

CHAPTER 3



Treatment of Offender Populations

Implications for Risk Management and Community Reintegration

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Traditionally, one of the goals of incarceration has been rehabilitation. However, there has been a great debate in the literature about the efficacy of different treatment interventions for offenders and the ability of these treatments to decrease recidivism rates. In the 1950s and 1960s there was some evidence that treating offenders worked (Bailey, 1966; Logan, 1972). However in 1974, Martinson conducted a review of 230 treatment studies and concluded that nothing works in the treatment of offenders (Martinson, 1974). These findings supported the growing movement in the criminal justice system from a rehabilitative approach to a punitive one.

While the field moved away from rehabilitation, criminal justice researchers became interested in developing a theory to explain why some treatments worked and others did not (Andrews et al., 1990). This resulted in the development of the risk–need–responsivity (RNR) model for evaluating program effectiveness (Andrews, Bonta, & Hoge, 1990). The RNR model has been empirically supported as a means of effectively evaluating offender treatment programs (Andrews & Bonta, 1998). The basic principles of RNR are that correctional interventions must be structured on three core rehabilitation principles: risk, need, and responsivity. The risk principle addresses the fact that

offender treatments must change according to the offender's risk to the community. In other words, offenders who are identified as being at high risk to reoffend should receive the most intensive treatment available, whereas offenders identified as low risk should receive less intensive treatment. According to the need principle, effective offender therapies must primarily address the offender's criminogenic needs and attempt to modify his or her dynamic risk factors (risk factors that are amenable to change). Lastly, the responsivity principle addresses the need for offender treatment therapies to match an offender's learning style, motivation level, and cultural background (Andrews & Bonta, 1998; Ward, Vess, & Collie, 2006). Programs that adhered to all three principles of the RNR model saw 17% and 35% decreases in recidivism for residential and community programs, respectively (Andrews & Bonta, 2006).

In order to adequately address these three principles for the purposes of treatment, researchers needed assessment instruments. These assessment instruments targeted the domains of offender risk level, dynamic criminogenic factors such as prosocial beliefs and cognitive distortions, and individual factors that could influence treatment outcome (Andrews & Bonta, 2006).

Finally, after the assessment and treatment of an offender, the final phase of rehabilitation is reintegration back into the community and risk management. Traditionally risk management has assumed a one-size-fits-all model. However, with the success of the RNR model of treatment, alternatives to risk management that adhere to this model and thus continue to target the RNR principles upon release are also being developed (Conroy, 2006).

Although the overarching goal of well-designed and well-executed rehabilitation programs is to use research to inform practice, that is not always the case in the criminal justice system. This chapter reviews the current state of assessment and treatment of violent offenders, sex offenders, perpetrators of intimate partner violence, juvenile offenders, female offenders, and offenders with serious mental illness and addresses how these affect risk management and community integration.

VIOLENT OFFENDERS

Violent offenders are among the most dangerous offenders in the criminal justice system, having been arrested, convicted, and imprisoned for felony crimes such as robbery, assault, rape, and homicide. Violent offenders are also among the most common type of offenders in the national prison system and constitute 49% of the state prison population. In addition, violent offenders accounted for approximately 53% of the growth of the state prison population for the 10-year period of 1990–2000. Moreover, the majority of violent

offenders (70%) have a prior arrest record, and more than half (56%) have been arrested for a previous violent felony. It is clear that successful treatment and rehabilitation of such a prolific and persistent group of offenders are of great value to society.

