FORUM

on Corrections Research

September 1995, Volume 7, Number 3

Featured issues

Offender Treatability

Motivation

Learning disability

The responsivity principle

Predicting treatment response

Correctional Service Canada
Service correctionnel Canada

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FORUM on Corrections Research

Guide for Prospective Authors

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To submit an article to FORUM, send two copies of the article in addition to a diskette copy (in WordPerfect 5.1 or MS Word) to

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Style

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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Edited articles are sent to the authors for final approval before printing.

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The Correctional Research and Development Sector of the Correctional Service of Canada

by ***Arden Thurber*** [1]
Assistant Commissioner, Correctional Research and Development, Correctional Service of Canada

The Correctional Research and Development Sector was formed in late 1994 as part of the reorganization of the Correctional Service of Canada's national headquarters. This "new" sector has incorporated the Service's former Research, Correctional Programs, and Staff Training and Development divisions into one group.

The unification is a significant step, as the three divisions should always be (and usually were) involved in the transformation of research findings into programming or staff-training efforts, or in the identification and development of new research initiatives. Their union should facilitate this cohesiveness, as well as hopefully sparking new creative energy, as some of the Service's most innovative people work more closely together.

Further, while restructuring, the Service has maintained its commitment to correctional research and program development. In an age of cutbacks, the funding committed to the Correctional Research and Development Sector remains equal to (if not slightly more than) the total funding previously given to its three core divisions prior to their unification.

What is the sector's mandate?

The Correctional Research and Development Sector, like all Correctional Service of Canada components, has a mandate to help achieve the Service's corporate objectives:

- to consistently manage offenders in accordance with their risk of violent reoffending and provide appropriate programming that contributes to the release of low-risk offenders when they become eligible;
- to provide a safe and healthy correctional environment for both staff and offenders;
- to ensure that Service staff follow policy, meet operational standards, use resources efficiently and effectively, and exercise professional judgment; and
- to help all staff make reasonable and informed decisions by providing timely, accurate, easily accessible and meaningful offender-related data.

The Correctional Research and Development Sector will contribute to the fulfillment of these objectives by helping the Service continually improve its understanding of the offender population, effective offender management, and trends in corrections, criminology and criminal justice.

The sector will also develop programs, approaches and tools related to all aspects of corrections (particularly risk reduction) and assist in their implementation, and will explain the Service's approach to its correctional mandate to staff and the public. Finally, the sector will use research and analysis to improve the Service's understanding of security-intelligence trends that may impact on current or future operations.

The team approach

The sector will use multidisciplinary teams in sector projects to ensure that the right expertise is focused on the right problem at the right time. This should improve the sector's ability to deliver knowledge and to arrive at more accurate estimates of the money and effort needed to translate this knowledge into practical results.

The sector is also experimenting with "team leader sessions" as an internal discussion and training forum. Once the format of these sessions has been finalized, they will become the sector's primary vehicle for identifying and discussing internal strategic issues and decisions.

Resource management

The Correctional Research and Development Sector will generate more detailed estimates of the *real* cost of projects (such as by obtaining field-staff estimates) to help improve the planning and management of sector resources. The sector will also use a time allocation formula to more accurately measure the time staff have available for project work. Hopefully, these efforts will give the sector a realistic picture of what it can achieve — or of what it needs to achieve more.

The Correctional Research and Development Committee

The Correctional Research and Development Committee is a strategic think tank within which ideas, concerns and concepts can be discussed. The Commissioner of the Service will chair the committee and its members will include the Correctional Research and Development Sector's three senior managers, as well as representatives from the Canadian Centre for Management Development, the National Parole Board, Citizens' Advisory Committees and the Service's regions (among others).

However, the committee is not a decision-making body. It is a sounding board for ideas and a mirror on the correctional environment that will, hopefully, allow the Service to both learn of new issues and receive expert advice on managing current ones.

The Correctional Research and Development Resource Centre

The Correctional Research and Development Resource Centre will bring together much of the information needed by sector staff in a single location. It will store research data, documents and reports, videotapes, and other materials, as well as acting as a distribution point for publications and equipment.

The centre will also provide links to electronically stored information in on-site data files, the Correctional Service of Canada network, the Solicitor General Ministry Secretariat library or the Internet. Printed documents may also eventually be scanned so they can be stored electronically. The goal is to reduce the staff time spent searching for information or recreating existing knowledge.

The centre will also coordinate the creation and distribution of information packages for staff, external partners (such as academics) and the public. One of the primary information products will be a series of packages tentatively titled *What Do We Know About...?*. Each package will summarize the Service's current knowledge on a particular topic (such as sex offenders). The centre will supplement these packages, where possible, with audio-visual material to simplify group presentations.

Knowledge to action

The first result of sector work will almost always be knowledge or tools. However, if we treat this knowledge as the end result, we will have failed to achieve our mandate. Simple knowledge, in and of itself, does not get us very far. It is only by transforming knowledge into practice that it gains real value. We must, therefore, embrace a "knowledge-to-action" approach in delivering products.

At the most basic level, this means actively participating in mechanisms created to solicit the sector's input. The most appropriate individuals must take part in such intersector activities. These representatives must canvass other sector members for useful contributions to the discussions and must deliver any responses as soon as possible to maximize the response time and options available to the Service.

Further, all Correctional Research and Development projects will provide estimates of any organizational impact (including costs) likely to result from implementation of the project's results. This will include an action plan for ensuring that all appropriate sectors are aware of, and poised to respond to, the impacts.

The sector will also invite a couple of operational managers (such as wardens or district directors) to provide a quick, focused "reality check" of the sector's impact analysis by reviewing sector conclusions. These individuals will be asked to confirm or challenge our conclusions and to suggest any improvements in the proposed implementation process.

Finally, all sector projects will include an information package (that can be circulated by the resource centre) that explains the implementation impact of the project to regional and field management, staff and offenders.

This commitment to transforming knowledge into action perhaps best symbolizes the role of the Correctional Research and Development Sector and of its research magazine – *Forum on Corrections Research*. ■

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Offender motivation for treatment as a responsivity factor

by ***Lynn Stewart***[1]
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and ***William A. Millson***
Balex Research and Statistical Consulting, Ottawa

The Correctional Service of Canada's Correctional Strategy is based on a rehabilitation model that assumes that offenders have needs that directly cause their criminal behaviour, that we can diagnose these needs accurately, that appropriate intervention is available, that intervention will reduce these needs, and that reduced need will diminish criminal behaviour.

More generally, effective correctional rehabilitation is commonly considered to be founded on four principles: the risk principle, the need principle, the responsivity principle and the principle of professional discretion.[2]

This article examines the responsivity principle — focusing on offender motivation for treatment as a responsivity factor. The article assesses the relationship between ratings of offender motivation for treatment and conditional release outcome.

Treatability

Discussions of treatability in non-correctional literature tend to focus on client characteristics associated with openness to treatment. However, those working in correctional settings rarely deal with responsive clients. Many in the offender population are not well-spoken, intelligent or highly motivated to change. In short, correctional staff are usually working with higher-risk clients whom many clinicians might consider untreatable.

The responsivity principle

While the responsivity principle emphasizes client characteristics, it also focuses on the conditions of program delivery that promote positive change. This generally involves behavioural intervention, using techniques such as modelling, graduated practice, role playing, reinforcement and cognitive restructuring.

Discussions of treatability in non-correctional literature tend to focus on client characteristics associated with openness to treatment. However, those working in correctional settings rarely deal with responsive clients. Many in the offender population are not well-spoken, intelligent or highly motivated to change.

Within the cognitive-behavioural framework, services should be designed to fit individual offender conceptual levels and personality styles. It is also critical to have a positive therapist-offender relationship.

However, offender motivation for treatment has proved to be an elusive responsivity factor in correctional populations. Offender willingness to address identified problems probably peaks as they prepare their case for a parole hearing. But few offenders would agree to participate in community-based programming after release — unless they have to.

In the past, many clinicians have refused to treat offenders who would not actively engage in the process. However, there is now an available body of literature that focuses on motivation as an intermediate treatment target and provides guidelines for increasing client motivation for treatment.

Methodology

The Correctional Service of Canada's Ontario Region recently developed an instrument that allows case workers to assess the level and type of offender need and to recommend appropriate intervention.[3]

The Community Offender Management Strategy requires case management officers to assess the level of offender need (low, medium or high) in seven domains linked to criminal behaviour. Case supervisors then rate offender motivation to address each area of need.

Table 1

Offender Motivation for Treatment and Conditional Release Outcome

Need domain	Motivation level	Release suspended within six months
Employment	Low	36.2%
	Moderate	31.1%
	High	22.9%
Marital/family	Low	34.4%
	Moderate	27.8%
	High	20.5%
Associates/social interaction	Low	31.0%
	Moderate	29.7%
	High	20.5%
Substance abuse	Low	36.2%
	Moderate	31.1%
	High	22.9%
Community functioning	Low	36.7%
	Moderate	28.9%
	High	18.8%
Personal/emotional orientation	Low	39.3%
	Moderate	26.0%
	High	21.3%
Attitude	Low	34.5%
	Moderate	27.0%
	High	19.3%

$p < .001$

A motivation rating of *low* means the offender strongly rejects the need for change or is unwilling to participate in recommended programs. *Moderate* means the offender may not fully accept the assessment but will participate in recommended programs, while *high* means the offender is self-motivated and actively addresses problem areas.

Case management officers complete the initial assessment within 30 days of an offender's release and reassess each offender at least every six months.

The data for this study were collected from almost all parole offices in the Service's Ontario Region over a two-year period covering 2,400 offender assessments.[4] Conditional release suspension data was collected and calculated after an average release period of six months.

Motivation and type of need

The case supervisors assessed about half of the offenders studied as highly motivated to address significant need areas. The domain these offenders were most willing to address through programming was employment (59.5% were highly motivated), while the domain they were least interested in addressing was attitude (44.1% were highly motivated).

The motivation level for all domains was significantly related to conditional release outcome. Offenders rated as highly motivated had generally better outcomes than offenders rated as moderately motivated and considerably better outcomes than those with low motivation (see Table 1).

Motivation and level of need

The combination of offender motivation ratings with offender level of need assessments for each domain improves predictions of conditional release outcome within six months of release.

In general, the greatest difference was found between high need / low motivation offenders and low need / high motivation offenders.

The high need / low motivation offenders were two to three times more likely to have their conditional release suspended than the low need / high motivation offenders (see Table 2).

Table 2

Level of Need/Offender Motivation and Conditional Release Outcome

Need domain	Level of need/ offender motivation	Release suspended within six months
Employment	Low need/high motivation	13.7%
	High need/low motivation	48.0%
Marital/family	Low need/high motivation	14.2%
	High need/low motivation	35.7%
Associates/social interaction	Low need/high motivation	14.9%
	High need/low motivation	41.2%
Substance abuse	Low need/high motivation	16.5%
	High need/low motivation	41.2%
Community functioning	Low need/high motivation	16.1%
	High need/low motivation	38.5%
Personal/emotional orientation	Low need/high motivation	15.5%
	High need/low motivation	40.0%
Attitude	Low need/high motivation	14.2%
	High need/low motivation	35.7%

$p < .001$

Motivation and risk level

As expected, high-risk offenders tended to be rated as less motivated than low-risk offenders. When general motivation across all seven domains was assessed for high- and low-risk offenders, 76.1% of the most motivated offenders (rated as highly motivated in all seven domains) were low-risk offenders, while 71.2% of the least motivated offenders (rated as having low motivation in all seven domains) were high-risk offenders.

Offenders with the best conditional release outcomes were low risk and highly motivated (just 8.5% of this type of offender had their conditional release suspended within the six-month period).

However, motivation level did not seem to significantly affect the conditional release outcomes of high-risk offenders. The conditional release suspension rate for high-risk offenders rated as highly motivated in all domains was not significantly different from the rate for high-risk offenders with low motivation in all domains (36.2% versus 35.4%).

Despite the empirical support for motivation as a responsivity factor, the relationship between motivation for treatment and conditional release outcome is not as strong as the relationship between risk and need ratings and outcome.

Motivation for treatment as a responsivity factor

These results indicate that motivation for treatment is a significant responsivity factor in correctional populations. Simple motivation ratings were significantly related to conditional release outcome for all seven need domains in the Community Offender Management Strategy. Further, high-need offenders with poor motivation had the poorest conditional release outcomes.

However, it appears that risk rating is not improved by also considering motivation level when dealing with high-risk offenders.

Despite the empirical support for motivation as a responsivity factor, the relationship between motivation for treatment and conditional release outcome is not as strong as the relationship between risk and need ratings and outcome. As such, motivation for treatment should be considered as just one component of a thorough assessment. ■

[1] Main Floor, 330 Keele Street, Toronto, Ontario M6P 2K7.

[2] These conclusions are based largely on the work of Don Andrews.

[3] C. Townson, "An improved risk-assessment process: Ontario Region's Community Offender Management Strategy," *Forum on Corrections Research*, 6, 3 (1994): 17—19.

[4] The total number of offenders varied slightly in each calculation because of missing data.

Coming up in *Forum on Corrections Research...*

The theme of the January 1996 issue of FORUM will be "Employing Offenders," while the May 1996 issue will focus on "Sex Offender Management." The September 1996 issue will be the 25th issue of FORUM to be published and will focus on "Effective Correctional Programming."

Factors influencing the outcome of offender substance abuse treatment

by ***John R. Weekes***[1]
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and ***Lynn O. Lightfoot***
Department of Psychology, Queen's University

Unfortunately, much of the assessment and treatment of offenders with substance abuse problems fails to recognize the varying severity of these problems.

