is

recognition that for lower risk and some moderate risk youth, an alternative to court that attempts to reconnect the youth to the values of their immediate community may have more long term benefits and provide a cost saving to the community.

Restorative justice programs typically include the involvement of a community justice panel or community group that meet with the youth and their family. This meeting symbolizes community level accountability and often will also include the victim or a representative of the victim (e.g., the manager of the store where a shoplifting incident took place). Some programs may utilize a form of 'public shaming' that is used to extract an apology while others will require not only an admission of guilt/responsibility but also tangible compensation back to the individual/community as reflected in the completion of a financial restitution order or community work.

Future directions

It is clear that considerable knowledge is now available to guide intervention not only at the practitioner level, but for policy and lawmakers as well. So many of the program issues related to young offenders relate to the courts, as well as other aspects of the children's mental health and child welfare systems and with the laws that govern practice at both the federal and provincial levels. An integrated children's service delivery system that is mindful of the latest findings from research and program evaluation is now seen as an imperative in capitalizing on current knowledge. Several issues however do stand out in their importance for service development in the young offender field. Several suggestions for future development include:

- Development of protocols that enhance the implementation of those programs that have shown themselves to be effective already. Implementation with integrity guided by adherence to proven models — what is referred to in some venues as *technology transfer* — is clearly needed to capitalize on the findings from the outcome literature.
- Emphasis on selected groups that have been largely overlooked in the literature thus far. These groups would include young girls and adolescent women as well as the very young offender. This group is comprised of those youth who, from as early as the age of 4 to 6 years, may begin to demonstrate behaviours that are predictive of later offending. Such work is a necessary precursor to the further development and refinement of prevention and early intervention programs for youths to inhibit their coming into contact with the formal juvenile justice system.
- Losel pointed out in his meta-analysis that there continues to be an absence of replication studies that seek further validation for those interventions that have shown themselves to be effective in reducing offending. It may very well be that through replication and refinements, generalization of those effective strategies can lead to a broader more influential knowledge base to guide the development of the next generation of effective programs. ■

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Assessment and treatment of sexual offenders

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The true prevalence of sexual offending can only be estimated. It is clear, for example, that many victims of sexual offending do not report the crime to the police or, all too often, to anyone at all.[3] *The Committee on Sexual Offences Against Children and Youth reporting the results of Canadian national surveys*[4] *found that one-half of females and one-third of males reported being subjected to some form of sexual abuse during their lives, with 70% of the males and 62% of the females indicating that it occurred prior to pubescence. There is, therefore, a pressing need to develop a comprehensive social response to this very serious social problem.*

One aspect to this response should include not only the treatment of identified offenders, but also the development of an understanding of these offenders; what features need to be addressed in treatment; how these features should be assessed; and the generation of an actuarial basis for estimating risk to reoffend and response to treatment. Of course, if treatment is implemented, its effectiveness must be evaluated.

For the past 26 years, Correctional Service of Canada (CSC) has been at the forefront of the development of assessment and treatment for incarcerated sexual offenders. Over the last 10 years, CSC has expanded and refined its programs for sexual offenders so that it now funds numerous institutional programs and community-based follow-up treatment for released sexual offenders. For the most part, programs that have proliferated in all Western societies over the past 10 years have adopted the "cognitive-behavioural/relapse prevention" approach developed in North America.[5] This is also the approach adopted by CSC from the first systematic application of sexual offender treatment in 1973.

In considering treatment, cognitive-behaviourists who adhere to the early form of relapse prevention take the view that sexual offending cannot be "cured" and claims the offender can be taught to "control" their propensity to abuse.

Measurement

Measurement is a critical feature of any program. Assessments are done for various reasons, and the types of measures chosen should be guided both by what is known about the problem in question (in the present case, sexual offending), and why testing is being done. In prison settings, assessments of sexual offenders may be used to determine: (1) the treatment needs of sexual offenders; (2) their security needs; (3) the effects of treatment; and (4) the offenders' risk to reoffend upon release. Such comprehensive evaluations can provide a basis for all the above decisions except, of course, that it would be necessary to repeat the assessment package after treatment was complete to determine the degree to which treatment targets have been met. In community settings, the same issues might be relevant, although hopefully the within-prison evaluations, if they are recent enough, should provide most of this information. In addition, community programs may be asked to provide an evaluation to assist in determining whether or not an offender is ready to return to their family or to some other setting where access to victims may occur.

The first concern clinicians should have when planning assessment is to determine the domains that need to be assessed. Once the targets of assessment have been identified, a search can be made for the best measures of each target.

Treatment

Conceptual model

The first thing to note about treatment for sexual offenders is that group therapy is usually the chosen approach due to the superior efficiency of group therapy, allowing, as it does, the possibility of treating far more clients in the same amount of time.

Responsivity

Setting

Although some writers suggest that treating an offender in the community is superior to treating them in prison, there seems no reason to force a choice between settings. The National Strategy described by Williams, Marcoux-Galarneau, Malcolm, Motiuk, Deurloo, Holden and Smiley[6] involves a continuum of services that are initiated during the incarceration phase at an intensity level commensurate with risk and needs, and continues

into the community as less intensive, but equally important, maintenance. This strategy also provides more structured maintenance treatment for sexual offenders at higher risk on release, and may involve placement in a supervised halfway house.

Contraindications

Most programs exclude offenders who are suffering from an acute psychiatric disorder because they are unlikely to gain from treatment and are a disruptive influence. However, as soon as the illness can be managed effectively (i.e., via medication), such sexual offenders should be permitted to join a suitable treatment program. Their offence chain should incorporate those idiosyncratic internal or external stimuli that may be part of the relapse process.

For all sexual offenders, management difficulties may arise in the course of treatment. These may include refusal to participate, breaking confidentiality, or disruptiveness during group sessions. All efforts should be made to engage the offender in the treatment process, but if individual counselling, peer confrontation, or, as a last resort, behavioural contracting, is ineffective, the group needs should take precedence over the individual. There is no evidence that individual therapy is conducive to changes in sexual offenders, and providing the option of one-on-one treatment may discourage the offender from discussing critical issues in group sessions.

Program timing

There is some debate regarding the best time to provide sexual offender treatment programs. Often the timing of treatment is related to availability of treatment services. By matching risk and need to treatment intensity, resources can be directed to the programs serving the largest populations.

Program sequencing

Programs which target thinking styles, impulsivity, educational upgrading, employment skills, alcohol and drug abuse, as well as family violence, could be provided while the higher risk sexual offender is awaiting specialized treatment. These programs could prepare the offender by addressing general therapeutic issues such as group processes, confidentiality, trust, openness, and by exposing offenders to specific strategies such as videotaping.

Special applications

Females make up a very small percentage of the total population of sexual offenders under federal jurisdiction in Canada (0.3%). A recent study by Kleinknecht, Williams and Nicholaichuk[7] identified only 70 convicted female sexual offenders who had served federal sentences between 1972 and 1998. However, there has been an increase in this population over these three decades.

Kleinknecht et al. surveying all female sexual offenders incarcerated since 1972, found that their primary characteristics were consistent with those of female offenders in general. They had little education, minimal or no employment history, and patterns of alcohol or drug abuse. The majority described childhood and adult histories of being emotionally, physically, and sexually abused. Many had diminished self-esteem, assertiveness deficits, relationship problems, and mental health concerns, such as depression, post-traumatic stress disorder, and eating disorders. Of those who had a criminal history, most involved acquisitive, drug-related, or prostitution offences.