Assessment for Treatment

The development and implementation of any treatment program for offenders start with a thorough assessment of the individual offender. Because treatment success in forensic settings is most often measured by subsequent reductions in offender recidivism rates, the measurement of an offender's risk of recidivism is an integral part of the development of any treatment plan. A number of such instruments have been developed over the last decade and generally fall into two categories: risk assessment instruments that measure static (i.e., historical or invariant) variables, such as the Violence Risk Appraisal Guide (Quinsey, Harris, Rice, & Cormier, 1998), and risk assessment instruments that incorporate both static and dynamic variables (variables related to reoffending that change over time, such as pro-criminal attitudes), such as the History, Clinical, Risk 20 (Webster, Douglas, Eaves, & Hart, 1997), the Violence Risk Scale (Wong & Gordon, 2006), and the Level of Service Inventory (Andrews & Bonta, 1995). Dynamic risk assessment instruments are favored in the development of treatment plans because they allow for the targeting of specific variables that are theoretically amenable to change. Although the Hare Psychopathy Checklist–Revised (Hare, 1991) and its screening version, the Psychopathy Checklist: Screening Version, are often used in risk assessment procedures, the presence of psychopathy is often considered only one significantly predictive clinical variable, albeit a powerful one, among a panoply of variables related to recidivism risk and therefore is not considered to be a stand-alone risk assessment instrument.

Treatment Techniques

Over the last 20 years or so, research on the development, implementation, and evaluation of treatment program effectiveness for violent offenders has proliferated (Polaschek & Dixon, 2001). With regard to the specific structure of treatment for violent offenders, research has demonstrated support for cognitive–behavioral and social learning theory–based intervention programs (Cullen & Gendreau, 1989; Quinsey, Harris, Rice, & Cormier, 2006). Although they contain many of the same elements as nonviolent offender treatment models, violent offender treatment programs typically encourage the

development of offenders' insight into the functional role of their violent behavior and attempt to teach offenders alternative behavioral strategies that will allow them to navigate conflict more effectively. An example of such a program was designed and implemented by Polaschek and Dixon (2001) with a New Zealand sample of violent offenders. It consisted of several components consistent with these theoretical approaches targeting anger management, communication skill training, and the acquisition of parenting, interpersonal, social problem solving, and general life skills. In addition, substance abuse and health education were incorporated into the program, concurrent with individual therapy sessions. Although this particular program consisted of up to four 90-minute sessions per day, 5 days per week for 3 months, recommendations for treatment duration vary. Gendreau and Goggin (1997) recommend that intense treatment should last for at least 4 months, with a minimum of 100 contact hours, whereas others argue that in order for a significant reduction in recidivism to be demonstrated, treatment should last at least 6 months (Bush, 1995).

In addition, researchers caution that special consideration must be exercised when treatment programs for psychopathic violent offenders are developed (Hare, 1999). Hare suggests that when dealing with psychopathic offenders, cognitive-behavioral treatment should deemphasize empathy development in favor of targeting the development of appropriate attributional styles (i.e., teaching offenders to accept sole responsibility for their actions rather than blaming victims). Additionally, psychopathic offenders' repertoires of behavioral responses should be expanded, enabling them to fulfill their needs using more prosocial methods.

Treatment Effectiveness

Surprisingly little research has investigated the effectiveness of treatment and rehabilitation programs designed to reduce recidivism in violent offenders (Polaschek & Dixon, 2001). Historically, what little research has been done regarding the effectiveness of offender rehabilitation and treatment has been less than optimistic (Andrews et al., 1990; Serin & Brown, 1996, 1997). However, reexamination of prior research (Andrews et al., 1990) and current research using more sophisticated methods, with greater scientific rigor, have provided much more promising results.

Some of the first violent offender treatment effectiveness data emerged from two studies conducted at the Vermont Department of Corrections cognitive-based treatment program, initiated in 1988. Both studies indicated that this treatment program significantly decreased rates of parole violation and rearrest

in a group of violent offenders (Bush, 1995; Henning & Frueh, 1996). Similarly, preliminary results from the New Zealand treatment program mentioned earlier demonstrated positive treatment effects, resulting in a significant reduction in the frequency and severity of reoffense in offenders released to the community (lower risk) and a significant reduction in the severity of reoffense in the parole sample (higher risk) (Polaschek & Dixon, 2001).