Recent research has demonstrated that about 30% of offenders do not have substance abuse problems, 30% have low-severity problems, 17% have intermediate problems, 13% have substantial problems, and 10% have severe problems.[2]

These wide differences suggest that a range of programming is needed to meet the treatment needs of all offenders. Some individuals may need relatively little treatment to control or eliminate their substance use, while others may require more extensive intervention, administered over a longer time period, with formal maintenance and follow-up.[3] *In short, not everyone needs the same amount or type of treatment.*

Researchers also often fail to consider the risk of recidivism, despite the fact that research has repeatedly demonstrated a strong link between substance use and criminal behaviour.[4] *The risk of recidivism may, therefore, be another important variable in predicting treatment outcome and offender post-release behaviour.*

Finally, treatment performance may be crucial to predicting an offender's likelihood of controlling or eliminating their substance use. However, there are few, if any, Canadian correctional substance abuse treatment programs that comprehensively and objectively assess each participant's performance. As a result, little research has examined whether offender treatment performance influences post-release behaviour.

This article, therefore, examines the impact of these three potentially key factors (severity of the substance abuse problem, risk of recidivism and treatment performance) on the substance abuse treatment outcome of inmates who are subsequently released.

However, there are few, if any, Canadian correctional substance abuse treatment programs that comprehensively and objectively assess each participant's performance. As a result, little research has examined whether offender treatment performance influences post-release behaviour.

The Offender Substance Abuse Pre-release program

The treatment program used in this study was the prototype for a program that has since been modified and implemented nationally by the Correctional Service of Canada as the Offender Substance Abuse Pre-release (OSAP) program.[5]

Although this program was designed for offenders with intermediate alcohol and drug problems, offenders with problems of all severities (from low severity to severe) went through the program during the study period because of the lack of other available programming.

The program is highly structured and makes active use of various behavioural and cognitive-behavioural approaches that have promise in changing substance abuse behaviour.[6] More specifically, the program addresses alcohol and drug education, self-management, problem solving, cognitive and behavioural skills training, social skills, job skills refresher training, leisure and lifestyle planning, relapse prevention, and pre-release planning.

The program also contains a comprehensive battery of measures designed to assess offender progress, both individually and collectively, from before entering the program to after its completion.

Methodology

A total of 324 adult offenders (315 men and 9 women), ranging in age from 18 to 66, participated in the Offender Substance Abuse Pre-release program at Bath Institution between January 1990 and August 1992. Bath Institution was a minimum-security institution at the time of the study.

The final sample was ultimately made up of 317 offenders, as seven offenders did not complete the program. The average offender sentence length was 40.5 months. Just 2.5% of the sample were serving a life sentence, while almost 82% were experiencing their first term of federal incarceration (a sentence of two years or longer). Just over 37% of the sample had been convicted of a violent crime, with 28.4% having been convicted of a nonviolent offence and 34.1% having been convicted of a drug- or alcohol-related offence.

The small number of female participants precluded any analysis of potential gender differences.

The severity of offender alcohol and drug problems was assessed before offenders entered the program with three screening instruments (that were originally developed and standardized using non-offender populations): the Alcohol Dependence Scale,[7] the Drug Abuse Screening Test[8] and the Michigan Alcohol Screening Test.[9]

The Community Risk/Needs Management Scale[10] was used to determine the risk of recidivism, while offender program performance was assessed using a battery of eight measures that were administered before and after offender program participation.[11]

Four of these measures focused specifically on aspects of alcohol use, including the negative effects of alcohol, strategies for declining offers of alcohol and ways of consuming alcohol responsibly. A fifth measure focused on the negative consequences of drug use, while the remaining three measures consisted of questions relating to both alcohol and drug use, such as the impact of substance use on employment.

The Offender Information System (which has since been replaced by the Offender Management System) provided all information on offender post-release criminal behaviour. The system provided extensive quantitative information on release, conditional release revocations, reconvictions and offence types.

Information on offender post-release alcohol and drug use was obtained by examining parole officer reports in files maintained by the National Parole Board.

More than 90% of the offenders who completed the program ultimately received some form of conditional release. Of these offenders, 72.1% were released on day parole, 7.7% on full parole and 20.2% on statutory release.

The follow-up period was, on average, about 15 months, post-release. During this period, 31.4% of the sample were returned to custody — 19.9% because of technical conditional release violations and 13.6% for new offences (2.1% returned because of both a technical violation and a new offence).

Review of the National Parole Board files revealed that about 73% of the offenders who were returned to custody had used alcohol and/or drugs while on release and that substance use had contributed to the termination of their release.

Severity of the substance abuse problem

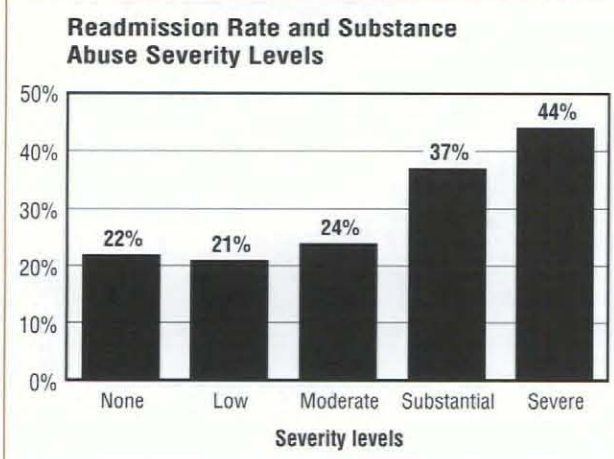
Offender alcohol and drug severity scores were pooled to classify each offender according to their most severe substance abuse problem (alcohol, drugs or both).

Under this classification, 16.2% of the offenders were identified as having a low-level substance abuse problem, 19.7% had an intermediate problem, 40.5% had a substantial problem, and 20.1% had a severe problem. Interestingly, 3.5% of the sample were not assessed as having either an alcohol or drug problem.

These findings indicate that approximately 80% of the offenders had alcohol problems, drug problems or combined alcohol and drug problems of sufficient severity to warrant their participation in the Offender Substance Abuse Pre-release program. The remaining 20% (those without a substance abuse problem or with a low-level problem) probably gained admittance to the program because of other information (such as case file information or interviews) identifying them as appropriate candidates.

The rate of readmission into custody (for any reason) increased dramatically according to the severity of offender substance abuse problems (see Figure 1). These differences were statistically significant ($p < .05$).

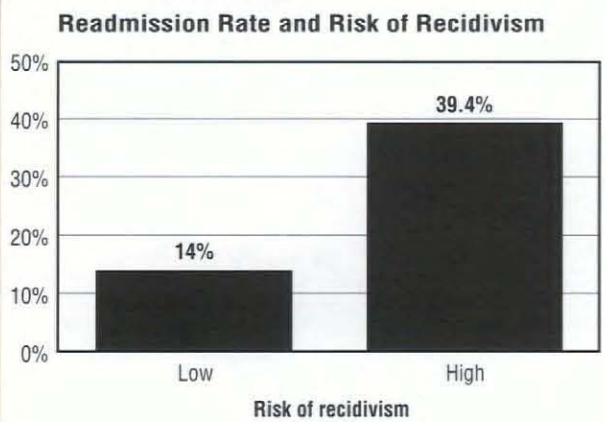
Figure 1



Risk of recidivism

Approximately 38.2% of the offenders released were assessed as being at low risk of recidivism, while the remaining 61.8% were determined to be high risk. The ultimate offender readmission rate differed significantly according to risk level ($p < .0001$). Just 14% of low-risk offenders were returned to custody (for any reason), compared to 39.4% of high-risk offenders (see Figure 2).

Figure 2



A similar pattern emerged in a subgroup of high-risk/high-need offenders with intermediate to severe substance abuse problems.

Program performance

Most of the offenders who participated in the program improved significantly on almost all assessment measures. However, a simple analysis of changes in offender responses to the battery of assessment measures (from pre- to post-program participation) revealed nothing about offender release behaviour.

A five-level performance index was, therefore, created by classifying offenders based on the number of measures on which they demonstrated improvement from the beginning to the end of the program. Interestingly, offender program performance was found to be unrelated to the rate of readmission for technical conditional release violations.

However, program performance was significantly related to the readmission rate for new offences ($p < .05$). This readmission rate dropped from 46% for the offenders with the poorest program performance to 11% for the offenders with the best performance (see Figure 3).

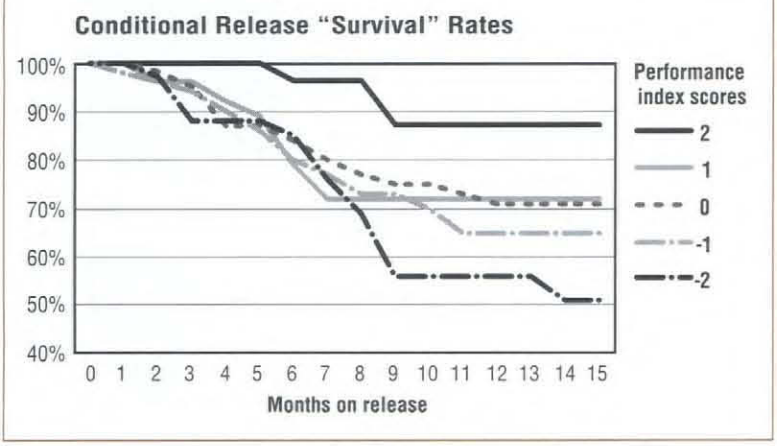
Figure 3

Offender post-release "survival" rates (those not returned to custody) were also examined by tracking offenders after release. The offenders who scored poorest on the performance index had the worst survival rate after the initial seven to eight months of release (see Figure 4). The differences were again statistically significant ($p < .05$).

Key factors

This study demonstrates that three important factors influence offender post-release behaviour (as measured by readmission into custody for technical conditional release violations or new offences). First, offenders

Figure 4



with more serious substance abuse problems (alcohol and/or drugs) were returned to custody at a significantly higher rate than offenders with less severe problems.

Second, offenders identified as being at higher risk of returning to their criminal ways returned to custody at a higher rate than low-risk offenders. Similar patterns were secured for even the highest risk/highest need offenders.

Finally, offender program performance (based on pre- and post-program assessment measures) was related to offender post-release outcome. Specifically, program performance was related to the likelihood of conviction for new offences.

Unfortunately, this study lacked a comparison group of offenders who did not receive substance abuse treatment. This would have allowed for a determination of the relative outcome improvement of treated offenders as compared to those without treatment.

Nevertheless, these findings clearly indicate that differences in the severity of offender substance abuse problems, their risk of recidivism and their program performance are important factors in predicting who is likely to return to custody after release.

The results underscore the need for a range of correctional treatment options, as well as the need for close monitoring and assessment of offender program performance during treatment. ■

[1] Correctional Policy and Corporate Planning, Correctional Service of Canada, 4th Floor, 340 Laurier Avenue West, Ottawa, Ontario K1A 0P9. For more information, please see *The Offender Substance Abuse Pre-release Program: Analysis of Intermediate and Post-release Outcomes* (Ottawa: Correctional Service of Canada, 1995). We offer our sincere appreciation to the following individuals, who supported this study and made significant contributions to this line of substance abuse research: Diane Black, John Eno, Elizabeth Fabiano, Greg Graves, Lee Marchildon, Nancy Morin, Larry Motiuk, Frank Porporino, David Robinson, Lois Rosine, Catherine Wenek and Linda Simourd.

[2] J. R. Weekes, E. Fabiano, F. J. Porporino, D. Robinson and W. A. Millson, Paper presented at the Canadian Psychological Association meeting, Montreal, Quebec, 1993.

[3] M. B. Sobell and L. C. Sobell, *Problem Drinkers: Guided Self-change Treatment* (New York: Guilford Press, 1993).

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The impact of time served and custody level on offender attitudes

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Some criminologists have argued that incarcerating offenders for long periods of time helps control crime. This argument is based on the belief that potential offenders will weigh the pains of severe punishment and refrain from criminal behaviour.[2] *As a result, the American criminal justice system is generally imposing longer prison sentences than in the past.*

However, violent crime rates continue to escalate.[3] *It is equally arguable, therefore, that long prison sentences fail to improve crime control. After all, most inmates are eventually released without serving their full sentence.*

More importantly, the concept of prisonization suggests that the longer inmates are confined, the stronger their identification with inmate norms and values and the greater their difficulty in adjusting to life once released.[4] *Further, a prison environment deprives the individual of liberty, worldly possessions, access to heterosexual relationships and personal autonomy. Since inmates share these deprivations, they tend to band together to reduce their individual pain.*[5]

This article, therefore, attempts to determine the impact of long prison sentences and high custody levels on offender attitudes, as well as the resulting disposition of offenders toward treatment and post-release success.

Methodology

An inmate study sample was asked what crime(s) they might commit, after release, if they knew they wouldn't be caught. The sample was made up of 462 inmates: 166 from a maximum-security prison, 131 from a medium-security prison, and 165 from a minimum-security or work-release centre.

The inmates were allowed to choose among the following: "sex with your woman even if she says no" (sexual assault), "rob $100,000" (robbery), " kill a person who put you down hard" (murder), "beat the heck out of a person who gets in your face" (aggravated assault), "take things you want that you can't buy" (theft), "take drugs and/or alcohol when it pleases you," and "none."

Length of sentence

Based on the responses to the question, the longer an inmate had been incarcerated, the greater their acceptance of crime. For example, just 9% of the inmates who had served 5–24 months and 4% of the inmates who had served 25–48 months reported that they might commit sexual assault, while 29% of the inmates who had served 49–72 months, 36% of the inmates who had served 73–96 months, and 33% of the inmates who had served 97–120 months said they might commit sexual assault.

Similar trends emerged when the other offence categories (such as robbery, murder and theft) were examined (see Table 1).