Treatment features

Therapist requirements

The only evidence currently available on the influence of therapist features in the treatment of sexual offenders comes from two studies by Beech and his colleagues in England.[8] The study found, in both community and prison programs, that therapists who treated clients with respect, challenged supportively, and displayed empathy toward clients, generated far greater behavioural change than did more authoritarian, confrontative, and unempathic therapists. The importance of therapist characteristics or style has been neglected, yet it is a seemingly important feature of sexual offender treatment that needs to be addressed. A joint project between the English Prison Service and Canadian researchers is underway to examine the influence of both therapists' behaviours and offenders' responsivity in the effectiveness of treatment with sexual offenders.[9] To date, this study has demonstrated that a number of therapist features can be reliably identified,[10] and that these are related to beneficial changes in the clients' targeted behaviours, thoughts, and feelings.[11]

Mode of delivery

Most treatment programs for sexual offenders in North America, Britain, Australia, and New Zealand are based on a cognitive-behavioural model incorporating relapse prevention strategies. These models lend themselves to the specification of treatment procedures.

There are three dimensions on which group therapy for sexual offenders may vary: it may be psycho-educational or more psychotherapeutic in approach; it may involve discrete components that are procedurally specified in detail, or it may simply set targets and be more process-oriented; and groups

may be open or closed. Presently we have no evidence that would allow us to decide between these alternatives, so it seems therapist preference should be the deciding factor.

Level of treatment

It would be both pointless and a waste of resources to provide the same level of treatment to all sexual offenders. CSC is among the few systems that actually adjusts the intensity and extensiveness of treatment to the level of need among its clients. CSC quite sensibly attempts matching treatment needs with differing intensities of treatment. In order to meet the needs of a heterogeneous population of sexual offenders, Williams et al. developed a National Strategy for Canadian sexual offenders under the jurisdiction of Correctional Service of Canada.[12] This strategy uses a specialized sexual offender assessment in conjunction with the Offender Intake Assessment (OIA) (PROCESS) to determine the risk, need, and responsivity factors for each sexual offender. Thorough evaluations permit the identification of three levels of need: high, moderate, and low.

CSC is among the few systems that actually adjusts the intensity and extensiveness of treatment to the level of need among its clients.

High needs offenders need more time to reach acceptable levels of functioning for each of the targets of treatment, and they will almost certainly need programming additional to sexual offender specific treatment (e.g., cognitive skills, living without violence, substance abuse).

It is important to note that increasing self-esteem facilitates changes in all other targets of treatment,[13] including the reduction of deviant sexual preferences.[14]

Treatment effectiveness

There are several aspects to determining the value of treatment, although the typical approach with sexual offenders has been to look at reductions in post-discharge recidivism. While this latter index is critical, even if recidivism is significantly reduced, a treatment program would be of little value if either few candidates entered treatment, or most withdrew or remained but were non-compliant. Thus, treatment refusals, dropouts, or failure to effectively comply are relevant indices of the utility of a treatment program. These variables can all be considered to be features of treatment participation.

Treatment outcome

There are two aspects to outcome evaluations. The first concerns an evaluation of whether or not participants meet the goals of treatment. This is assessed by evaluating changes from pre- to post-treatment on measures that assess functioning on each of the targets (or components) of treatment. If a treatment program aims at increasing self-esteem, correcting cognitive distortions, enhancing empathy, improving social and relationship skills, eliminating deviant sexual preferences, and generating clear offence chains and relapse prevention plans, then measures of these targets must demonstrate change. Treatment providers must first demonstrate that the procedures and processes they use typically generate the anticipated changes, otherwise it is unfair to hold any individual offender responsible for not having reached the expected goals. A series of studies have demonstrated that the procedures outlined above produce the desired changes in self-esteem, empathy, denial, minimization, loneliness and intimacy.

Recidivism studies

One of the problems that beset those who attempt to evaluate treatment effectiveness is the low base rate of reoffending among untreated sexual offenders. As Barbaree points out, this low base rate increases the probability that we may falsely reject the hypothesis that treatment has beneficial effects, simply because we do not have the statistical power to discern real effects.[15] Quinsey and his colleagues, on the other hand, have expressed concern that we may too hastily conclude that treatment is effective when in fact properly designed studies may subsequently reveal no effects for treatment.[16] To date, no resolution has been reached on the best way to deal with these problems.

It is somewhat incomplete to determine the benefits of treatment solely in terms of reducing future victimization. This, of course, ought to be our concern, but we also have to be fiscally responsible; that is, it may be possible to provide effective treatment, but the cost may be beyond society's willingness to pay for such benefits. This may be particularly so if reductions in recidivism are statistically significant but not remarkable.

While overall the presently available data may not convincingly demonstrate to all readers the benefits of treating sexual offenders, we are inclined to believe that, at the very least, they encourage optimism about the value of treatment. ■

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R-88 ***Results of an Evaluation of the Peer Support Program at Joliette Institution for Women***

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Programming for violent offenders

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The preoccupation with violent offenders has heightened following the emphasis on risk appraisal over the past decade. It is therefore not surprising that in addition to changes in sentencing and policy, correctional jurisdictions are now attending to the treatment and management of high-risk and violent offenders. This article focuses on interventions and programs for violent offenders that are intended to reduce recidivism. Further, these programs can be linked to the specific treatment needs of violent offenders rather than criminality more generally.

Defining violent offenders

A major impediment in the treatment of violent offenders has been confusion over their definition. Violent offenders are usually defined in terms that are not mutually exclusive such as criminal convictions (e.g., assaults), attitudes (e.g., hostility), emotions (e.g., anger), and victim selection (e.g., spousal assault). The failure to specifically delineate types of violent offenders has obscured the identification of treatment needs and confounds program effectiveness research.[2] For example, predominantly instrumentally aggressive clients are unlikely to show substantive gains in an arousal management-based anger control program. Further, even observable and measurable changes by an offender (e.g., knowledge of anger principles), may well be unrelated to reductions in future violence simply because the domain was not criminogenic for that particular offender. Upon evaluation, such a program might then be considered to be ineffective. More accurately, it should be considered ineffective for certain types of violent offenders.

Treatment needs and targets

Literature reviews of risk factors in chronically violent or aggressive individuals yield such problems as:

- hostility
- impulsivity
- substance abuse
- major mental disorders — acute symptoms
- antisocial personality, psychopathy
- social information-processing deficits
- experience of poor parenting
- neglect as a child.

These factors or treatment targets can be organized into domains and compared among different types of violent offenders to demonstrate the need for matching offenders' treatment needs with program content. These five domains can be related to the expression or inhibition of violent behaviour. These domains are:

- competence (social skills and empathy)
- arousal (anger)
- schema (aggressive beliefs and hostile attributions)
- self-regulation (impulsivity)
- anxiety (neuroticism).

Tolan and Guerra have described four different types of violent offenders, which include predatory, relationship, situational, and psychopathological.[3] Clearly, one treatment program cannot adequately address the needs of all violent offenders, given their heterogeneity. Specifically, predatory offenders (e.g., armed robbers), are considered to have deficits in terms of competence, schema, and self-regulation, but not arousal and anxiety. Therefore, gains in managing arousal and anxiety should not be expected to result in the inhibition of violence for these offenders. That is, according to this model, anger-based intervention for predatory offenders should fail to yield reductions in violent recidivism because arousal and anxiety are unrelated to their use of violence. Such a conceptual model, however, requires validation.