However, the most current results come from several studies published in England and Canada. These studies found that intervention programs based on the RNR treatment philosophy, incorporating cognitive-behavioral and social learning theory-based techniques embedded in a relapse prevention framework were effective in reducing rates of high-risk offender recidivism 2 years after release (Di Placido, Simon, Witte, Gu, & Wong, 2006; Fylan & Clarke, 2006; Wong, Gordon, & Gu, 2007; Wong et al., 2005). More specifically, treated offenders demonstrated a significant reduction in serious institutional infractions and a decrease in commission of serious violent offenses after release. Interestingly, these same studies demonstrated modest positive treatment effects, in terms of harm reduction, for offenders with elevated levels of psychopathy. Although treatment did not significantly reduce overall rates of recidivism or the frequency of reoffense in high-psychopathy offenders, it did result in a decrease in severity of reoffenses. Such findings may be welcome news in a field that is largely doubtful of its ability to induce therapeutic change in a subset of notoriously treatment-resistant offenders (Hare, 1998; Losel, 1998; Rice, Harris, & Cormier, 1992).

Risk Management

Despite the promising results of these most recent studies, there is a general consensus in the clinical and research communities that in order for any therapeutic gains to be maintained, treatment must not end upon an offender's release (Marshall, Eccles, & Barbaree, 1993; Tate, Reppucci, & Mulvey, 1995). Effective treatment modalities must be implemented as comprehensive, ongoing treatment programs that continue after release, often necessitating the involvement of a therapeutic community environment and careful monitoring by parole or probation offices.

SEXUAL OFFENDERS

Although sexual offenders are often treated as a monolithic group, they are quite heterogeneous with regard to offense patterns, characteristics, and risk

for future offending. Therefore, most typological distinctions make reference to age of victim (adult vs. child), gender of victim, nature of offense (e.g., contact vs. noncontact offense), or level of fixation (i.e., how intense and exclusive is the interest in deviant sexual behavior). Assessment strategies and treatment interventions may thus necessitate different techniques, and risk management strategies must take into account variation in motivations and patterns, because these factors can be important in estimating the risk of recidivism.

Assessment for Treatment

An offender's risk level is an important consideration before treatment services are provided. The RNR model posits that offenders who pose the highest risk of reoffense should receive the most intensive treatment services (Andrews & Bonta, 1998). A number of risk assessment tools have been developed to specifically assess risk for recidivism among sex offenders. Although these tools are critical in assessing an offender's risk for reoffending before release or other change in custodial status, such risk-related information is also an important consideration for pretreatment planning, insofar as these tools are used to determine which sex offenders need the most intensive treatment services.

Although general measures of cognitive ability (e.g., the Wechsler Adult Intelligence Scale [Wechsler, 1997]) or personality style (e.g., the Minnesota Multiphasic Personality Inventory [Butcher, Dahlstrom, Graham, Tellegen, & Kaemmer, 1989]) are often used before treatment to enhance understanding of offender motivational or personality structure or to match learning or interpersonal style to treatment groups or program offerings, a number of specialized assessment instruments have also been developed for use with this population. The Multiphasic Sex Inventory-II (Nichols & Molinder, 1984) is a self-report inventory that includes an assessment of deviant sexual history and interests and an examination of thought patterns and other behavioral and emotional characteristics related to deviant sexual interest. The Abel Assessment for Sexual Interest (Abel, Huffman, Warberg, & Holland, 1998), a computer-based screening measure, was designed to identify the presence of deviant sexual interest in children. Involving a series of images of children, adolescents, and adults of varying age ranges, this screening tool includes a measure of visual reaction time to images of these various sexual interest subgroups, allowing evaluators to compare viewing time with established norms. Given that evaluatees are not aware that the viewing time is being measured, the Abel measure may be of particular utility in assessing deviant sexual interest where honest disclosure may be an issue.