Table 1

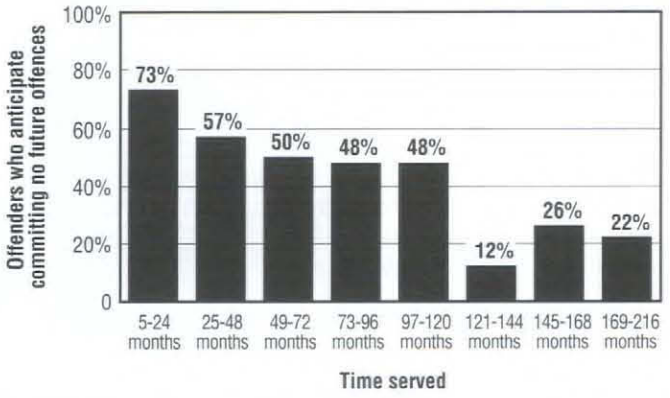
Length of Incarceration and Anticipated Offences (462 Inmates)

	Time served							
Anticipated offence	**5–24 months**	**25–48 months**	**49–72 months**	**73–96 months**	**97–120 months**	**121–144 months**	**145–168 months**	**169–216 months**
Murder	5%	7%	18%	16%	15%	25%	16%	0
Sexual assault	9%	4%	29%	36%	33%	50%	32%	22%
Robbery	27%	53%	47%	48%	43%	88%	63%	56%
Assault	27%	27%	38%	46%	48%	25%	32%	22%
Drugs/alcohol	14%	33%	39%	45%	45%	88%	42%	67%
Theft	18%	17%	29%	35%	33%	50%	42%	33%
None	73%	57%	50%	48%	48%	12%	26%	22%

Note: The percentages total more than 100% for each time-served grouping, as some inmates chose more than one offence. However, if "none" was chosen, all other choices were ignored.

Figure 1

Length of Incarceration and Inmate Anticipation of No Future Offences



On the other hand, 73% of the inmates who had served 5–24 months anticipated committing no future crime, compared with 57% of the inmates who had served 25–48 months, 50% of the inmates who had served 49–72 months and, ultimately, 22% of the inmates who had served 169–216 months.

In short, the longer the offenders were in prison, the more likely they were to see crime as part of their future (see Figure 1).

The fact that the inmates most likely to anticipate a crime-free future were those who had spent the least time in prison (and vice versa) is consistent with the argument that perceived severity of sentence is little deterrent to future criminality.[6]

Custody level

The inmates incarcerated in a minimum-security or work-release facility were more likely to favour a crime-free future than inmates housed in medium- or maximum-security prisons.

For example, 37% of the inmates in maximum-security prisons and 43% of the inmates in medium-security prisons stated that they might commit a future sexual assault, compared with none of the offenders in the minimum-security facility.

As for murder, 21% of the maximum-security inmates and 24% of the medium-security inmates indicated that they might commit murder once released. Again, none of the minimum-security offenders expressed such sentiments. Similar trends emerged for all other offence categories (see Table 2).

If we assume that the minimum-security inmates were less violent before incarceration, these data may support a class perspective in dealing with inmates — based on the notion that inmates bring their street attitudes with them into prison.[7]

However, 44% of the minimum-security inmates had committed violent crimes (including murder and sexual assault), and many were from the same "streets" as the inmates housed in the medium- and maximum-security prisons.

Violent and nonviolent offenders

Many of the previously violent inmates changed their minds about crime. Roughly 58% of the sample reported that they had committed a violent crime in the past. However, these inmates account for 46% of those who anticipated committing no further offences (see Table 3).

Unfortunately, not all of the inmates with nonviolent histories maintained this perspective.

Table 2

Custody Levels and Anticipated Offences (462 Inmates)

	Custody level		
Anticipated offence	**Maximum security (166)**	**Medium security (131)**	**Minimum security (165)**
Murder	21%	24%	0
Sexual assault	37%	43%	0
Robbery	54%	39%	20%
Assault	48%	48%	18%
Drugs/alcohol	49%	54%	18%
Theft	32%	41%	14%
None	24%	18%	98%

Note: The percentages total more than 100% for all custody-level groupings, as some inmates chose more than one offence.

This group of inmates accounted for 45% of those who said they might commit sexual assault, 32% of those who said they might commit robbery, 55% of those who said they might commit murder, and 42% of those who said they might commit assault. Overall, these

offenders accounted for just 54% of those who said they might remain crime free.

One explanation for this change may be a prisonization effect, although this explanation would also illustrate that not all inmates are affected by prisonization.

However, more than half of the inmates (both violent and nonviolent) who preferred a crime-free future had spent less than 48 months in prison.

Table 3

Level of Previous Violence and Anticipated Offences (462 Inmates)

	Previous Offence	
Anticipated offence	**Violent (266)**	**Non-violent (196)**
Murder	45%	55%
Sexual assault	55%	45%
Robbery	68%	32%
Assault	58%	42%
Drugs/alcohol	60%	40%
Theft	47%	53%
None	46%	54%

A new approach...

Time served and custody level clearly affect inmate attitudes. Inmates who had served shorter sentences in a minimum-security facility favoured crime-free futures more often than offenders who had served longer sentences under close supervision.

This holds true independent of any pre-incarceration offender orientations toward violence.

In short, organizational membership affects attitudes.[8] It could, therefore, be argued that short prison sentences have a more favourable impact on inmate attitudes than longer sentences.

In fact, many countries successfully use short sentences as a tool to control both recidivism and government expenditures.[9]

Long prison sentences for nonviolent offenders may, therefore, not serve their intended purpose — they add to correctional costs and may contribute to higher recidivism levels because of their impact on inmate attitudes.

The preferred response to nonviolent criminality should, therefore, perhaps be mandatory short-term (two years or less) incarceration in a community work-release centre.

Not only would this approach be more conducive to offender attitudes favourable to treatment and post-release success, but it would also allow offenders to maintain employment and close contact with their family. ■

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Correctional work supervisor leadership and credibility: Their influence on offender work motivation

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Research has indicated that many offenders have little or no work experience.[2] *Further, two thirds of the offenders surveyed in a recent study*[3] *stated that their needs arose from a lack of education and employment skills.*

It has, therefore, been argued that steady employment during incarceration is instrumental to offender development of the work habits and values necessary for successful community employment.[4] *Offenders have echoed these sentiments.*[5]

In addition to the skills promoted or imparted by a particular correctional employment program, the resulting positive attitudes and behaviours displayed by offenders may vary in accordance with the work supervisor's leadership style (such as the promotion of work skills or positive work attitudes).

Several studies have examined a number of such characteristics in therapeutic settings, but few have examined these characteristics among correctional work supervisors. One of the few corrections-focused studies found that offender work supervisors trained in "transformational" leadership were able to enhance offender productivity, skills development, work habits and personal growth.[6]

This article evaluates the impact of work supervisors' leadership behaviour, perceived credibility and performance, based on offender self-report measures of work motivation, job involvement, the extra effort they were willing to exert and their punctuality for work.

Transactional leaders reward employees for attaining predetermined objectives and punish for failure to achieve such goals. Transformational leaders go beyond the transactional relationship by encouraging employees to strive for additional goals and interests — don't just meet goals, achieve your best.

Methodology

In an attempt to examine a variety of correctional work supervisor leadership styles, supervisors and offenders were sampled from seven Correctional Service of Canada institutions. A multi-source assessment approach was used to assess the impact of supervisor attributes on offender work motivation, incorporating measures obtained from work supervisors, offenders and work supervisor managers. Thirty-five work supervisors, 143 offenders and seven managers completed self-report questionnaires.

Supervisor leadership styles were examined using the Multifactor Leadership Questionnaire,[7] which assesses transactional, transformational and nonleadership behaviour.

Transactional leaders reward employees for attaining predetermined objectives and punish for failure to achieve such goals. Transformational leaders go beyond the transactional relationship by encouraging employees to strive for additional goals and interests — don't just meet goals, achieve your best. Transformational leaders tend, therefore, to inspire and motivate employees by promoting shifts in attitudes, beliefs, values and needs. Nonleadership behaviour refers to a laissez-faire, or more passive approach.

The questionnaire also examines organizational outcome measures, such as the extra effort made by employees.

Offenders must perceive correctional staff as credible for correctional intervention to be effective. Credibility (which involves trust,

inspiration and competence) is also essential to effective leadership.[8] Given the potential impact of work supervisor credibility on employee motivation, this study also measured the perceived credibility of supervisors.

Supervisors and offenders completed the leadership questionnaire, while just the offenders assessed the perceived credibility of supervisors. In addition, offenders completed measures designed to assess their work motivation — including intrinsic job motivation, the meaningfulness of their work, responsibility for work outcomes and job involvement. Offender punctuality ratings compiled by supervisors provided a concrete, behavioural measure of motivation.

Finally, managers completed a short questionnaire that examined supervisor effectiveness in obtaining extra effort from the offenders in their shop and increasing shop productivity. This questionnaire was a modified version of the supervisor leadership questionnaire.

More specifically, supervisors who displayed transformational leadership exerted a positive influence on the amount of extra effort offenders were willing to make, work motivation, job involvement, and offender punctuality ratings.

Leadership style does have an impact

A series of analyses were used to explore the relationship between supervisor leadership behaviour and credibility and offender work attitudes. The results indicate that offenders who rated their work supervisors as transformational leaders had more positive work attitudes and greater work motivation.

More specifically, supervisors who displayed transformational leadership exerted a positive influence on the amount of extra effort offenders were willing to make (see Figure 1), work motivation, job involvement, and offender punctuality ratings.

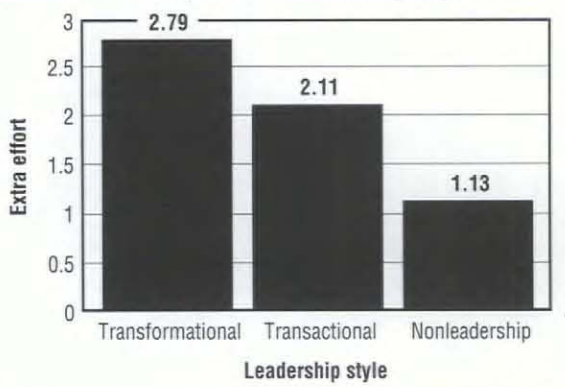
In contrast, offenders who rated their supervisors as displaying passive, nonleadership behaviour reported lower work motivation, job involvement and less willingness to exert extra effort. Nonleadership behaviour was, however, unrelated to punctuality ratings. Supervisors rated as transactional had no impact on offender motivational outcomes or punctuality ratings.

Similar to supervisors with transformational leadership, those perceived as credible were associated with higher work motivation, job involvement and extra effort. However, credible supervisors had no impact on offender punctuality ratings.

Manager ratings of supervisor effectiveness (with offenders) yielded perhaps the strongest findings, as they provided an objective measure of supervisor performance related to offender outcome. Specifically, supervisor effectiveness was found to be related to the extra effort offenders were willing to make, as well as to punctuality ratings (the behavioural indicator of offender motivation).

Figure 1

The Amount of Extra Effort Offenders Were Willing to Make and Supervisor Leadership Style



This study, therefore, indicates that leadership style differentially affects self-report and behavioural measures of offender work motivation. Further, the work supervisors perceived as transformational leaders by offenders were also supervisors that offenders saw as credible, demonstrating a potential link between transformational leadership, perceived credibility and offender motivation.

Important links

This study investigated an area that has, thus far, received little attention. Previous research on correctional staff focused primarily on staff perceptions of, and attitudes toward, working with offenders. The results of this study are meaningful because they indicate that correctional industry and correctional staff do have an impact on offenders.

Although correctional industrial shops are typically skills oriented, everyday interaction with supervisors influences offender attitudes and behaviours. This study suggests that important links exist between correctional staff characteristics and offender outcomes, which have definite practical implications for staff selection and training as correctional agencies look to provide effective correctional intervention. ■

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The learning modes of an incarcerated population

As prisons become increasingly overcrowded and correctional budgets continue to shrink, many suggest that improved inmate education within the prison system might be an effective way to keep inmates from "coming back."

The typical approach to inmate education has historically been very individual-focused. The approach has been to test inmates, identify specific deficiencies and design educational plans to overcome academic weaknesses.

Prison educational systems have also tended to use a student-centred instructional style because inmates can, for the most part, freely enter and exit prison educational systems. Further, inmates tend to view the teacher as their only source of information because of the authoritarian environment in which they live. This is accentuated by the fact that small prison student populations allow for little freedom of choice among teachers and classes.

However, is the student-centred instructional style compatible with inmate learning styles? Learning style theorists contend that academic achievement is enhanced when a student is matched with a compatible teaching style. In fact, it has been argued that optimal learning occurs when learning and instructional styles are matched. Understanding the conditions under which inmates learn could, therefore, lead to improvements in prison education and reduced recidivism.

Studies have investigated the learning style preferences of college students, but there has been little consideration thus far of whether the learning styles of inmates are compatible with the instructional styles of correctional educators. General studies have shown that a discrepancy between instructional and learning styles can lead to dissatisfaction or maladjustment. Therefore, the wrong mix of learning and instructional styles might not only fail to help reduce recidivism — it could conceivably worsen the problem.

This article summarizes a recent research study that attempted to address this concern by pinpointing the mode of learning of inmates. The purpose of the study was simply to gather data on the mode of learning of inmates to provide a basis for further research.

Methodology

The study was based on the hypothesis that inmates would prefer a method of obtaining new information. The four basic modes of learning tested were listening, reading, iconic and direct experience (see Table 1). The study also considered inmate levels of schooling (high school, college or none) and major offence type.

The study sample consisted of 120 male inmates at the Utah State Prison, who were selected to participate in a recidivism-reduction program called Project Horizons. Inmates chosen for this program cannot be sex offenders, intellectually handicapped or suffering from mental health problems. They must also have a parole date within a maximum of three years and a minimum of 10 months.

Table 1

Modes of Learning

Mode of learning	Definition
Listening	Obtaining new information by listening to such things as lectures, speeches and tapes
Reading	Examining written information and reading such things as pamphlets and textbooks
Iconic	Interpreting such things as graphs, charts, slides and illustrations
Direct experience	Hands-on situations, such as labs and field trips

The instrument used was Canfield's Learning Styles Inventory. This instrument is a highly structured questionnaire that breaks the motivational component into four major categories and a learning typology. The instrument is a pencil-and-paper self-report inventory for either individual or group administration. It presents 30 statements and asks respondents to rank their responses to the statements according to how well the responses describe their reactions or feelings.