Predominantly, the treatment of violent offenders has focused on anger control. This approach views violence as resulting from an offender's inability to identify and manage anger. More recently, measures of treatment readiness, cognitive style in the form of hostile attribution biases, social problem solving, and relapse prevention knowledge and skills have been incorporated into violent offender assessments.[4]

Treatment intensity

The strategy for determining treatment intensity for violent offenders is not well defined. Treatment intensity must balance frequency and duration of sessions, and program integrity. Clinicians' resilience and mental health must also be considered in determining treatment intensity because violent offenders are a challenging group. The setting in which treatment is provided also complicates the issue of the intensity of a program, as it is far more difficult to provide higher intensity programs in the community than in institutions or residential programs.

The range and severity of the treatment needs, then, not criminal convictions should determine the ideal length of a program for violent offenders. Currently the range in duration of such programs is 4 to 6 months with a minimum of 135 hours programming, although some programs provide 240 hours of combined group and individual treatment.

Residential versus community-based programs

Poor attendance is a key issue in community-based intervention. Demanding more intensive treatment, then, would be problematic in the community. Residential programs provide increased control to clinicians and compliance is higher, although attendance and punctuality are far from perfect. Also, programming can be more flexible, (e.g., longer programs are more easily accommodated, as are programs that require more frequent sessions or morning or afternoon sessions). Lastly, institutional programs increasingly seem to focus on identifying and coping with high-risk situations as an important aspect of treatment.

Treatment programs

It should be clear thus far that interventions for chronic or persistently violent offenders must be multi-modal and multi-faceted. A review of tertiary level pharmacological and psychological programs follows.

Pharmacological interventions

At this time, no medication has been developed or approved specifically for the treatment of violent behaviour. Several classes of psychotropic medications, however, have been utilized with some success with specific types of violent individuals.

While positive reports about the impact of medication on violent behaviour are encouraging, this literature is plagued with numerous methodological problems, including small sample sizes, lack of control groups, failure to utilize double-blind procedures, issues of non-compliance, and poor diagnostic accuracy. As well, although medication may have an impact on certain biological causes of violent behaviour, on its own it is rarely effective in reducing violence over the long term.

Psychological interventions

Psychotherapy and social casework have not proved effective at reducing antisocial behaviour.[5] In the juvenile literature, multidimensional programs such as those involving family systems have had the greatest impact. Implicit in the proliferation of anger control programs is that violent offenders are angry and that their level of anger exceeds that of non violent offenders. Accordingly, reduced levels of anger are anticipated to result in less frequent and optimally less violent behaviour. This is a curious notion in that violence is relatively infrequent, unreliably measured, and often appears to be motivated for reasons other than anger.[6] Recent programs now include skills practice in the areas of social skills, assertion, problem solving, and empathy.

The Rational Behaviour Therapy approach more specifically emphasizes the role of cognitions, notably irrational beliefs, in the provocation and maintenance of anger levels. Offenders are taught that their irrational beliefs result in increased arousal (anger) and that their arousal precipitates aggressive behaviour. Intervention targets the link between thoughts and feelings, challenging offenders to refute irrational beliefs, presumably decreasing the likelihood of aggressive responses.

Program effectiveness

Several studies have examined the efficacy of cognitive-behavioural interventions for aggressive adult offenders. Hunter[7] offered a 10-week anger management program to 28 incarcerated male offenders who had a propensity for interpersonal violence, using a control group of 27 inmates. The intervention included relaxation therapy, stress management, conflict resolution, and cognitive therapy, the latter targeting errors in thinking (hostile and aggressive thoughts), irrational beliefs, and negative self-talk. She found that treated offenders showed significant gains relative to non-treated offenders across self-report and behavioural ratings.

Hughes[8] provided a 12-week anger management program to 52 incarcerated adult offenders and attempted to compare them to a control group of

27 offenders. The latter were men who either dropped out of the program after one or two sessions, or who opted not to participate in the program for a variety of reasons. The program, described as both educational and experiential, consisted of relaxation therapy, assertiveness training, moral reasoning, problem-solving, and rational emotive therapy. Hughes found that treated offenders reported post-treatment gains regarding anger scores, irrational beliefs, and in role-plays. However, there was no difference in recidivism rates between the treated and non-treated groups.

Kennedy[9] compared the relative efficacy of stress inoculation treatment to a behavioral skills treatment with a sample of 37 incarcerated adult offenders. Offenders completed several self-report measures both pre- and post-treatment. As well, Kennedy completed pre- and post-treatment behavioral ratings of structured role-plays, and reviewed offender files for relevant incident reports. She found that offenders showed post-treatment gains on several of the measures. However, she also completed an interim assessment of treatment gain and found that order of presentation of treatment had no effect. The greatest treatment gain occurred in the initial phase of treatment regardless of which treatment was offered initially.

Guerra and Slaby's[10] intervention consisted of 120 aggressive adolescents, equally divided by gender, being randomly assigned to a 12-week cognitive mediation training, attention control, or no-treatment control. Pre- and post-treatment assessment incorporated measures of social cognition (beliefs about aggression), behaviour ratings, and self-report. Post-treatment gains for the treatment group were noted in terms of increased skills in solving social problems, reduced support of aggressive beliefs, and reduced aggressive behaviours (based on blind raters). The follow-up period was 24 months for the recidivism analyses. The inference is that these socio-cognitive factors regulate aggressive behaviour, yet recidivism rates for the treated subjects, although reduced, were not significantly lower than the controls.

The Correctional Service of Canada has begun the evaluation of an Anger and Emotions Management program. Recidivism data for a matched sample (on risk, age and major admitting offence) of 110 male offenders who completed the Anger and Emotions Management Program indicate it was effective. Greatest effects were noted for higher-risk offenders, with a 69% reduction in non-violent recidivism and 86% reduction in violent recidivism, although the two groups differed with respect to time at risk.[11] Further, change scores on several self-report measures were significantly related to outcome. Subsequent analyses[12] have indicated that treatment dropouts have violent failure rates 8 times that of the treatment group (40% versus 5%) and twice that of the controls (40% versus 17%). A newly created program performance factor was significantly correlated with recidivism ($r = .32$, $p < .01$), and approached statistical significance in a regression analysis. Finally, a comparison of 41 matched (age, risk, past program performance) pairs of offenders indicated that the controls had rates of recidivism three times that of the treated group, but this difference was not statistically significant

Lastly, in 1996 the Correctional Service of Canada developed an intensive treatment demonstration program for incarcerated persistently violent adult offenders.[13] The treatment program is intense, involving four group sessions and one individual session per week for 16 weeks. Treatment is provided by two staff — a doctoral level registered psychologist and a bachelor's level therapist. Based on a review of the literature, treatment targets include motivation for treatment and behaviour change, aggressive beliefs, cognitive distortions, arousal management, impulsivity, conflict resolution, problem-solving, assertiveness, empathy enhancement, and relapse prevention. An exhaustive multi-method assessment protocol has been developed and preliminary data are available[14] that support modest gains, as measured by the test battery and behavioural ratings with more detailed analyses in terms of outcome to be forthcoming. The program received accreditation by an external panel in 1999. The conceptual framework for this program has also been adapted for implementation in a large number of sites within the Service under the auspices of a Violence Prevention Program.[15]

Future directions

Notwithstanding the concern about violent offenders, there exists a surprisingly small body of literature describing effective treatment efforts, particularly in contrast to other groups such as sexual offenders and spousal abusers. Most published studies do report treatment gains, but this has mainly been restricted to self-reports and has not generalized to improved recidivism rates. To date, measurement of treatment efficacy has been confounded by this over-reliance on self-report questionnaires, the absence of control groups, and problems in the definition of violent offenders.

Implicit in the proliferation of programs for violent offenders is that this will lead to reductions in violent recidivism. The evidence across programs is encouraging but not compelling. Nonetheless,

offenders who complete programs appear to be more likely to succeed. The most impressive studies regarding both methodology and outcome are from the juvenile literature and reflect comprehensive multisystemic programs. Efforts should be initiated to better incorporate best practices from the juvenile literature into treatment programs for violent adult offenders. The juvenile literature also places greater emphasis on skill acquisition in the areas of family dynamics and problem solving as compared to the emphasis with adults on arousal management, although this appears to be changing. Conceptual models, then, that integrate arousal level, self-regulation, and cognitive style may prove helpful as clinicians strive to provide programs for an array of different types of violent offenders. This appears to be the direction im which the field is moving as various correctional jurisdictions de-emphasize arousal-based anger control programs or augment the range of available programs.

What are the implications for incorporating treatment into risk management strategies for violent offenders? In those programs that focus on relapse prevention, the offense cycle provides a mechanism to discover antecedents or proximal factors to an offender's use of violence. Also, in those programs that utilize comprehensive risk appraisals, treatment provides an opportunity to comment on the intensity and nature of community aftercare and supervision. Explicit decision rules to assist clinicians against unbridled optimism might be advantageous in incorporating treatment performance into risk management strategies.

Lastly, there is increasing consensus regarding the "correct" components for a treatment program, methods to address treatment resistance, and methodology to demonstrate treatment gain and treatment effectiveness. Equally importantly, these are increasingly being applied to the specific target of violent offending. ■

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Don't be shy

Feel free to drop us a line and let us know what you think of FORUM. We are always happy to hear from our readers and interested in any suggestions about our content, our look and our approach.

Problems of self-regulation among adult offenders

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Self-control has been utilised extensively as an explanatory concept in the field of psychology and in forensic psychology in particular. A number of researchers and theorists have linked self-control, as often measured by impulsivity, risk-taking, failure to delay gratification, egocentrism, temper, and limited goal setting, with criminality.[3] *Despite its extensive use, there remains a lack of consensus in the literature regarding the definition of self-control or the mechanisms of self-regulation. Instead, impulsivity, seen as a result of a deficiency in the self-regulation process, is frequently used as a catchword to clarify a wide variety of antisocial tendencies that otherwise lack sufficient explanation.*

Recently, Barkley has developed a hybrid model of self-regulation based on developments in the area of Attention Deficit Hyperactivity Disorder (ADHD) that could provide the necessary theoretical framework to advance the research in the area.[4] The model accounts for the developmental features of ADHD and is consistent with empirical findings regarding children, adolescents and adults with the disorder. The theory provides an explicit and theoretically sound definition of self-control and identifies the cognitive and behavioural problems in self-regulation that can be expected based on the model. The model is particularly useful because it points to a number of potential targets that could be addressed in treatment programs.

Barkley argues that ADHD is a deficit in behavioural inhibition that affects the normal development of four neurophysiological functions: working memory, the self-regulation of affect and motivation and arousal, internalization of speech and motor control and sequencing, and behavioural analysis and synthesis. Performance of the executive functions implicates self directed actions; the organization of behavioural contingencies across time; the use of self directed speech, rules, or plans; deferred gratification; and goal-directed, future-oriented, purposive, or intentional actions.

Extent of the problem among federal offenders

The population of serious offenders would be expected to have high rates of problems with self-regulation. At admission into the correctional system, each offender undergoes a comprehensive assessment based on file review and interview. Among the items that compose the assessment, several pertain directly and indirectly to problems in self-regulation. Over 80% of federal offenders are assessed by intake officers as having one or more of the problems related to self regulation included in Table 1. Research indicates that problems in self-regulation are associated with poorer outcomes. As the Table highlights, offenders who reoffend within one year after release, were significantly more likely to have problems in self-regulation. Conversely, an absence of any problems in the area of self-regulation reduces offenders' probability of reoffending within a year of release. Eighty-eight percent of offenders with no problems in self-regulation remain offence free after one year of release as compared to an expected rate (general survival rate) of 64.2%.

Table 1

Percentage of federal offenders identified with problems related to self-regulation

OIA Indicators	Recidivists*	Non Recidivists	*p*
Lacks direction	75.2	59.9	.001
Impulsive	80.5	67.2	.001
Thrill seeking	37.5	27.3	.001
Poor conflict resolution	75.6	67.4	.001
Poor regard for others	62.6	52.5	.001
Low frustration tolerance	53.6	43.7	.001
Unrealistic goal setting	36.5	27.7	.001
Non reflective	59.8	50.4	.001
Poor problem solving	77.8	70.1	.001
Unable to generate choices	67.7	60.6	.001

**Offenders who have reoffended within one year of release*

Measures of impulsivity

Tests have been constructed as a means to operationalize impulsivity without an explanation of the mechanisms underlying impulsivity. As such, impulsivity has become defined by the task or tests used to operationalize it. The reliance of the psychological literature on instruments that measure

impulsivity without a consensus of definition and a lack of theory in the field is clearly problematic.

In a review of the research on the impulsivity construct, Milich and Kramer listed three specific problems with the test-specific approach to defining and understanding impulsivity.[5] First, up until the time of their publication, they found that most of the measures failed to offer any incremental validity beyond age and IQ in understanding impulsivity. Second, there was a lack of any empirical convergence in the literature. This suggested that many measures were tapping into different constructs and that some, or all, were failing to tap into the impulsivity construct. Third, was the complete dearth of theory driven research. It would seem that the atheoretical nature of the construct of impulsivity is largely responsible for limiting progress in this area.[6]

The literature reveals the following consistent problems with self-report inventories of impulsivity:

- Lack of external criterion measures and biological measures other than other questionnaire scales.[7]
- Questionnaire measures of impulsivity are at least significantly intercorrelated but have low order and often insignificant correlations with behavioural or cognitive measures of impulsivity.[8]
- At present, there is a lack of research into the dynamic nature of these instruments.

It is evident that many techniques that purport to measure impulsivity are not measuring the same construct. The circular nature of the debates will not end until measurement of the concept applies external criterion.

The lack of consensus regarding the conceptualisation of impulsivity is indisputable. This inconsistency in the use of this concept has certainly found its way into the measurement of the construct. A strong theoretical orientation needs to be provided that can guide future efforts at scale construction in order to expose the links between impulsivity, its various manifestations, and antisocial conduct. For this reason we have turned to Barkley's[9] conceptualisation of the self-regulation process. Barkley's model not only attempts to identify the mechanisms that serve the self-regulatory system but also specifically documents the nature of these systems and the structure in which they function.