The inventory was given to each inmate, along with a letter of introduction. The inmates were asked not to reveal their names, but were asked to indicate whether they were attending high school or college at the time of their offence and the nature of their offence. Frequency distribution and statistical analysis were performed on all inventory scores to

determine whether a particular mode of learning predominated, or was correlated with, student status or a particular type of offence.

Key results

The frequency distribution for the four methods of obtaining new information revealed that the inmates had a significantly weak preference for the iconic mode of learning (more than one standard deviation below the average of the *t*-scores). Of the 43 returned inventories, 22 reflected a weak preference for iconic learning (see Table 2).

Table 2

Inmate Preferences for Modes of Learning (43 Inmates)

Mode of learning	Weak preference	Average preference	Strong preference
Listening	5%	72%	23%
Reading	9%	61%	30%
Iconic	51%	35%	14%
Direct experience	23%	63%	14%

Note: Weak preference is more than one standard deviation below the average t-score. *Average preference is within one standard deviation of the average* t-score. *Strong preference is more than one standard deviation above the average* t-score.

This suggests that most inmates preferred the other three modes of obtaining new information to iconic learning. There were no significant differences between the other three modes of learning.

Interestingly, cross tabulations between mode of learning and student status revealed that none of the inmates with some level of college education had a weak preference for listening or a strong preference for direct experience. A cross tabulation between mode of learning and type of offence revealed no significant differences, probably because of the small number of respondents compared with the number of offences.

Discussion

The clearest result is that more than half of the respondents rated iconic learning (interpreting slides, graphs and charts) as their least preferred method of obtaining new information. This should certainly be considered by prison educators when determining how to teach certain material.

As for student status, inmates with some level of college education may have shown average or strong preferences for listening because the dominant college teaching style is lecturing. Generally, college-level classes require students to gather new information by listening. As such, college students probably either have no general dislike for listening as a mode of learning or have adapted to it to the point where listening is, at worst, not their least preferred mode of learning.

Further, no inmates with some level of college education had a strong preference for direct experience as a mode of learning. This could also be because college students obtain information primarily by listening to lectures. College students may have adjusted to being presented with lectures or readings on new information before being permitted hands-on experience.

A chi-square test on the four modes of learning revealed that inmate preferences for reading (7.97, $p < .05$) and iconic (44.38, $p < .001$) modes of learning were significantly different from preferences found in the standardization population. This implies that inmates are significantly different from the general population as to their preferences for reading and iconic means of obtaining new information.

Some cautions are warranted, however, about the results of this study. First, it must be remembered that the study was based on a relatively small sample, although the return rate was greater than 35%. Further, consideration must also be given to the possibility that the inmates responded dishonestly to questions, to the potential impact of Utah's distinct religious ethic, and to the potential distorting effects of various socio-economic, racial, regional or other variables. ■

Adapted from T. L. Felton, "The Learning Modes of an Incarcerated Population," *Journal of Correctional Education*, 45, 3 (1994): 118–121

The impact of learning disabilities on correctional treatment

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Offenders who have had serious difficulties in acquiring academic skills may not benefit adequately from treatment programs that assume they possess these skills. Therefore, when offender treatment programs fall short of expected results, their lack of success may be related to a constellation of difficulties referred to as learning disabilities.

It is important to note that the mastery of academic skills extends beyond mechanical proficiency. For example, the ability to read requires matching written symbols to sounds then to words and, finally, extracting meaning from the text. Difficulty with any of these steps may be related to a learning disability.

Further, while learning disabilities are primarily difficulties with academic skills, they also often co-occur with social skill or impulse control problems, attention disorders, or extreme restlessness and hyperactivity.

This article, therefore, examines how learning disabilities are defined and identified, their prevalence within the institutional population and, perhaps most important, how offender treatment or programming can accommodate the unique needs of offenders with learning disabilities.

Defining learning disabilities

Learning disabilities can best be described as a group of problems resulting from disorders in the receipt of information and its transmission to the brain. Individuals are born with learning disabilities, even though such conditions may not become evident until formal schooling begins. A person also does not outgrow a learning disability — it usually remains present throughout their life.

Learning disabilities are sometimes referred to as "invisible" disabilities because people with these problems appear to function normally in most areas of life and often have average to above-average intelligence. In fact, a significant discrepancy between intellectual ability and academic achievement is one indication of a learning disability.

These disabilities affect various sensory modes involved in processing information. The process of receiving and expressing information can be broken down into four stages:[2]

- input (the receipt of information by the senses);
- integration (the organization and comprehension of information);
- memory (the storage and retrieval of information); and
- output (the oral or written expression of information).

Learning disabilities may occur at any of these stages. For example, individuals who have difficulty following instructions may have auditory input problems resulting from an inability to focus their attention. On the other hand, those who have difficulty with oral expression may have memory or output problems. Slow and laboured self-expression is often the result of difficulty in accessing words from memory to transform thoughts into oral or written expression. The individual may also not have developed a "self-talk" system that allows them to plan what to say before speaking.

Learning disabilities do not impact exclusively on academic learning situations. They also interfere with non-intentional learning, which is learning that occurs out of simple awareness (such as learning to speak). Problems related to academic skills are referred to as primary disabilities, while problems related to self-regulatory behaviour (such as attention focusing or impulse control) are considered to be secondary disabilities.

The effects of learning disabilities

Learning disabilities tend to reveal themselves in adults in a variety of ways:

- having excellent speaking ability, but an inability to express thoughts on paper;
- having mechanical aptitude, but difficulty with reading, writing or spelling;

- learning well when shown, but being unable to follow written or spoken instructions;
- being unable to organize belongings, time, activities or responsibilities;
- having a history of academic failure;
- making frequent excuses to avoid reading (such as "I forgot my glasses"); and
- avoiding asking questions because of a fear of appearing "dumb."

Further evidence of a learning disability may be the inability to maintain relationships or make friends, a constant feeling of anxiety, tension or depression, poor self-image, an inability to concentrate, or extreme restlessness.

However, many people experience one or more of these symptoms. It is only when several are present to a significant degree that it may indicate a learning disability. A formal assessment by a psychologist or psychiatrist with specialized training can determine the presence of such a disability.

Learning disabilities in the institutional population

There is strong evidence that the incidence of learning disabilities is significantly greater in the institutional population than in the community at large. Just 5% to 10% of the general population have a learning disability, while the incidence of learning disabilities in the prison population fluctuates between 7% and 77%.

Two Canadian studies have reported incidence rates of between 7% and 25% in federal institutions,[3] but U.S. studies have reported rates ranging from 8% to 77%.[4] This discrepancy may be the result of different definitions of learning disabilities, varying cut-off points for selected measures or the use of abbreviated versions of tests to identify disabilities.

Identifying offenders with learning disabilities

Psychological testing for learning disabilities generally involves a battery of tests to determine intellectual potential, academic achievement, and strengths and weaknesses in both intellectual and psychosocial development.[5]

However, psychological testing is time consuming and costly. Even a conservative estimate of the incidence of learning disabilities among offenders (such as 25%) suggests that psychological testing would have to be restricted to the most severe cases. Therefore, alternative ways of identifying offenders with learning disabilities are needed.

Offenders are routinely group-tested upon entry into the correctional system to determine grade placement and academic achievement level. Ideally, the diagnosis of learning disabilities should occur at this time and become part of the offender's correctional plan.

An alternative approach would involve the computerized testing of intellectual potential and academic achievement. Brief tests to measure intellectual potential could then be given to offenders whose initial scores indicated that they were at risk of having a learning disability.

Computerized testing would allow for individualized testing without the time and cost of person-to-person testing. Computers could also immediately generate an offender profile of strengths, weaknesses, intellectual potential and grade equivalents, as well as of the time taken to answer questions, error pattern analysis and correlations among different test results. Para-professionals could administer the second round of brief tests, which could be developed to address the needs of specific institutions (such as facilities for young offenders).

However, testing offenders on admission to the system may produce unreliable results. Offenders may still be experiencing disorientation, adjustment problems or the residual effects of drug use. It would be advisable, therefore, to re-test the offenders at least three months later to ensure the accuracy of assessments so that offenders receive an appropriate correctional plan.

Treatment/programming accommodation

The identification of adults with learning disabilities is a recent phenomenon. It had long been believed that children would simply outgrow learning difficulties when they became adults. However, it has now been

acknowledged that although adults may learn to compensate for their difficulties, learning disabilities never completely disappear.

Various types of intervention specifically address the needs of adults with learning disabilities, such as support groups, self-help groups, and group and individual counselling. However, research as to success of these approaches is only in its initial stages.[6]

Ultimately, any form of treatment or programming must address the fundamental issues related to learning disabilities, to enable individuals with these problems to integrate new information into their repertoire of behaviours.[7]

For example, treatment or programming accommodation for offenders with learning disabilities may involve their using a tape recorder or computer. Electronic aids can greatly improve an offender's ability to retain information, while computer word-processing programs (with spelling and grammar check components) might help offenders who have difficulty with the fine motor control involved in writing.

Alternatively, these offenders should receive extra time to complete tests or assignments or permission to tape record their responses. Portable tape recorders might also help offenders who are impulsive or easily distracted, as might their keeping a notebook and pencil handy for writing down thoughts as they occur.

The inability to quickly organize thoughts could lead, in group sessions, to either constant interruptions or the offender remaining silent. Therefore, group leaders should use a relatively structured format, directive questions and constant monitoring to remain on topic and involve these offenders.

Offenders with learning disabilities could also be given practical suggestions on self-organization, such as how to set up a personal schedule or diary. They could also be encouraged to create daily lists of responsibilities (such as assignments and classes), so they develop self-management skills.

Finally, teachers and group leaders should develop the habit of having offenders with learning disabilities repeat, in their own words, what they have understood in a particular session. This creates an opportunity for feedback and correction, as well as reinforcing the presented material.

Learning disabilities interfere with individuals' ability to extract meaning from written or spoken information. To be effective, treatment programs must, therefore, address the special learning needs of offenders who have trouble processing information.

Ultimately, training and treatment programs focus on lowering recidivism rates. Programming that accommodates offenders with learning disabilities is more effective for more offenders, bringing programming closer to its ultimate goal. ■

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Treatment responsivity in criminal psychopaths

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Despite general pessimism in the research community about the effectiveness of psychopathy treatment,[2] correctional staff are encouraged to pursue intervention (treatment or incapacitation) with psychopathic offenders for a variety of legal and ethical reasons.[3] Perhaps the most important of these reasons is that criminal psychopaths have a high rate of violent recidivism.[4]

This article, therefore, reviews current issues in the identification, treatment and management of criminal psychopaths — highlighting the apparently moderating effect that a diagnosis of psychopathy has on offender compliance with, and response to, treatment.

Assessment

The primary assessment tool for psychopathy is the Hare Psychopathy Checklist (revised), a 20-item rating scale that assesses information from offender files and interviews. Each item is scored based on its presence "within" the offender (ranging from 0 = not present, to 2= completely present).

This instrument has proven reliable[5] and, perhaps most important, it identifies a more specific group of offenders than other assessment strategies (such as the Antisocial Personality Disorder criteria).[6] As a result, the checklist is being increasingly relied on across North America to diagnose psychopathy. However, it may be somewhat optimistic to believe that this more stringent diagnosis yields a homogeneous group of offenders with respect to treatment needs.[7]

The focus on personal characteristics conceptualizes psychopathy as a personality disorder with enduring traits, suggesting that treatment should focus on personal change and control rather than on a medical cure.[8] In short, treatment should involve a risk-management approach.[9]

Treatment might, therefore, be best viewed as part of a broader risk-management strategy, particularly for high-risk offenders. Risk is not reduced by treatment as much as managed by the offender's improvement in self-regulation[10] and by the monitoring and avoidance of high-risk situations in the community.[11]

This concept has been successfully applied to both sex offenders[12] and offenders with substance abuse problems,[13] and researchers have considered its use with violent offenders.[14] However, the specific role of this relapse-prevention approach in enhancing treatment requires further investigation.

Finally, if treatment outcome studies are to be meaningfully compared, a standard assessment strategy must be adopted. However, the use of the Hare Psychopathy Checklist (revised) in assessing personality change may be limited by the restricted nature (0, 1 or 2) of its item scoring and its focus on lifetime traits and behaviour.

Improved measurement techniques are, therefore, needed to better identify treatment targets and assess gains, preferably through a multi-method approach. Treatment targets should be criminogenic needs, not merely symptoms, although the reduction of symptoms is important to improving the offender's quality of life.[15]

Treatment effectiveness

Treatment integrity is central to treatment effectiveness. However, theory is not static, and programs considered state of the art may eventually find their integrity diminished as the field of study evolves. For example, programming may include elements (such as nude encounter groups) that would no longer be included in contemporary programs.

Recent studies[16] have also revealed that psychopaths tend to exploit unstructured programs, masking their resistance with verbal skills. Further, psychopaths have been found to have much higher attrition rates than non-psychopaths.[17] These results would seem to be related to the apparent lack of treatment

effectiveness with psychopaths, and are major obstacles for correctional workers trying to provide appropriate intervention.

Unfortunately, few examinations of the effectiveness of intervention with criminal psychopaths have met high methodological standards (such as the use of control groups or multiple-outcome measures).[18] However, recent efforts to address these concerns found no decrease in recidivism with improved methodological rigour.[19]

This is certainly disconcerting, but it should not overshadow recent theoretical advances, nor compromise our understanding of good correctional treatment.[20]

Treatability

Despite increasing consensus as to the assessment of psychopathy and the characteristics of good correctional programming, the treatability of psychopaths remains unresolved.

For example, a recent study[21] revealed that although Antisocial Personality Disorder tends to reveal itself while an individual is still young (80% of the study sample experienced their first symptom by age 11), half of this study sample no longer experienced symptoms by age 29 (80% by age 45). Unfortunately, the more specific diagnosis of psychopathy is more resistant — there is limited reduction in symptoms over time.[22]

A further concern is that the reliable measurement of treatability seems problematic.[23] One study has proposed, however, that treatability components (such as an offender's prior response to a strategy) be specifically examined to move beyond general impressions of whether an offender is "treatable."[24] The use of certain self-report measures also appears promising (see the Baxter article in this issue).