There does not seem to be an overwhelming array of options to evaluate self-regulation processes of criminal offenders. Future instruments should attempt to measure the performance and abilities of individuals to inhibit task-irrelevant responses, executing goal-directed responses, execute novel/complex motor sequences, persist in goal-directed behaviour, respond appropriately to feedback, exhibit behavioural flexibility, re-engage in a task following disruption, and control their behaviour by internally-represented information. Recent hi-tech innovations in brain imaging provide precise modelling of the functions of the brain in response to stimuli. These advances could one day permit the biological criterion for components of self-regulation for both self-report and behavioural measures.

Treatment implications for adult offenders

If we accept that deficits in self-regulation linked to neurophysiological underfunction are present in chronic offender populations and are implicated in their repetitive antisocial behaviours, a medication regime similar to that prescribed for hyperactive children may be a logical treatment option for these adults as well. There is, however, limited evidence for the utility of any kind of medication to address problems in self-regulation among adult offender populations. Most of the rare studies in the area are plagued by methodological problems of small sample size, lack of control groups and high rates of attrition. Two controlled pharmacological studies in the literature assessing the use of stimulants on adults with ADHD found a positive treatment response analogous to that of treated children, albeit a number of subjects experienced unpleasant side effects.[10] Other studies have treated impulsive adults with tranquillisers[11] and anticonvulsants.[12] Cocarro's work links impulsive aggression in adults with low serotonin levels. He and his team have reported on successfully treating impulsively aggressive adults with SSRIs and the non responders (to the SSRIs) with antimanic medications.[13]

Another intervention strategy is to directly train individuals in the cognitive and coping skills they have not developed due to impairments in inhibition. Meta-cognitive strategies for slowing down cognitive processes and training in the development of skills that less impulsive individuals use to achieve their goals (through self-regulation) are components of such intervention programs. Table 2 outlines the deficits that should be addressed in a program designed to treat problems in self-regulation. In addition to these, we have pointed out that problems in self-regulation often lead to an antisocial orientation and an endorsement of beliefs and a lifestyle that are supportive of crime and rejecting of prosocial conventions and values. For this reason, the *content* of offenders' thinking should be addressed as well as their thinking process.

Meichenbaum's early work on the self-instructional learning pointed the way for those working with clients with problems in self-regulation.[14] He proposed that self-instruction, composed of training in guided self-talk, assisted clients by allowing them to better perform five functions: direct their attention to relevant events; interrupt an automated response to environmental stimuli; search for and select alternative courses of action; uses rules and principles to guide behaviour (i.e. self-instruction criteria for success, aid in the recall of certain actions and focus thinking along relevant dimensions; and maintain a sequence of action in short term memory so that they can be enacted.

Among offenders, over the last 15 years cognitive-behaviour interventions that emphasise the training of self-regulatory skills have been identified as the treatment approach most often associated with reductions in offender recidivism. Reviews that have applied meta-analytic techniques to the evaluation of a large body of published, and in some cases, unpublished, research reports find an average small (.08 to .15), but significant, treatment effect size for correctional treatment with the cognitive behavioural interventions being cited as among the approaches consistently associated with positive outcomes. Although about 80% of the studies included in the meta-analyses involve juveniles, there are a number of studies involving adult subjects that point to a similar positive trend in the application of this approach. The most optimistic interpreters of the literature estimate that when "appropriate" interventions are applied, effects sizes above .30 can be expected.[15] This translates into between 10 to 15% differences in recidivism rates between treated and untreated controls (for example, 40% recidivism rates as opposed to 50% or 55%).[16]

Over the last 15 years cognitive-behaviour interventions that emphasise the training of self-regulatory skills have been identified as the treatment approach most often associated with reductions in offender recidivism.

A number of programs that teach thinking skills are now delivered in correctional settings. However, no one program has been so widely adopted as the Cognitive Skills Training or Reasoning and Rehabilitation program as it is also known, was developed by Robert Ross and Elizabeth Fabiano. Cognitive Skills has become a core program in the federal Canadian correctional system and it has been implemented world wide in such constituencies as the United States, Europe, Australia, New Zealand, and throughout the British Prison system and the Probation Service in the United Kingdom. The program is the base program in a menu of six Living Skills programs offered to federal offenders within CSC. The other programs are Anger and Other Emotions Management, Living Without Family Violence, Parenting Skills, Community Integration and Leisure Education. There are also community maintenance programs for the Cognitive Skills and Anger and Other Emotions programs.

In the Cognitive Skills program each component areas is addressed over several sessions with considerable overlap in material designed to provide adequate opportunity to over-learn the skills. A key to the successful delivery of the program has been the selection of a variety of training techniques that create an enjoyable classroom experience for the participants. The program avoids a didactic presentation of material. Rather, the trainers — or coaches, as they are called, use role plays, video-taped feedback, modelling, group discussion, games, and practical homework review to teach the skills.

Future directions

Treatment effectiveness may be enhanced for higher risk offenders by providing more intensive treatment and longer term follow-up or through efficient correctional planning. The Correctional Service of Canada is fortunate in this regard in that there is an extensive menu of programs designed to address a number of treatment needs and most community parole offices are now funded to provide adequate community follow-up once offenders are released from the institutions. Recently CSC has developed standardised high intensity programs designed to address the treatment needs of the highest risk offenders. Although the programs each address different content areas (Violence Prevention, Family Violence Prevention, Substance Abuse Prevention (in development)), the core components of the programs are devoted to training offenders on most of the cognitive behaviour techniques contained in the Cognitive Skills program and allows for more time to for offenders to overlearn the skills and more discussion time to help them understand the application of the techniques to their lives and circumstances. As outlined in Table 1, these newly implemented programs train offenders in the skills and strategies that Barkley's model suggests would be lacking in highly impulsive individuals. The high intensity programs train in an enriched

Table 2

Problems in self-regulation and treatment options to address the deficits

Regulatory behaviour problems (Barkley)	Possible Treatment Options
1. Impairments in working memory. Symptoms problems in means end thinking, external locus of control, behaviour dictated by the immediate situation.	➔ Training to anticipate consequences ➔ Training in problem solving to development a sense of self control rather than external control ➔ Training in setting smaller realistic goals so that behaviour is not dictated by the "here and now"
2. Problems in emotional self control and lapses in motivation and lack of perseverance	➔ Teaching counters to self control failure ➔ Self monitoring and other arousal reduction techniques; using verbal self regulation to "stop and think" ➔ Developing personal goal setting to increase motivation to adhere to the use of the skills; managing distractions ➔ Techniques for self reinforcement and self punishment
3. Impairment in the internalisation of speech and consequentially poor self regulation of behaviour	➔ Teaching verbal self regulation skills to help to identify the event → thinking → feeling → behaviour link and develop and use helpful self talk ➔ Development of behavioural rules or strategies to approach interpersonal problems ➔ Setting standards of conduct (generation of rules)
4. Poor analysis and synthesis of behaviour; failures to use response feedback	➔ Identifying the "behavioural chains" so that the sequence involved in the output behaviour is clarified (relapse prevention techniques) ➔ Evaluating standards and rules and merging with long term goals ➔ Acquiring feedback ➔ Environmental control

range of skills that include many of those contained in the Cognitive Skills as well as items 2, 3 and 4 identified in Table 2.