Responsivity

Treatment responsivity emphasizes matching a particular intervention to an offender.

Consideration of criminogenic needs and risk levels are intended to optimize effective treatment. It has, however, been argued that psychopaths have a particular style of interpersonal interaction and manner of processing information that must be considered in designing treatment.[25]

Consideration of criminogenic needs and risk levels are intended to optimize effective treatment. It has, however, been argued that psychopaths have a particular style of interpersonal interaction and manner of processing information that must be considered in designing treatment.

This would certainly help explain the recurring difficulties of psychopaths' noncompliance with treatment. To these offenders, treatment is often merely a vehicle for securing particular goals (such as early release or a shorter sentence), not a process in and of itself.

Most treatment providers recognize this self-centred motivation for "commitment" to treatment but, regardless, few are completely pessimistic about the usefulness of the treatment. Many do, however, differ as to the form such treatment should take.[26]

One consideration is that laboratory evidence of passive avoidance deficits (failure to learn to avoid negative events, by not responding) suggests that psychopaths are more reward- or incentive-oriented, and will persist in pursuing a goal despite cues to the contrary.[27] It is also, therefore, probably unrealistic to expect psychopaths to learn to pause and reflect.

Psychopaths' persistent rule-breaking behaviour and egocentricity would also seem to make them immune to appeals based on morality or concern for others, and recent suggestions that psychopaths have deficits in emotional language skills[28] hint that this impoverishment may have a neurological basis.

If psychopathy does affect treatment effectiveness, then perhaps an analogy can be drawn between psychopaths and low-functioning offenders. Treatment programs specifically developed for low-functioning offenders match treatment to these offenders' ability to process and integrate information (see the Boer article in this issue). Clinicians

view these offenders as having a disability and skill deficits that interfere with their ability to interact with people more appropriately.

If psychopathy is similarly viewed, then treatment becomes, in part, the recognition of, and compensation for, the offender's disability — with the goal of improving the offender's interaction with others.

Along the same lines, substance abuse treatment has turned toward challenging offender beliefs using a problem-solving framework,[29] while sex offender programming routinely forces the offenders to resolve any issues of denial or minimization *before* treatment begins.[30] These strategies could arguably be adapted for use in treating psychopaths.

Discussion

Criminal psychopaths have proven to be a highly resistant group of offenders. Existing intervention strategies have been largely ineffective, and methodological improvements alone seem unlikely to generate substantive gains. As well, the recognition of general responsivity factors should limit unsophisticated conclusions about treatment gains.

There are some suggested means of treating psychopaths, such as the incorporation of cognitive-style research into the assessment and treatment processes, but they require judicious implementation. Further, the identification of specific treatment targets must be improved.

Finally, the measurement of the treatment process and any resulting gains must be improved before progress can be expected. Hopefully, recent gains in our understanding of assessment, the course and duration of psychopathy, and the obstacles to intervention will also result in more effective programs. ■

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A new resource

The new Correctional Research and Development Information Centre at Correctional Service of Canada National Headquarters houses a wide variety of documents, reports and other materials, as well as providing links to electronically stored information in a variety of sites. The goal of the Information Centre is to provide easy access to Correctional Research and Development documents, as well as to other corrections-related information.

Forensic mental health treatment: Do we really know what we are talking about?

by ***Anthony Greenwood***[1]
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Although most people would say they understand the word "treatment," it may have different meanings depending on the context in which it is used.

For example, psychiatric treatment can be defined as responding to mental disorder by using medication and/or teaching the patient to function independently, while correctional treatment refers to altering antisocial attitudes, behaviour and personality.

Obviously, problems may develop if it becomes unclear which definition is being used. For example, when "treatment" is used in a forensic environment, it is often implicitly assumed that it means treatment that will reduce recidivism. It is assumed that offenders' mental disorders are connected with their offences — even though the term is often intended to refer to psychiatric treatment.

This confusion raises a fundamental question. Is the goal of treating mentally disordered offenders to reduce recidivism or mental disorder? In fact, is mental health treatment likely to reduce criminal behaviour at all?

This article provides the answer to both questions — questions that must be answered and understood to provide the necessary context for any examination of forensic mental health treatment.

Does mental disorder result in violence or criminality?

The assumption that mental disorder leads to violence or criminality has persisted throughout history. Research has shown that although there is a relationship between the two, the relationship is not a strong one.[2]

Roughly 90% of individuals (incarcerated or not) with a major mental disorder are not likely to be violent. Further, personal-distress variables such as anxiety, self-esteem, depression and mental disorder are weak predictors of criminal behaviour, and clinical treatment of these variables does not reduce recidivism.[3]

In fact, some researchers have discovered a significant (but small) negative correlation between the diagnosis of schizophrenia and violent recidivism.[4] Therefore, while a small number of mentally disordered offenders may be violent, most are not.[5]

In short, the relationship between mental disorder and violence or criminality is not as strong as most people think. It is unlikely that the typical mentally disordered patient will be dangerous solely as a result of their mental disorder.

Any link between mental disorder and acts of violence is very complex.[6]

For example, positive symptoms of schizophrenia may be associated with an increase in the tendency to engage in violent or criminal acts, while the existence of negative symptoms may be associated with a reduction in such tendencies.[7]

However, even this level of precision may not be accurate, as in the case of a delusional (positive symptom) paranoid patient who simply withdraws when he or she thinks people are talking about him or her.

Further, mental disorder categories were simply not designed to evaluate or predict criminal or violent behaviour.[8]

In short, the relationship between mental disorder and violence or criminality is not as strong as most people think. It is unlikely that the typical mentally disordered patient will be dangerous solely as a result of their mental disorder.

Further, criminogenic variables such as antisocial attitudes, behaviour and personality best predict risk — even in offenders with a mental disorder.

Mental health treatment may not equal reduced recidivism

The goal of mental health treatment is to address mental disorder, while the goal of correctional treatment is to decrease the likelihood of recidivism. These goals are not mutually exclusive, but they do not always work in tandem.

Correctional treatment targets criminogenic needs such as criminal associations, antisocial attitudes and criminal behaviour.[9]

Mental health treatment, on the other hand, attempts to ensure an ability to function — not just symptom-free, but to be able to look after daily needs, interact with others, find and keep a job, and enjoy leisure activities, sexual and social relationships, and a general sense of well-being.

Nevertheless, psychiatric or psychological treatment remains valid in a correctional environment. After all, would it be ethical to withhold treatment simply because the patient chooses to lead a criminal lifestyle when his or her symptoms are under control?

Further, the provision of essential mental health services is part of the Correctional Service of Canada's mandate.[10]

The goal of mental health treatment is to address mental disorder, while the goal of correctional treatment is to decrease the likelihood of recidivism. These goals are not mutually exclusive, but they do not always work in tandem.

Evaluating mental health treatment

Most correctional programs are evaluated on the basis of their effect on recidivism. This is fine for programs directed at criminogenic factors, but it is not likely to be very useful in evaluating the benefits of treating mental disorders. Such an examination might find weak treatment effects, if any.

Other measures are needed to validate the efficacy of the treatment, such as psychiatric rating scales, measurement of independent behaviourial functioning and analysis of the use of mental health services.

However, in evaluating the effectiveness of such treatment, it is perhaps most important to return to the meaning of the word treatment.

It is very easy to get the term's two meanings confused when determining whether to keep an offender in mental health treatment.

For example, what if a sex offender is schizophrenic and is placed in mental health treatment? The treatment's main goal is to improve the offender's mental health and related functioning. Additional treatment, of course, targets the sexual component of the offence.

But suppose the offender will not discuss the offence. Should he or she have to leave the program? After all, if the ultimate goal is to reduce recidivism, why keep offenders in treatment if they refuse to address their criminal behaviour?

The problem with this reasoning is in the use of the word treatment. It seems to refer to criminogenic and mental health treatment interchangeably. The first priority in treating a patient for a mental disorder must remain treatment of that disorder, and that is how treatment must be evaluated.

However, in practice, psychiatric rehabilitation may help offenders better deal with factors that lead to their offending.

For example, their more effective use of leisure time and improved communication and assertiveness skills may help them stay away from criminal associates.

Mental health treatment may, therefore, reduce recidivism somewhat — even though this is not the main goal of such treatment.

In short, there may be a relationship between the symptoms of a small number of mentally disordered offenders and criminal behaviour. Therefore, the relationship between an offender's mental disorder and his or her criminal behaviour should be evaluated at the outset.

This will allow treatment expectations to be determined based on objective assessments, rather than on the assumption that there is a strong relationship between mental disorder and the risk of crime or violence.

Where there is no obvious relationship between an offender's mental disorder and criminal behaviour, it could then be decided independently what additional treatment is required to target the specific factors that led to the individual's offending.

For example, our hypothetical sex offender may go on, following the completion of mental health programming, to receive sex offender programming.

It may also be possible for an offender to receive such treatment while receiving mental health treatment — if the offender is able to cope with both at once.

This is the current approach at the Service's Prairie Region Regional Psychiatric Centre. The centre provides a specific program in their psychiatric rehabilitation unit (Bow Unit) to help offenders understand their cycle of criminal behaviour, while they undergo full-time psychiatric rehabilitation.

It is crucial to clarify which definition of treatment (correctional or psychiatric) is being used when prescribing treatment.

We must know what we are talking about

It is crucial to clarify which definition of treatment (correctional or psychiatric) is being used when prescribing treatment.

The end result will be more informed treatment, with a clear idea of what may or may not be achieved. It is only then that we will truly be able to measure the effectiveness of various mental health treatment programs. ■

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Offender treat~ability

Offender treatability refers to being able to give correctional care to (an offender) ***or*** *for (criminal behaviour).*

Treating intellectually disabled sex offenders

by ***Douglas P. Boer,*** [1] ***John Dorward,*** [1] ***Claudine M. Gauthier*** [1] *and* ***David R. Watson*** [1]
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Intellectually disabled offenders (who are also commonly referred to as psychosocially challenged, learning disabled or mentally retarded) are offenders who, like many persons who are mentally ill, tend to cycle through hospitals, community agencies and correctional facilities.

These offenders may be excluded from certain treatment programs as a result of their borderline intelligence, illiteracy, impulsiveness or inadequate social skills. However, if such an offender is deemed unsuitable for regular sex offender programming or is main-streamed through such a program, their likelihood of recidivism will probably not be significantly reduced — their unique treatment needs will not have been met.

These offenders are not treatment failures, rather they were simply not provided with suitable treatment. It was the realization that intellectually disabled offenders were having difficulty in conventional sex offender programs that prompted the creation of the Northstar Program at the Regional Health Centre (Pacific) more than seven years ago.

The Northstar Program is designed to meet a significant proportion of the treatment needs of these offenders through techniques ranging from psychoeducational modules, to arousal reconditioning, to individual treatment. This article examines why intellectually disabled sex offenders require this type of specialized treatment, as well as the specific treatment approaches that are utilized.

It was the realization that intellectually disabled offenders were having difficulty in conventional sex offender programs that prompted the creation of the Northstar Program at the Regional Health Centre (Pacific) more than seven years ago.

How are intellectually disabled sex offenders different from other sex offenders?

The majority of intellectually disabled sex offenders in the correctional system do not fall into the profound or severely retarded range of intellectual functioning. They instead fit into the mild to borderline range of mental retardation.[2]

In fact, not all intellectually disabled sex offenders are intellectually disabled according to intelligence tests. For example, several of these offenders have significant social functioning (social skills and knowledge) difficulties and/or problems gaining insight into their behavioural difficulties, but have low to average IQs. In general, however, intellectually disabled sex offenders are characterized by lower intellectual functioning than intellectually "normal" sex offenders.

It has been estimated that up to 74% of intellectually disabled sex offenders have organic brain syndrome as a result of brain injury. Intellectually disabled sex offenders with a brain injury tend to be more functionally impaired than those without such a problem, since the injury may further complicate their other learning disabilities.

Brain injury may also cause sexual disinhibition, hypersexuality, changes in sexual preference, poor abstract reasoning, an inability to sequence events, poor memory, aggressiveness, explosiveness and anxiety disorders.[3]

This likelihood of brain injury among intellectually disabled sex offenders, a higher incidence of substance abuse and deviant sexuality combine to burden these offenders with a complex set of problems. Although other sex offenders also suffer from many of these problems, low intellectual functioning exacerbates the problems for intellectually disabled sex offenders.

Intellectually disabled sex offenders also differ from other sex offenders in other ways, some of which suggest an increased risk of reoffending.

For example, although intellectually disabled sex offenders and other sex offenders do not differ as to offence type, intellectually disabled sex offenders tend to be more opportunistic and impulsive in both their everyday behaviour and offences. Further, they tend to have fewer victims, to establish no close relationships with their victims (choosing acquaintances as opposed to relatives), and to be indiscriminate about their victims' age, gender or appearance.

As such, it is more difficult to gauge the predatory behaviour of intellectually disabled sex offenders, because they don't have a specific type of victim.

These sex offenders also tend to use *instrumental* violence (the use of threats or violence sufficient to gain victim compliance) rather than *expressive* violence (causing injury as part of their arousal pattern) in their offences because they are less able to verbally manipulate their victims into compliance.

Intellectually disabled offenders also generally victimize individuals who are smaller, less able to verbally protest (more passive) and less able to defend themselves.[4]

There is some evidence that due to poor social skills (and the resulting lack of intimate relationships), intellectually disabled sex offenders are primarily lonely men who spend an inordinate amount of time fantasizing and masturbating — in contrast to other sex offenders.

These sex offenders usually perceive themselves as victims, are unable to understand the needs of others, and tend to think that their only mistake was getting caught. They also tend to have little sense of self-worth, as their parents and peers have often ridiculed them during their childhood and adolescence.