With expected advances in pharmacological research, future interventions for chronic high risk offenders with diagnosed problems in impulse control might benefit from combining high intensity cognitive behavioural treatment programs with a medication regime that could assist them in modulating their response to the environment. ■

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Guidelines for asking the right questions and communicating results

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Why, what, where, who and how are the key questions that must be asked to conduct a program evaluation. **Why**, *is the most fundamental question regarding an evaluation. The question addresses the reason an evaluation is conducted and the intended goals of the program being evaluated. In asking* **What**, *one must define the precise nature of intervention, the social and/or psychological mechanism that are to be affected, the nature of outcomes, and the program setting. The* **Where** *of program evaluation concerns the location of the program and the timing in relation to the chronology of the offenders' correctional career.* **Who**, *refers to the program participants and their characteristics. This question is important in deciding what level of generalization is made after the evaluation is conducted. The* **How** *of program evaluation refers to both quantitative and qualitative methods of evaluation. This article presents these fundamental questions and also touches on the issue of the effective communication of results.*

The Why of program evaluation

Even though this is the most fundamental question regarding an evaluation, it is probably the least likely to be addressed and the least understood. When an administrator asks for an evaluation, it is very important to get an understanding of what he or she wishes to accomplish. Too often these questions of purpose or goals are not asked. An evaluation is conducted. The results are presented and the administrator protests, "That is not what I wanted to know."

Policymakers, administrators, program designers, often do not know how to articulate their interests in what an evaluation will achieve. Thus, the evaluator must make sure that he or she understands what is being asked. This may seem a trivial point when it comes to program evaluations for correctional interventions. Surely we know that the aim of the program is to address some deficiency of the offender and to assist his or her re-integration. But these goals are often too vague. One policymaker may have in mind that for a program to be successful a large proportion of program participants must show dramatic success. An administrator may have in mind that the program will probably only help some offenders and not others and our expectation should not be too high. Some administrators are interested in knowing how to improve a program. A program designer may think that a program success is achieved if the participant changes his or her attitudes about wanting to change their behaviour; yet this may be too low an expectation from the administrator's point of view.

Thus, the evaluator must be able to define the goals of the study, articulate measures or criteria that will satisfy the interested parties and get the stakeholders concurrence either that the research will address their concerns or that some questions will have to await further inquiry. This is best done prior to the research design and before the implementation of the program, particularly for those programs that are new or innovative. If a program is ongoing, it is still important to clarify the administrator's goals.

Rossi and Freeman[2] have devoted an entire chapter on "The Social Context of Evaluation." In that chapter they discuss the implication of evaluation, stakeholders, and the political process involved.

To give these concepts substance, I use one of the most highly charged and politically sensitive areas of inquiry that currently exists in corrections — the effectiveness of prison privatization. In one sense, the total operation of a prison can be viewed as the broadest of program interventions. In fact, there are those that argue that the ultimate judgement of prison privatization depends on whether the industry is capable of doing a better job of reintegrating the offender back into society.

Privatization is a case where the competitors are easy to identify and where the consequences of any evaluation will be hotly contested. The stakeholders consist of policymakers and decision makers (legislators and high ranking government officials). The program sponsors are either private corrections companies or government officials advocating privatization. Evaluation sponsors are typically consulting firms or universities with foundations that do outside consulting. The target participants are the inmates assigned to a particular prison or program. The program management team is composed of corporate CEO's and administrators. The program staff are all those who are hired to deliver services. The program competitors are those companies who competitively bid to deliver a program and in some cases the competitors may be public sector employees. The contextual

stakeholders are not only the individual private companies but also public labour unions and public prison administrators or legislators who line up on both sides of the issue.

Once the goals and purposes of a program evaluation have been defined, the stakeholders identified and the political context recognized, the next step is to analyze all of the components of the program and the nature of the change mechanisms that the program is supposed to address.

It is crucial to understand that the evaluation has a political context and that the results of even a well-conducted evaluation may have little or no impact on policy decisions given the political power of the various stakeholders. The proper role of the evaluator is to conduct a well designed study; to address as many of the questions that stakeholders are interested in; and to report findings and the limitations of the conclusions. Rossi and Freeman cite Donald T. Campbell's proposal that evaluators should act as the servants of "the Experimenting Society".[3] Campbell thought that the proper role of the evaluator is to report one's findings rather than to advocate for a particular program of policy. He also cautioned against a lack of humility in presenting findings.

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The What of program evaluation

There are many considerations at this stage. One must define the precise nature of the intervention, the social and or psychological mechanisms that are to be affected, the nature of the outcomes, and the program setting. Rossi and Freeman advocate the development of an impact model. This is "an attempt to translate conceptual ideas regarding the regulation, modification, and control of behaviour or conditions into hypotheses on which action can be based".[4] They also discuss causal, intervention, and action hypotheses. The impact model contains a causal hypothesis that outlines the nature of the problem being addressed. How does one become an alcoholic? What is the nature of drug addiction? What are the mechanisms of sexual dysfunction? The intervention hypothesis states how the intervention will affect the mechanism of dysfunction. The action hypothesis states whether the intervention is somehow different from the mechanism that caused a problem to occur in the first place. For example, if one is designing a program to teach employment skills, the causal hypothesis states that certain skill sets and competencies are necessary to become employed. The intervention hypothesis says that vocational training will improve the set of skills; however, the action hypothesis says that while vocational training improves skills, it does not address all of the competencies required for successful employment. Other competencies include the ability to get along with co-workers or the ability to listen and take orders.

The Where of program evaluation

The where of program evaluation concerns the location of the program and the timing in relation to the chronology of the offender's correctional career. Program location may seem unimportant; however, it can often be the deciding factor whether a program is successful or not. A residential drug abuse program located in an environment where drugs are readily accessible or where staff, other than the program staff, are not supportive of the intervention is unlikely to succeed regardless of how well the program is designed. Program support is something that is not typically documented by program evaluators. This can have grave consequences for program success.

The Who of program evaluation

Defining program participants is as important as defining the nature of the program. In some cases, the characteristics of the program participants may be so important that the evaluator will want to experimentally manipulate the relation between the intervention and the target population. The risk principle is a global statement of the nature between interventions and the program participants. It says that regardless of the nature of the program or the intervention, the program will demonstrate a greater success for those offenders who are at higher risk. There are of course many other characteristics of the target population that could affect the inferences to be made. Are there gender-specific types of interventions? Are there socio-economic factors? What types of interventions have the target population participated in before? All of these questions are necessary not only to control for background characteristics of the population. They are important in deciding what level of generalization we want to make after the evaluation is conducted.

The How of program evaluation

Quantitative versus qualitative approaches

Most of the modern research on program evaluation emphasizes quantitative methods to determine whether an intervention has been successful. I am an advocate of quantitative research because I think it is the only way that the social sciences will be able to establish laws about human behaviour. But there is a great deal of room for the qualitative analyst in the social sciences and in evaluation research. Even though we assume that interventions are based upon the best science available and we may be simply expanding on an intervention that has been used before, a great deal can be learned by participant observation, interviewing program participants, or simply observing program participation with an open mind set. Anyone who has conducted serious quantitative analysis knows how much variability there is to the human response. Some of this variability may be explained by a host of variables that we use to analyze the data. But there will almost always be a great deal of residual variance. One way to approach that quantitative phenomenon is to use qualitative methods to explore the differences in human responses. Using this approach, qualitative methods are complementary to quantitative techniques.