A significant proportion of these sex offenders were also sexually victimized themselves. Further, their families often minimize the severity of their offences and the risk to others, reinforcing the offenders' views of themselves as victims and of their sentences as excessively harsh.[5]

Finally, intellectually disabled sex offenders tend to lack assertion skills and, therefore, routinely give in to the demands of their peers.

In short, it appears that despite some similarities, intellectually disabled sex offenders present a broader constellation of problems and treatment needs than other sex offenders. Further, their unique problems appear to place these offenders in the high-risk/high-needs category.[6]

In short, it appears that despite some similarities, intellectually disabled sex offenders present a broader constellation of problems and treatment needs than other sex offenders. Further, their unique problems appear to place these offenders in the high-risk/ high-needs category.

Treatment methods

The Northstar Program uses a wide variety of treatment methods to address the treatment and criminogenic needs of intellectually disabled sex offenders. All program components are supported by research that demonstrates their effectiveness with this group of offenders.

A multidisciplinary team delivers the program's various components. It has been demonstrated that consistent messages from a variety of program deliverers in a variety of modalities is the most effective way to help these offenders change their behaviour.

The program's various components include individual sessions, behavioural therapies, medical interventions, adjunctive therapies and group therapy modules (see Table 1). The overall program is made up of three trimesters.

In general, the various group therapy modules are based on social learning theory and follow a logical, hierarchical sequence, with the goal being that offenders learn new, more rewarding and adaptive behaviour.

For example, the anger management module begins with an education phase about the nature of anger. This is followed by a skills acquisition phase that emphasizes learning new ways of dealing with anger through analysis of current situations and discussion of appropriate responses. Finally, an application phase helps offenders apply the techniques to their specific pre-incarceration experiences.

The sexual deviance, feelings, victim empathy, relationship skills and sex education modules have a similar setup — offenders learn basic information and then apply it to important past and present aspects of their lives.

Due to the cognitive limitations of these offenders, conceptual jargon is kept to a minimum. Therefore, "seemingly unimportant decisions" becomes "thinking mistakes," "abstinence violation effect" becomes "the what the heck, I deserve it effect," and "cognitive distortions" becomes "excuses."

One particular program component is made up of the disclosure, crime cycle and relapse prevention modules. The disclosure module gives offenders a non-confrontational opportunity to describe, from their viewpoint, what their offence(s) involved. A set of standardized questions is used to identify any differences between the offender and official versions. This process allows for the expression of each offender's thoughts and feelings (and minimizations), which is invaluable to formulating an offender's crime cycle.

The crime cycle module identifies the risk factors and cognitive-behavioural patterns that typify the offender's criminal actions — in a manner clearly understandable to the offender. Finally, the relapse prevention module is designed to help individuals cope effectively with high-risk factors and to identify (and respond to) early warning signals that indicate that high-risk factors are imminent.

Three modules run throughout the nine-month program cycle: the personal concerns, communications and goal review modules. The personal concerns module is a forum for learning and applying basic problem-solving skills. The communications module is a systematic, structured educational program that teaches offenders to communicate effectively with the wide range of people they encounter daily. The goal review module helps offenders formulate reasonable and attainable goals within time frames that provide an opportunity for success.

In general, the various group therapy modules are based on social learning theory and follow a logical, hierarchical sequence, with the goal being that offenders learn new, more rewarding and adaptive behaviour.

The program uses a wide variety of other therapeutic methods to address offender treatment needs. It uses individual issue-focused sessions to reinforce information obtained from group modules and behavioural contracts to address specific offender deficits or problematic behaviour. The program also uses self-monitoring, arousal reconditioning and sex-drive reducing medication, as well as adjunctive therapies (such as horticulture, art, school and recreation), to encourage skill development and increase offender repertoires of appropriate behaviour.

Table 1

The Northstar Program's Group Therapy Modules

Trimester 1	Trimester 2	Trimester 3
Sex education	Relationship skills	Substance abuse
Goal review	Goal review	Goal review
Communications	Communications	Communications
Personal concerns	Personal concerns	Personal concerns
Anger management	Anger management	Problem solving
Disclosure	Crime cycle	Relapse prevention
Sexual deviancy	Managing deviancy	Victim empathy
Identifying feelings	Managing feelings	Living without violence

Note: One trimester = three months.

A principled approach

The Northstar Program is based on several fundamental premises. Every module or

therapy delivered must have firm research support for its effectiveness with intellectually disabled sex offenders.

Concepts are kept simple, taught thoroughly, practised often and reinforced consistently through a variety of therapeutic methods by a variety of therapists. Therapeutic relationships must also be well managed because these clients are dependent and demanding.

Finally, to ensure continued progress, community follow-up personnel need to be fully informed of the treatment needs and gains of these offenders. By following these guidelines and, therefore, meeting the treatment needs of intellectually disabled sex offenders more effectively, it is hoped that more of these offenders will ultimately be classified as treatment "successes" rather than "failures." ■

[1] Regional Health Centre (Pacific), Correctional Service of Canada, Box 3000, Abbotsford, British Columbia V2S 4P4.

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Just released ...

The Research Division of the Correctional Research and Development Sector of the Correctional Service of Canada recently released the following publications:

- *A Profile of Robbery Offenders in Canada*, Research Brief B–10 (Ottawa: Correctional Service of Canada, 1995)
- L. L. Motiuk and R. L. Belcourt, *Statistical Profiles of Homicide, Sex, Robbery and Drug Offenders in Federal Corrections*, Research Brief B–11 (Ottawa: Correctional Service of Canada, 1995).
- *A Profile of Homicide Offenders in Canada*, Research Brief B–12 (Ottawa: Correctional Service of Canada, 1995).

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The responsivity principle and offender rehabilitation

by ***James Bonta***[1]
Ministry Secretariat, Solicitor General Canada

Researchers began to seriously question the effectiveness of correctional programs in reducing recidivism in the mid-1970s. Many had come to believe that offender treatment simply did not "work." As a result, pro-rehabilitationists actively researched "what works" with offenders and, through this process, we developed a clearer theoretical understanding of effective treatment.

However, it quickly became apparent that some offenders benefit more from certain types of treatment provided by certain types of therapists.[2]

Why does treatment effectiveness depend on matching types of treatment and therapists to types of offenders? The answer, at least in part, is the responsivity principle — offender characteristics affect how they will respond to a therapist or treatment.[3]

The basic assumption underlying the responsivity principle is that offenders are not all the same. Although various categorizations attempt to minimize offender differences (such as referring to offenders by a number), individual offenders can still be identified by their intelligence, communication style and emotionality. These characteristics also influence how offenders respond to efforts to change their behaviour, thoughts and attitudes.

This article, therefore, provides a brief examination of the responsivity principle, focusing particularly on its utility within the correctional treatment process.

Why consider responsivity factors?

Clinicians have long recognized the need to alter the way they interact with certain clients. Even Freud warned against using his highly verbal and insight-oriented therapy with patients who had limited verbal skills or introspective ability.

The basic assumption underlying the responsivity principle is that offenders are not all the same. Although various categorizations attempt to minimize offender differences (such as referring to offenders by a number), individual offenders can still be identified by their intelligence, communication style and emotionality.

Correctional staff are also well aware that they may have to deal with one offender very differently from the way they deal with another. There is a growing body of literature that illustrates that staff characteristics and type of treatment can have different effects on offenders.

Staff characteristics

Just as offenders are different, so are staff. Look around at the people you work with and you can probably readily identify the most self-confident, impulsive or cautious. Watch these people as they interact with others and you will also see different styles. Some people like to "talk out" problems, while others simply state the rules and enforce them.

Within the correctional context, some staff go out of their way to make contact with offenders, while others prefer to wait for the offender to make the first move. More careful observation may reveal that certain characteristics determine how individuals deal with specific activities. For example, a socially skilled, empathic and highly verbal staff member may be more likely to actively engage offenders to deal with their problems.

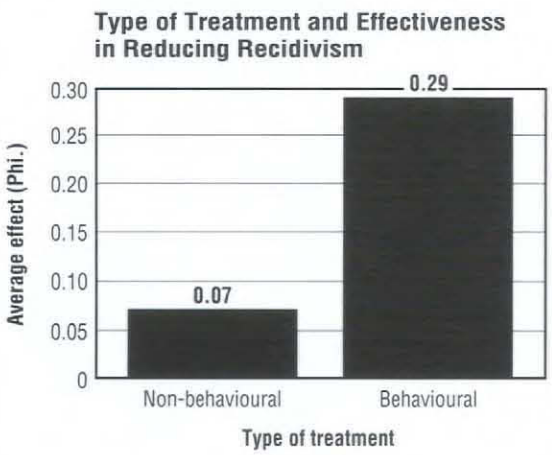
Research has linked staff characteristics to how staff influence offenders.[4] Probation officers who scored higher on measures of interpersonal sensitivity and awareness of social rules not only received the most favourable ratings from offenders, they were also more likely to display prosocial behaviour and disapproval of antisocial behaviour.

Most important, the offenders served by these probation officers had the lowest recidivism rates. In other words, certain types of probation officers who used certain treatment techniques were better able to help their clients avoid conflict with the law.

Type of treatment

Structured cognitive behavioural treatment appears to be the best approach to working with offenders — as compared to non-behavioural, more relationship-oriented approaches (see Figure 1). When warm, interpersonally skilled therapists provide the treatment, offenders respond even better.

Figure 1



Although both treatment approaches reduce recidivism, the approach that gives offenders direction and a clear idea of rewards and punishment within a positive client-therapist relationship (structured cognitive-behavioural treatment) has more significant impact.

Client responsivity factors

Client characteristics also have a bearing on their responsiveness to a particular therapist or treatment. Although people can be described in many ways, the responsivity principle focuses on personal characteristics that regulate an individual's ability and motivation to learn. Treatment is very much a learning experience and individual factors that interfere with, or facilitate, learning are responsivity factors.

There are several potential responsivity factors (see Table 1). However, there has been very little research conducted in this area (particularly with offenders), so these examples of client responsivity factors should be viewed as tentative. The list will surely change with more research.

Table 1

Client Responsivity Factors

General population	Factors more common in offenders
Anxiety	Poor social skills
Self-esteem	Inadequate problem-solving skills
Depression	Concrete-oriented thinking
Mental illness	Poor verbal skills
Age	
Gender	
Race/ethnicity	

Each of the general population factors may be present in *any* client group. The factors regulate the ways clients respond to treatment and learn from instruction. However, some responsivity factors are more common in offender populations. A perusal of these factors makes it quite clear why structured behavioural intervention is more effective than other treatment strategies with offenders.

Given a group of clients (such as offenders) who generally have poor social skills, have little internal motivation to change and are concrete-oriented in their thinking, it is not surprising that a treatment program is more effective if it sets clear behavioural goals and work assignments and provides numerous opportunities for success.

As mentioned, the other responsivity factors are no more common in offenders than in any other client group. In fact, anxiety or shyness can be found in anyone — regardless of whether they are in therapy. Yet, these traits affect responsivity to treatment.

For example, a shy and highly anxious person may not benefit from group therapy, where each person must perform in front of others. On the other hand, this approach may be an excellent vehicle for change in an extroverted, relaxed individual.

Responsivity and risk/need factors

Risk factors are characteristics of offenders and their situations that predict future criminal behaviour. For example, individuals with a history of prior convictions are more likely to commit a new offence than those without such a history.

There are both criminogenic and non-criminogenic offender needs. Criminogenic needs are *dynamic* risk indicators — when they change, so does the likelihood of criminal conduct. Non-criminogenic needs also change, but these changes have little influence on criminal behaviour. Needs also almost always define treatment goals. For example, treatment may aim to reduce substance abuse (criminogenic need) or increase self-esteem (non-criminogenic need).

Responsivity factors also often change, but they are not necessarily need factors. In general, responsivity factors do not serve as treatment targets, they are simply individual attributes that affect the achievement of treatment goals. At times, responsivity factors bear no relation to criminal behaviour and are, therefore, not risk factors.

For example, one research study[5] classified offenders into two groups: "amenables," who were bright, verbal and anxious, and "nonamenables." However, it was found that the classification of untreated offenders as amenable or nonamenable bore no relation to parole failure. In short, amenability was not a risk factor.

Amenability was also not a criminogenic need. It was not a treatment goal to make the client more verbal, less anxious or smarter. Yet, the amenable delinquents benefited from psychodynamic casework that focused on gaining personal insight. This form of treatment was apparently able to reach just offenders who had the necessary skills as it reduced only the recidivism of amenable offenders. Psychodynamic casework actually had an opposite effect on nonamenable offenders, although this relationship was not statistically significant.

Anxiety, depression and perhaps even some severe forms of mental disorder are key responsivity factors. However, for the most part, research has found these factors to be unrelated to recidivism. Further, there is no convincing evidence that addressing these factors (treating them as non-criminogenic needs) will lower recidivism.

Responsivity factors also often change, but they are not necessarily need factors. In general, responsivity factors do not serve as treatment targets, they are simply individual attributes that affect the achievement of treatment goals. At times, responsivity factors bear no relation to criminal behaviour and are, therefore, not risk factors.

Nevertheless, before targeting criminogenic needs such as antisocial attitudes, responsivity factors may need to be addressed to prepare the offender to learn prosocial behaviour. In short, any interference must be addressed before an offender can be expected to respond to therapist direction.

Another important set of responsivity factors may be gender, race and ethnicity. Programming sensitive to gender and cultural issues may, therefore, enhance treatment effectiveness. For example, feminist-oriented groups for female offenders and healing circles for aboriginal offenders provide a context for increasing motivation and targeting criminogenic needs.

The introduction of innovative programming in the new women's correctional facilities and the current wider exploration of aboriginal healing practices should allow for increased clarification of the role of gender and race as responsivity factors.

Many of the responsivity factors frequently found among offenders do, however, also function as risk factors. A diagnosis of antisocial personality or psychopathy are examples of the ways risk, criminogenic needs and responsivity may operate together.

Not only are such individuals more likely to recidivate (risk), but therapists may attempt to target aspects of the antisocial personality, such as impulsivity (criminogenic need). Further, research suggests that group work may not be the best approach for treating psychopaths (responsivity).[6]

Discussion

The reason some correctional treatment programs appear to "work" can be traced to the matching of treatment intensity to offender risk level and the targeting of criminogenic needs. However, accounting for certain offender characteristics and matching them to programs and therapists may further enhance treatment effectiveness.

The responsivity principle focuses attention on client characteristics that influence their ability to learn within a therapeutic situation. Some responsivity factors (such as concrete thinking and poor verbal skills) appear more frequently among offenders, suggesting that structured behavioural programs may be more effective than other intervention strategies.

The reason some correctional treatment programs appear to "work" can be traced to the matching of treatment intensity to offender risk level and the targeting of criminogenic needs. However, accounting for certain offender characteristics and matching them to programs and therapists may further enhance treatment effectiveness.

Other responsivity factors (such as anxiety and shyness) are not specific to offenders, but must still be considered in programming that targets criminogenic needs.

Research on the role of responsivity in treatment is extremely sparse. However, this leaves a tremendous range of issues open to exploration. For example, how can we systematically assess responsivity? The I-Level[7] and Conceptual Level[8] are offender-based classification tools that could potentially tap responsivity factors.

Other research could focus on the role of gender and race as responsivity factors, therapist options for increasing motivation and treatment responsivity, or the identification of features of mental illness that act as risk indicators and those that act as responsivity factors.

In short, there are many questions to both ask and answer in this challenging and largely unexplored area. This pursuit should prove to be both interesting and, ultimately, of great benefit to offender programming. ■

[1] Ministry Secretariat, Solicitor General Canada, 11th Floor, 340 Laurier Avenue West, Ottawa, Ontario K1A 0P8.

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Predicting treatment response in correctional settings

by ***David J. Baxter,*** [1] ***Anne-Josée Marion*** [1] *and* ***Bernie Goguen*** [1]
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Researchers have recently established that certain correctional treatment programs effectively reduce recidivism. This has led to the identification of the characteristics of programs that "work" and programs that "don't."[2] *However, little attention has been paid to how individual offender traits might interact with program characteristics and affect treatment outcome.*

The Attitudes Toward Correctional Treatment Scale directly addresses this issue.[3] *There were two main reasons for the development of the scale. A device was needed to reliably identify offenders who are motivated for treatment, as well as offender attitudes and traits that might inhibit treatment and should, therefore, be addressed beforehand.*

Further, there had been no real means of specifically assessing offender motivation. In fact, few of the established tools in this area were relevant to correctional settings.

This article, therefore, provides a brief description of the scale, as well as an assessment of its effectiveness. Perhaps most important, the article analyzes the potential impact of this scale on both offender assessment and treatment.

Offender attitudes and treatment

Although there have been several comprehensive reviews of the general factors that influence psychotherapy outcomes,[4] few studies have attempted to predict offender response to treatment. Clearly, correctional treatment settings differ from other treatment environments and offenders differ from other treatment clients.

In particular, studies have often suggested that antisocial personality characteristics, psychopathic traits or strong pro-criminal attitudes could be significant obstacles to therapy.[5]

Some studies have recommended certain scales as potential predictors of offender treatment response, but the research in this area has produced conflicting results and few of the studies have had direct relevance to correctional settings.[6]

The current version of the Attitudes Toward Correctional Treatment Scale consists of 33 items that offenders score on a five-point scale, ranging from *strongly disagree*, to *uncertain*, to *strongly agree*.

The Attitudes Toward Correctional Treatment Scale

The current version of the Attitudes Toward Correctional Treatment Scale consists of 33 items that offenders score on a five-point scale, ranging from *strongly disagree*, to *uncertain*, to *strongly agree*.

This produces a total score, as well as scores in five subscale categories (the higher the subscale score, the greater the motivation or the more positive the attitude):

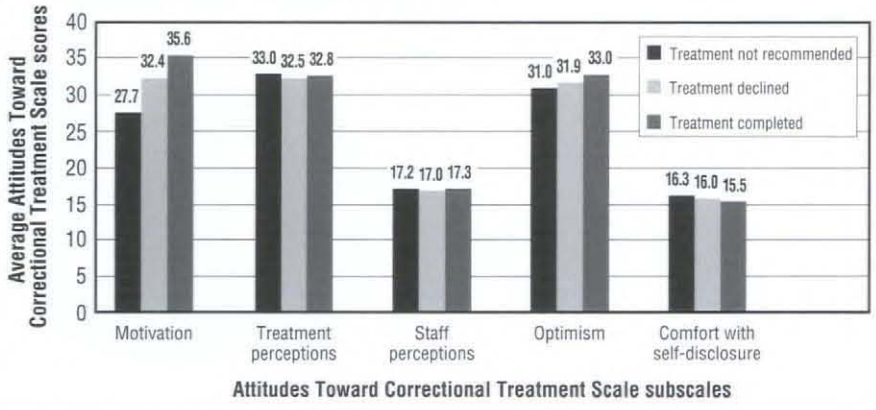
- motivation and perceived need for treatment;
- perceptions of treatment and the institution;
- perceptions of staff;
- optimism/pessimism regarding treatment outcome; and
- comfort/discomfort with self-disclosure in groups.

Data relating to the scale has now been compiled for 1,433 men assessed at the Rideau Correctional and Treatment Centre during the past three years. The internal consistency statistics for the subscales were satisfactory (range .70 to .87), as are preliminary test-retest coefficients (range .58 to .72).

It should be noted that during the time between the test and retest (10–14 days), the offenders had several contacts with both

Figure 1

The Attitudes Toward Correctional Treatment Scale and Assessment Outcome



correctional and clinical staff, and participated in a pretreatment communication skills group. Consequently, some of the variability between test and retest scores may reflect a desirable sensitivity to short-term changes resulting from the offenders' intervening therapeutic experiences.

A comparison of the sample's basic demographic and offence data with those of other recent studies suggests that the present sample is not atypical for provincially incarcerated inmates, except for a somewhat higher than average prevalence of substance abuse.[7]

The sample's average offender was about 30 years old, had a grade 10 education and had been incarcerated three or four times previously (primarily for property or alcohol/drug offences).

Assessment outcome

To examine the relationship between the Attitudes Toward Correctional Treatment Scale scores and assessment outcome, 1,327 offenders with confirmed disposition data were divided into three outcome groups: no treatment recommended (55 offenders), treatment recommended but declined (256 offenders), and treatment recommended and completed (1,016 offenders).

All of the offenders completed the Attitudes Toward Correctional Treatment Scale (and several other instruments) during the standard pretreatment assessment process.

The results indicated that higher scale scores were associated with a better assessment outcome. Both the total scale score and two subscale scores (motivation and optimism) showed significant progressive increases across the three groups (see Figure 1). Differences in the remaining subscales were not statistically significant.

Treatment outcome

A quasi-random procedure was used to select 476 offenders (24 others were rejected because of incomplete data) from those who entered the centre's assessment unit between 1992 and 1994, and went on to participate in the Rideau Addictions Program and/or the Anger Management Program.

Both programs use a basic cognitive-behavioural skills-oriented approach, although the anger program is somewhat smaller and more intensive than the addictions program, with more individual attention.

Treatment outcome was measured through the final ratings of overall program participation and progress for each offender, as rated by program leaders on an eight-point scale, ranging from 1 (unsatisfactory), to 4 (good), to 8 (excellent).

Both the total scale score and all of the subscale scores correlated positively (if modestly) with treatment outcome ratings for both the anger and additions treatment groups.[8] The highest correlations were with the overall score and the motivation subscale (see Table 1).

Table 1

Correlations Between Attitudes Toward Correctional Treatment Scale Scores and Treatment Outcome

Subscale	Rideau Addictions Program outcome	Anger Management Program outcome
Motivation	.26	.26
Treatment perceptions	.12	.18
Staff perceptions	.11	.19
Optimism	.16	.28
Comfort with self-disclosure	.15	.18
Total	.24	.31

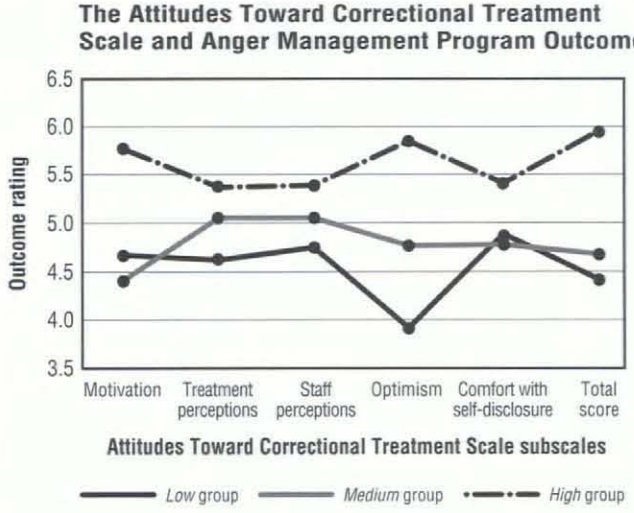
Note: All correlations are significant at $p < .05$ *or better.*

The 476 offenders were then divided into three groups based on their overall and subscale scores — the lowest 25% (the *low* group), the highest 25% (the *high* group) and the middle 50% (the *medium* group). The groups differed significantly in age and education, so these variables were entered as covariates, where appropriate, in statistical analyses.

Significant differences in both Rideau Addictions Program and Anger Management Program ratings were found among the groups in their overall scores and in their motivation scores. Significant differences were also found in the addictions program ratings in the treatment perception and optimism scores.

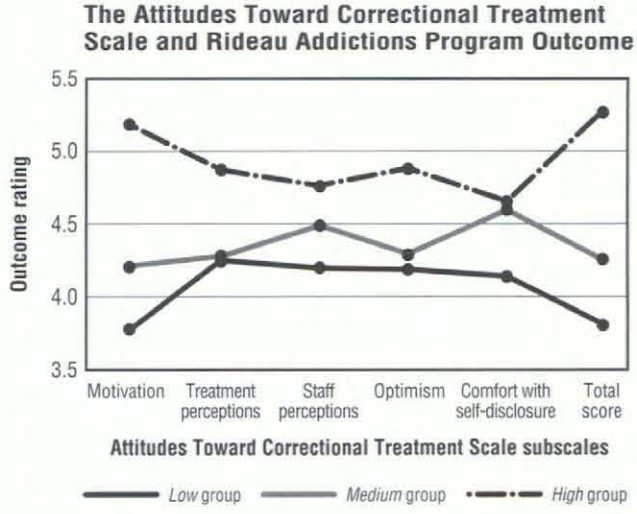
Further, the *high* group had significantly better anger program outcome ratings than the *low* and *medium* groups in relation to their motivation and optimism subscale scores and total scores (see Figure 2).

Figure 2



As for the addictions program, the *high* group had significantly better outcome ratings than the *low* group for all scores except the comfort with self-disclosure subscale score, while the *medium* group did not differ significantly from the other two groups (see Figure 3).

Figure 3



The MMPI-2 Negative Treatment Indicators scale

MMPI-2 Negative Treatment Indicators scale (a new "content" scale on the revised Minnesota Multiphasic Personality Inventory) results were inversely correlated with all Attitudes Toward Correctional Treatment Scale subscales.

High scores on this scale indicate personality traits or attitudes toward treatment that suggest resistance to change,[9] so this provides some evidence of concurrent validity for the Attitudes Toward Correctional Treatment Scale.

However, the correlations between the MMPI-2 Negative Treatment Indicators scale results and the treatment perceptions, staff perceptions and comfort with self-disclosure subscales were substantially higher than those for motivation and optimism.

This suggests, among other things, that the MMPI-2 Negative Treatment Indicators scale should not be interpreted as a measure of motivation for treatment *per se*, but as a reflection of general negative attitudes toward treatment and mental health professionals.[10]

More than anything, this illustrates that "treatment motivation" and "amenability to treatment" are multidimensional concepts,

encompassing a variety of attitudes, beliefs, perceptions and misperceptions about the nature of treatment and the therapists involved.

What does it all mean?

These results suggest that the Attitudes Toward Correctional Treatment Scale is a valid and reliable predictor of offender treatment outcome. There were some differences between the two treatment groups sampled, but this is not surprising given their format and content differences.

In short, the scale can seemingly serve as an objective tool for evaluating offender suitability for treatment which, until now, has been largely based on clinical judgment (informed guesswork).

In short, the scale can seemingly serve as an objective tool for evaluating offender suitability for treatment which, until now, has been largely based on clinical judgment (informed guesswork).

With the chronic shortage of correctional treatment resources, we must have a reliable means of identifying who will benefit most from treatment. This scale should help prioritize offenders and minimize dropout rates.

Perhaps more important, the scale may help to maximize the benefits of treatment for specific offenders, through early identification of attitudes and beliefs likely to impede treatment progress, allowing therapists to address these attitudes and beliefs in pretreatment counselling. ■

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[2] D. A. Andrews and J. Bonta, *The Psychology of Criminal Conduct* (Cincinnati: Anderson Publishing, 1994). See also D. A. Andrews, J. Bonta and R. D. Hoge, "Classification for Effective Rehabilitation: Rediscovering Psychology," *Criminal Justice and Behavior*, 17 (1990): 19–52. And see D. A. Andrews, I. Zinger, R. D. Hoge, J. Bonta, P. Gendreau and F. T. Cullen, "Does Correctional Treatment Work? A Psychologically Informed Meta-analysis," *Criminology*, 28 (1990): 369–404. And see P. Gendreau and R. R. Ross, "Revivification of Rehabilitation: Evidence from the 1980s," *Justice Quarterly*, 4 (1987): 349–407.

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[4] D. A. Andrews and J. S. Wormith, *Criminal Sentiments and Criminal Behaviour* (Ottawa: Solicitor General of Canada, 1984).