Complementing quantitative with qualitative information

I borrow several examples from Patton's book on qualitative methods[5] to show how qualitative evaluation can be used to supplement quantitative analysis. Patton describes an evaluation of a literacy program where the evaluators used quantitative methods to measure the gain score in literacy and scales to assess participants' satisfaction with the program. While students did show positive gains from the program, the evaluators dug deeper and used individual case examples to explain the nature of the gains and open-ended interviews to enhance their understanding of satisfaction with the program.

When program participants were asked to describe their opinions about the program, they gave specific reasons why they were so satisfied. No longer constrained to the specific responses in the satisfaction questionnaire, participants described how they could now read the newspaper; make a shopping list; understand the instructions on their medicine bottles; navigate city streets better; and, how they could take the written test for their drivers license.

Qualitative data is not simply an exposition of quantitative data, it often suggests that the categories we choose to uniformly measure a phenomenon may not be the "phenomenology" of the participant. Open-ended interviews or open-ended items allows the participant to express attitudes, opinions, or beliefs that may provide a fresh insight into the program impact. This may be especially important during the early phases of a program design or implementation.

Appropriate use of qualitative methods

Patton has also outlined "Particularly Appropriate Uses of Qualitative Methods".[6] The following briefly describe each of these.

Process studies and process evaluations

Process evaluations examine the nature of how an outcome is achieved. Program evaluations should always be based on theory that articulates how an intervention will modify human behaviour. To understand the mechanism of change, the researcher can supplement quantitative measures of mediating outcomes with interviews that probe the client on the nature and causes of his or her behaviour. It is my experience that even in successful intervention programs, attempts to quantitatively relate process to outcome typically have limited success. In quasi-experimental designs or observational studies, it is particularly important to rule out artifactual or unintended causes of an outcome. Process evaluations not only examine the mechanisms of changes but the change agents themselves. Thus, program providers are also under study in a qualitative process evaluation. Patton lists the following questions: "What are the things people experience that make this program what it is? What are the strengths and weaknesses of the program? How are clients brought into the program and how do they move through the program once they are participants? What is the nature of staff-client interactions?"[7]

Formative evaluations for program improvement

Formative evaluations are intended to improve a program. These are also process evaluations that emphasize the strengths and weaknesses of a program. A program may be well-designed, based on sound theory, and well measured; yet, there may be internal group or individual dynamics that interfere with program progress. Perhaps staff are not well trained or they are not "connecting" with the clients. Formative process evaluations seek to uncover these problems.

Evaluating individualized outcomes

The matching of treatments and program services to the needs of clients is the mantra of many social workers, psychologists, and educators. Yet, matching is rarely an explicit part of a program assessment process. One way to approach matching is to do qualitative studies in which the researcher provides descriptions of the different ways clients react to different treatments, treatment styles, and treatment providers. Evaluators document the unique perspectives of clients to the treatment regimen. This may lead to a typology and eventually to a quantitative assessment of specific matching hypotheses.

Case studies to learn about special interest, information-rich cases

Cases can be chosen that represent particularly incisive information about a particular program. Perhaps case studies of extreme program failure are relevant. Structured interviews with these clients may indicate alternative strategies for subclasses of individuals. Such inquiries may extend to dropouts, or to people who show dramatic gains from a program. In each case, the researcher is interested in understanding the nature of failure or success so that the program can be improved.

Comparing programs to document diversity

When one tries to adapt a national program or a "universal intervention" to a specific location, there are many reasons to expect that there are local nuances in program implementation or potential differences in the clients. These differences may contribute to unexpected outcomes. These differences can be documented both quantitatively and qualitatively.

Implementation evaluations

The best interventions will fail if attention is not given to the implementation of a program. Most evaluators using objective, quantitative data go about their measurement of outcomes assuming that the program has been successfully implemented. There are quantitative methods to assess program implementation; however, qualitative methods can also be of assistance here. Patton addresses the problem with the following qualitative dimensions: "What do clients in the program experience? What services are provided to clients? What does staff do? What is it like to be in the program? How is the program organized?"[8] This qualitative approach should be supplemented with tests of what the client has learned or ratings of the effectiveness of the treatment provider by other knowledgeable people. Thus, once again we can complement one type of information with the other.

Identifying a program's or organizations's theory of action

According to Patton, a theory of action relates program inputs and actions to outcomes. This sounds very much like a well articulated theory. However, citing Argyris[9] Patton discusses "espoused theories" from "theories-in-use. The former are those principles advocated by program designers or program theorists. The latter are the beliefs of the treatment provider, the street level bureaucrat actually doing the work. A qualitative assessment of both will indicate the extent to which there is parallelism in the plans of the treatment designer and the treatment provider. This may be especially crucial in a new groundbreaking approach.

Focusing on program quality or quality of life

Patton argues that even if a program evaluation can be clearly defined and measured in a quantitative way, it is still important in many cases, to assess the texture and contours of meaning of program impact by doing a qualitative assessment as well. For example, if we find that an offender is less likely to use drugs after a drug treatment program, what else does this imply about the offender's quality of life? A qualitative response may add insight into the nuances of different responses given by people. What does it mean to be somewhat satisfied as opposed to be completely satisfied with one's treatment?

Documenting development over time

Developmental changes are extremely important in analyzing human and organizational growth (decline) over time. While quantitative data may indicate developmental changes are occurring, qualitative inquiry may give greater insight into the growth process. When we measure growth, we often use linear or sometimes non-linear patterns to demonstrate growth has occurred. But these may be idealized growth curves. Growth may represent sudden transitions in states for some individuals or organizations and slow or little growth in others. Trying to ascertain the growth phenomenon through qualitative analysis may provide a greater understanding of the processes under consideration.

The How of quantitative evaluation and communicating results

The how of quantitative evaluation could cover volumes. It involves research design, quantitative methods, measurement theory, meta-analysis, decisions about cost-benefit procedures, simulations, and many other technical areas. It involves precise operational definitions of the program intervention, the processes it is intended to change, and the outcomes of interest. The skill sets of the evaluators should also to be considered. Psychologists,

sociologists, economists, operations researchers, and computer simulation experts all can bring different perspectives to the evaluation approach. The few comments I want to make here relate to communicating the results of the quantitative analysis.

In their concluding chapter, "The Social Context of Evaluation"[10] Rossi and Freeman discuss the need for evaluators to become "secondary disseminators." Most evaluators are quite good at producing a technical report on the results of the evaluation. These reports are usually only read by peers and not by the stakeholders who are most affected by the evaluation results. Thus, secondary dissemination refers to the communication of research results to the stakeholders in ways that they can understand and that are useful to making further policy decisions. This kind of communication should be direct and short. It should provide any necessary qualifications or limitations of the study, often missing from executive summaries. It should also use language that the stakeholders can understand omitting the technical jargon of the discipline. It can be a humbling experience to ask your audience what they learned from your presentation. But it is also my experience that getting their feedback is better than their silence. ■

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3 Campbell, D. T. (1991) "Methods for the Experimenting Society," Evaluation Practice. 12, no 3.