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[7] I. E. McKenzie, *Psychometric Correlates of Behaviourial Impulsivity in Adult Male Criminal Offenders*, Unpublished M.A. thesis, Carleton University, Department of Psychology, 1992. See also M. Tweedale, *Interpersonal Problem-solving and Deterrence: Effects on Prison Adjustment and Recidivism*, Ph.D. thesis, University of Ottawa, School of Psychology, 1990.

[8] Correlations between many of the MMPI-2 scales and the outcome ratings were also significant, but the magnitude of the correlations was lower than those obtained with the Attitudes Toward Correctional Treatment Scale.

[9] Butcher, *The MMPI-2 in Psychological Treatment*.

[10] Butcher, *The MMPI-2 in Psychological Treatment*. See also J. R. Graham, *MMPI-2: Assessing Personality and Psychopathology*.

Don't be shy...

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Offender responsivity to intensive supervision

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Intensive supervision became popular in community corrections in the mid-1980s, with a variety of forms developing in various countries. The goal of this type of supervision is to increase parole officer contact with, and more closely monitor, offenders at the greatest risk of reoffending.

This approach is consistent with the accepted principle of reserving the most intensive services for offenders who represent the greatest risk. Further, the development of intensive supervision units has improved the management of these offenders.

In Canada, intensive supervision programs were implemented in the major cities. In Toronto, the program became known as team supervision. The team approach increases the intensity of the process — the offender is responsible to two parole officers and there are two parole officers familiar with each case.

This article, therefore, chronicles the operation of the Team Supervision Unit in Toronto, as well as providing a general assessment of offender responsivity to intensive supervision.

What type of offenders receive intensive supervision?

The target population for the Team Supervision Unit is offenders released on statutory release (after serving two thirds of their sentence) who have scored negatively on the Statistical Information on Recidivism Scale and/or are in need of more focused help with their re-integration into the community (based on their criminal history and past releases).

Offenders released on "one-chance" conditional release are another target group for this unit. These offenders are usually placed on this type of release (instead of statutory release) because of a history of violent behaviour. If their conditional release is revoked for any reason, they must then serve the rest of their sentence in an institution.

The first few weeks are the most critical for offenders released under intensive supervision. Therefore, offenders receive documentation prior to release outlining the expectations of intensive supervision, their institutional case management officer further outlines the process and the offenders receive a detailed orientation session upon release.

Parole officers from other Toronto offices also refer offenders to the unit. These offenders tend to be either simply difficult to supervise or have an increasing risk of recidivism because of the resurfacing of factors relating to their criminal history (intensive supervision is used as an alternative to suspension of their conditional release).

Finally, the unit usually monitors untreated sex offenders referred to the high-risk sex offender program at the Clarke Institute of Psychiatry. Program providers and therapists have a close working relationship with the unit's parole officers.

Initial offender response to intensive supervision

The first few weeks are the most critical for offenders released under intensive supervision.

Therefore, offenders receive documentation prior to release outlining the expectations of intensive supervision, their institutional case management officer further outlines the process and the offenders receive a detailed orientation session upon release.

However, many offenders run into problems within the first few days of release. They often do not believe that the parole officers will monitor their activities as closely as they do.

Further, the officers take immediate action (including suspension of conditional release) to deal with any breach of the conditions established by the National Parole Board or the parole officers themselves.

In the first four months of 1995, the unit issued 25 suspension warrants. Five of the warrants were issued within days of release because the offenders did not follow through on an agreed-on plan established at their initial interview.

These warrants were subsequently cancelled and the offenders returned to the community after they reviewed their release conditions and agreed to abide by them. Offenders quickly get the message that the terms of the intensive supervision process are mandatory and not negotiable.

Some offenders initially think this type of supervision is excessive and intrusive. However, they soon learn that although they are in the unit because of their risk of reoffending, the parole officers are very willing to help with their re-integration into the community.

The parole officers all have excellent working relationships with local program coordinators, doctors, mental health professionals, social assistance personnel and housing authorities.

When an offender faces a problem in adjusting to community living, the parole officers are able to quickly refer the offender to the appropriate service. This helps convince offenders that the team will provide assistance, not just exercise control.

Up-to-date offender assessments are also crucial in getting offenders to "buy into" intensive supervision.

Like all forms of conditional release, an offender risk/needs assessment is completed within 30 days of release. A full review of the offender's current needs, relating them to past criminal behaviour, is very effective in demonstrating the need for intensive supervision to the offender.

Parole officers then develop a correctional plan with the offenders to address the needs identified in their assessments. Given the unit's clientele, the list of needs is usually long. A systematic analysis of these needs makes it very clear to the offenders why they are in certain programs and why their activities require close supervision and regular contact with parole officers.

The frequency of offender-parole officer contact also depends on the individual offender's risk/needs assessment. Minimum contact during the first phase of intensive supervision consists of two face-to-face interviews per week, plus one weekly unannounced curfew check (curfews range from 9:00 p.m. to 11:00 p.m.).

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Parole officers

There are two teams of two parole officers at the Team Supervision Unit. These teams combine to manage up to a total of 48 offenders.

Parole officers must operate as active interventionists in intensive supervision, so they must be capable of appropriately confronting offenders.

Given the background of these offenders, it is also critical that any action be taken immediately to ensure that the risk to the public is appropriately managed.

The parole officers must be able to act assertively and take control, while at the same time establishing a positive rapport with offenders and their families.

The parole officers must also work effectively with other government agencies, the police, program providers, private after-care agencies and the public.

The strength of the intensive supervision approach and the responsivity of offenders to it are directly linked to the quality of the unit's staff. Since the unit's target population includes offenders who either are not suitable for discretionary conditional release or have failed on past releases, there tends to be a greater need for regular intervention.

Is intensive supervision successful?

It is difficult to measure the success of intensive supervision, given the many variables involved. However, the key to offender responsivity to intensive supervision is the degree to which parole officers explain the steps taken to assist the offender's re-integration into the community.

This communication is vital to making the offender understand that the intent of intensive supervision is to manage their risk of reoffending *and* to assist them in becoming law-abiding citizens by directing them toward appropriate community programs and activities.

Throughout the supervision period, periodic offender risk/needs assessments and linking risk assessment to the development/revision of a correctional plan are also critical.

This process makes it very clear to the offender which areas of his or her life contribute to criminal behaviour and what action will be taken to manage that risk.

Intensive supervision's increased frequency of contact allows for the close monitoring of factors that contribute to criminal behaviour, through regular face-to-face contact, home and work visits (both during the day and in the evening), and regular contacts with significant individuals in the offender's life.

The unit closely monitors offenders with established and documented crime cycles with regard to the factors connected to their crime cycles. Parole officers review these factors during every contact with the offender — whether it be an office interview, a community meeting or a curfew check.

Of course, there are always offenders who do not respond to any type of intervention or to the accountability involved in intensive supervision.

These offenders are typically not interested in becoming law abiding and, therefore, have no interest in following a correctional plan or working with parole officers.

As a result, their conditional release is usually quickly suspended for failing to comply with release conditions.

On the other hand, many offenders try to meet their release conditions and make progress in dealing with the problems that led to their criminal behaviour.

Several offenders have even returned regularly after the expiry of their sentence to let their parole officers know they are still functioning in the community.

No research to date suggests that intensive supervision affects long-term recidivism rates. However, it is believed that this approach improves risk management and the potential for an offender's successful return to the community.

Why?

Intensive supervision allows parole staff to quickly intervene with offenders, thereby reducing the chance of their returning to crime. It also allows parole staff to concentrate on working closely with the offenders who require intensive assistance and guidance, which again reduces the chances of recidivism. ■

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The legal right of offenders to refuse treatment

by ***Claire McKinnon***[1]
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Politicians, victims' rights groups and members of the public have often raised the possibility of mandatory treatment for sex offenders. This type of treatment could arguably range from counselling to castration. Still, the public perception that sex offenders will recidivate spurs the cries for mandatory treatment.

However, sex offender treatment is only one issue. There are countless other mental and physical infirmities that offenders could develop that also raise the spectre of mandatory treatment. Can offenders be forced to receive treatment against their wishes?

Consider the following scenario. After serving his full 10-year sentence, a sex offender who refused all rehabilitative treatment is released. The Correctional Service of Canada held the offender as long as legally possible, but he is now completely free to move about as he pleases and the chances are good that he will reoffend.

The Service no longer has jurisdiction over the offender, but would/should it have been possible for the Service to have forced treatment on the offender while he was incarcerated? Apart from practical considerations that make mandatory offender treatment of questionable value, there are significant legal impediments to mandatory treatment of any kind for any person, including sex offenders.

The rights of offenders

Paragraph 4(e) of the *Corrections and Conditional Release Act* states that "offenders retain the rights and privileges of all members of society, except those rights and privileges that are necessarily removed or restricted as a consequence of that sentence."[2]

Clearly, an inmate's sentence necessarily restricts his or her freedom of movement. However, the legislation does not seem to suggest that incarceration removes an individual's basic right to refuse unwanted treatment. Offenders still have the right to self-determination.

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Subsections 88[1](a)/(b) of the *Corrections and Conditional Release Act* further state that an inmate shall not receive treatment, or continue to receive it once it has started, unless the inmate voluntarily gives informed consent. An inmate has the right to refuse or withdraw from treatment at any time.

This position is qualified somewhat by subsection 88[5] which allows that treatment **may** be administered without consent when the inmate does not have the capacity to give informed consent. However, this is consistent with provincial standards for the administration of treatment to persons unable to give informed consent.

There are specific provincial legislative provisions that outline the circumstances where treatment may be administered, without consent, to an individual who lacks the mental capacity to consent. Generally, the legislation allows "substitute" decision-makers to provide the necessary consent.

The Service's regional psychiatric hospitals are governed by the applicable provincial mental health act and are, therefore, able to treat offenders who are not mentally capable of giving informed consent.

An individual's right to refuse medical treatment

With the exception of treatment of mentally incompetent persons and those with communicable diseases, any medical treatment administered without the consent of the recipient is battery.

No one has the right to touch another person without that person's consent. The right to make choices about one's own body is deeply rooted in our common law and is now protected by the *Charter of Rights and Freedoms*.

Section 7 of the *Charter* guarantees everyone the right to life, liberty and security of the person, as well as the right not to be deprived of these guarantees except in accordance with the principles of fundamental justice. Any attempt to impose treatment without the consent of the offender would likely violate this provision.

Further, the forced treatment of an offender could be cruel and unusual punishment, which is contrary to section 12 of the *Charter*.

The courts have given great deference to the individual's right to autonomy and bodily integrity free from the interference of the state — even if this may result in the death of the individual.[3]

In 1991, the Ontario Court of Appeal discussed, at length, an individual's right to refuse treatment.[4] A mental patient, while competent, had asked that he not be given certain drugs when he became incompetent.

The court ruled that legislation authorizing a board of review to override such a request was contrary to the *Charter*. The fact that serious risks or consequences could result from a refusal of medical treatment does not vitiate the individual's right to medical self-determination.

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The court argued that few medical procedures are more intrusive than the forcible injection of mind-altering drugs, which are often accompanied by severe and sometimes irreversible adverse side effects.

To force patients to submit to such medication against their competent wishes, or without the consent of their legally appointed substitute decision-makers, clearly infringes on their *Charter* right to security of the person.

In a similar case, the British Columbia Court of Appeal ruled that a probation order requiring an accused individual to submit to psychiatric treatment or medication was an unreasonable restraint on the liberty and security of the person.[5]

Therefore, although the courts have consistently held that offenders under sentence have fewer liberty rights than individuals who are merely accused, it is doubtful that the courts would endorse legislation that interferes with an offender's right to choose whether to receive medical or psychological treatment.

The National Parole Board can, however, require an offender to consent to treatment as a condition of conditional release. This is not considered forced treatment because the offender obtains a benefit in exchange for his or her compliance.

This reasoning is also tied to risk management, because the offender would presumably pose too much of a risk to be released without the treatment.

The situation can, therefore, be distinguished from probation. A probation order is punishment, as opposed to a benefit exchanged for an offender's agreement to meet release conditions.

Infectious and contagious diseases

Provincial laws authorize the compulsory treatment of persons with communicable diseases (such as tuberculosis), overriding the individual's right to refuse treatment.

For example, Ontario's *Health Protection and Promotion Act* authorizes the Medical Officer of Health to apply for a court order requiring anybody inflicted with a deadly disease to place himself or herself under the care of a doctor.

Refusal to comply with such an order can result in hospital detention and forced treatment.

This infringement is justified by arguing that the individual's liberty interest must come second to public safety.

In other words, public interest prevails over the rights of the individual in the case of communicable diseases.

However, this narrow exception does not affect the individual's right to refuse any other treatment.

There is no equivalent federal legislation allowing for compulsory medical treatment, although the *Quarantine Act* does allow for the quarantine of persons infected with a deadly disease.

A fundamental right

Control over one's body is one of the most fundamental rights protected by our legal system.

This right can only be limited in very narrow circumstances when mental incompetence prevents an individual from giving informed consent to treatment or when the person has a communicable disease covered by provincial legislation.

An attempt under any other circumstance to infringe on this deeply entrenched principle of self-determination would meet much scepticism in the courts.

As such, any legislation permitting the forced treatment of mentally competent individuals would have little chance of surviving a legal challenge.

Such legislation would have a chance only in very narrow and well-justified situations, where the public interest in seeing treatment administered is highly compelling, such as in the case of a deadly infectious disease.

In short, the right to determine the fate of one's own body is a fundamental tenet of our society.

This right will be limited only in the most narrow of circumstances where individual rights must necessarily give way to the collective interests of society.

The mandatory treatment of offenders probably does not meet this test. ■

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[2] This codified the Supreme Court of Canada decision in *Solosky v. The Queen* (1979), 50 C.C.C. (2d) 495.

[3] *Rodriguez v. British Columbia (Attorney General)*, [1993] 3 S.C.R. 519.

[4] *Fleming v. Reid* (1991), 82 D.L.R. (4th) 298 (Ont. C.A.).

[5] *R. v. Rogers* (1991), 2 C.R. (4th) 192 (B.C. C.A.).

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