4 Rossi and Freeman, p. 119.

5 Rossi and Freeman, p. 119

6 Patton, M.Q. (1990) *Qualitative Evaluation and Research Methods: Second Edition*, Newbury Park, CA, Sage.

7 Patton, Chapter 4, p. 92-141.

8 Patton, p. 95.

9 Patton, p. 105.

10 Argyris, C. (1982) Reasoning, Learning, and Action: Individual and Organizational. San Francisco: Jossey-Bass.

Cost-effective correctional treatment

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The evidence is overwhelming — human service-based interventions reduce criminal recidivism; punishment does not. Recently synthesised findings based on over 500 studies spanning five decades of research clearly indicate that any kind of human-service based treatment reduces recidivism on average by 10%.[2] Moreover, treatment approaches that follow empirically validated principles of effective intervention yield substantially higher reductions ranging from 26% to 40%.[3] Clearly, we know what works with certain offenders. Equally important, however, is determining whether or not effective interventions are cost-effective from an economic perspective. The research over the last 10 to 15 years clearly establishes programs that reduce recidivism can generate substantial cost-savings in the long run. Cost savings have typically included reduced criminal justice costs, reduced monetary victim expenses such as forgone wages, medical expenses, property losses, and more recently, intangible victim losses such as reduced pain and suffering and reduced loss of life. Prominent findings from the last 10 to 15 years are highlighted in this article.

Efficiency evaluations, more commonly known as cost-benefit or cost-effectiveness analyses, strive to promote optimal resource allocation. Cost-benefit analyses generate conclusions such as "every dollar spent on program X saves the taxpayer $10.00 in the long run". In contrast, cost-effectiveness analyses report the benefits of a given program in substantive rather than monetary terms. Thus, a cost-effectiveness analysis might conclude, "sex offender treatment costs $12,000 per potential victim saved".[4] Research comparing the cost-effectiveness of punishment versus treatment strategies is reviewed followed by a review of specialised treatment programs.

A well-publicized article[5] from the mid 1980s concluded that prisons are a highly cost-effective means of reducing crime given that every dollar spent on imprisonment generates $17.00 in tangible returns. However, the article was widely criticised for several theoretical, methodological, and ethical reasons.[6] Further, contemporary research findings indicate that treatment is a substantially superior alternative.

A recent meta-analytic review[7] analyzed 108 correctional treatment outcome studies from a cost-benefit perspective. Traditionally, meta-analytic techniques have been used to aggregate the findings of a large number of treatment studies to ascertain the average impact that treatment has on reducing recidivism. The aforementioned review represents the first attempt at estimating average cost-savings using meta-analytic techniques.

Cost savings were reported for several different treatment categories from two perspectives: the taxpayer and the victim. The taxpayer's perspective focused exclusively on criminal justice savings (e.g. police, adjudication, corrections) while the victim's perspective incorporated criminal justice savings as well as monetary victim losses (e.g. medical & mental health care expenses, property damage and losses, reduced future earnings). Intangible victim costs such as pain and suffering and loss of life were excluded. In sum, the review demonstrated that on average, every dollar spent on human-service orientated interventions (N = 88) saves the taxpayer approximately $5.00, and the victim, $7.00. Conversely, punishment-orientated interventions such as boot camps and intensive supervision programs that rely on expensive strategies such as random curfew checks, electronic monitoring, and urinalysis testing (N = 20) yielded substantially lower economic returns ranging from 50¢ to 75¢ for every program dollar spent.

Also notable is a recent article[8] that conducted a cost-effectiveness comparison of California's three-strikes law versus early intervention programs. Two of the most promising intervention programs included graduation incentives and parenting skills training. Briefly, graduation-incentive programs financially compensate disadvantaged high school students to encourage their graduation. Alternatively, parenting skills programs involve in-home training for parents with aggressive children. The study estimates that California's three-strikes law will reduce crime by 21% at an annual increased incarceration cost of 5.5 billion dollars. However, graduation incentive programs coupled with parenting skills training could roughly double the crime reduction rate for 1/5 of the cost, approximately 1 billion dollars.

The literature has also examined the relative cost-savings attributable to specific treatment regimes. For example, cost-savings have been estimated for juvenile offender treatment as well as for a number of adult treatment targets including education and

employment, substance abuse, sexual offending and cognitive-behavioural deficits. The meta-analysis previously mentioned reviewed 21 human-service orientated juvenile offender treatment programs including parent skills training, diversion programs, and aggression replacement training. The results indicated that each juvenile treatment dollar generates between $7.62 to $31.40 in future economic returns.

It has also been estimated that one chronic juvenile offender will incur between 1.3 and 1.5 million dollars in criminal justice expenses (20%), intangible victim costs (50%), tangible victim costs (25%), and foregone offender productivity (5%).[9] This implies that relatively small treatment effects can generate substantial cost savings. For example, a program that costs $500,000 to treat 100 chronic juvenile offenders would still be deemed cost-effective with a success rate as low as 1%. However, in reality, success rates are substantially higher, particularly for intensive juvenile treatment programs such as multi-systemic therapy (MST). While the meta-analytic review reported that MST generates $13.45 dollars in return for every dollar invested in the program (based on the 1.3 to 1.5 million dollar estimate), MST could potentially generate $60.00 in economic returns for every program dollar. This latter estimate is based on the assumption that MST has a 20% success rate. The discrepancy ($13.45 vs $60.00) is most likely attributable to the fact that the meta-analytic review excluded intangible victim costs whereas intangible victim costs accounted for 50% of the 1.3 to 1.5 million-dollar estimate.

The efficiency literature has reported that adult offender treatment can be cost-effective.

The efficiency literature has reported that adult offender treatment can be cost-effective. For example, every dollar allocated towards vocational and basic education programs yields cost savings ranging from $1.71 to $3.23. Similarly, job search and/or counselling programs generate positive returns ranging from $2.84 to $4.00. Conversely, short-term financial assistance and subsidized job placement programs generate break even returns (e.g. 1 dollar spent = 1 dollar gained). As well, adult cognitive-behavioural treatment programs generate economic returns ranging from $2.54 to $11.48 for every invested program dollar.[10]

The efficiency literature has also given considerable attention to substance abuse treatment. While drug diversion programs have generated modest returns (e.g. $1.69 to $2.18 for every program dollar), interventions classified as case management substance abuse programs have actually generated negative returns, whereby every program dollar actually costs the taxpayer 15¢, and the victim 21¢.[11] However, more encouraging findings are also available. For example, a recent Canadian study demonstrated that one of the Correctional Service of Canada's core substance abuse treatment programs generated approximately $2,000 in annual savings per offender.[12] Similarly, research conducted on substance abusers, rather than criminal offenders suggests that for every 100 treated substance abusers, society accrues between 1.4 and 2.2 million dollars in reduce crime-related costs including reduced criminal justice costs, reduced tangible victim losses, reduced intangible victim losses, and reduced forgone offender productivity.[13]

In terms of sex offender treatment, the literature has produced conflicting results. Three separate cost-benefit analyses conducted in Canada, the United States and Australia have estimated that by treating 100 sex offenders society can potentially accrue between 4 and 7 million dollars in economic gain.[14] In contrast, the meta-analytic study concluded that sex offender treatment was not cost-effective and reported that every dollar spent on sex offender programming generates 25¢ in economic returns. However, the meta-analytic conclusions were based solely on six studies whereas a more recent endeavour identified 34 sex offender treatment outcome studies.[15] A more comprehensive cost-benefit analysis that incorporates all 34 studies is forthcoming.

In sum, cost benefit analysis relies extensively on uncertain assumptions and at times, less then reliable cost estimates. Further, attributing monetary value to human pain and suffering as well as human life remains controversial. Nonetheless, as the competition for limited resources intensifies, cost-benefit evaluations will undoubtedly play a prominent role in policy development. ■

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