The penile plethysmograph (PPG), which includes a measure of blood flow to the penis and other measures of physiological arousal, is perhaps the most direct measure of sexual response and interest. Through presentation of video or audio stimuli involving suggestive sexual content, the PPG allows the identification of those who have a physiological response to inappropriate or deviant sexual stimuli. Although its use in legal settings may be problematic (Barker & Howell, 1992), the PPG can provide an important measure of pre-treatment and post-treatment response and, like the Abel measure, may be particularly useful where disclosure is of concern.

Treatment Techniques

The relapse prevention model, adopted from the substance abuse literature, aims to help sex offenders recognize their offense patterns, toward the goal of identifying cognitive, emotional, and situational factors that lead to offending. The aim of this model is to allow offenders to proactively intervene in their offense cycle so as to prevent reoffense. Cognitive-behavioral therapy (CBT), a short-term and typically time-limited set of techniques, involves strategies to modify both behavioral habits and cognitive assumptions that may be linked to some form of, in this case, sexual deviance. CBT techniques, which are often used in relapse prevention models, focus on identifying and modifying thoughts, behaviors, or feelings that have some link to sexually deviant behavior. Because CBT has received a great deal of empirical support, it is generally considered to be an efficacious form of therapy with this population. The central tenet of the good lives model approach to the treatment of sex offenders is enhancement of human well-being. By focusing on the development of prosocial behaviors and the acquisition of human goods (e.g., intimacy, safety, creativity, or education), the treatment reduces motivation to reoffend.

Treatment Efficacy

Doubt remains as to the effectiveness of sex offender treatment. Although the field has evolved greatly over the past couple of decades (Ward, Mann, & Gannon, 2007) and evidence suggests that newer treatment models are more effective than older forms of therapy (Hanson et al., 2002), the question as to whether sex offender treatment works continues to arouse debate. However, researchers have generally found that sex offender treatment can reduce both

sexual and general recidivism (Hall, 1995; Hanson et al., 2002; Looman, Dickie, & Abracen, 2005).

Hanson et al. (2002), who conducted a meta-analysis of 43 sexual offender treatment outcome studies, found that 12.3% of sex offenders who completed treatment sexually recidivated (i.e., committed a new sexual offense, typically defined in these studies as rearrest or reconviction), whereas 16.8% of those who did not complete treatment sexually recidivated over the follow-up period (average 46 months). Moreover, Hanson et al. reported recidivism rates of 9.9% for offenders who completed more modern forms of treatment (e.g., CBT) and 17.4% for offenders who did not receive these newer forms of treatment. Similar sexual and nonsexual recidivism reduction rates based on CBT interventions have also been identified by other researchers (e.g., Barbaree & Seto, 1997; Gallagher, Wilson, Hirschfield, Coggeshall, & MacKenzie, 1999; Hanson, 2000; Looman, Abracen, & Nicholaichuk, 2000; Marshall, Barbaree, & Eccles, 1991; McGrath, Cumming, Livingston, & Hoke, 2003; McGrath, Hoke, & Vojtisek, 1998; Nicholaichuk, Gordon, Deqiang, & Wong, 2000; Scalora & Garbin, 2003). A more recent meta-analysis showed that sexual offender treatment programs that adhered to RNR principles showed the largest reduction in both sexual and nonsexual recidivism (Hanson, Bourgon, Helmus, & Hodgson, 2009).

This finding supports Andrews and Bonta's (1998) contention under the RNR model that effective treatment programs should target offenders who are deemed to be at highest risk to recidivate, focus on treating criminogenic needs, and be responsive to unique offender learning styles. Given evidence of lower rates of recidivism associated with more modern treatment models, CBT techniques and the RNR framework are among the most promising models of treatment with this population.

Risk Management

Given heightened concern about reoffense with this population, evaluation of sex offenders typically involves an evaluation of recidivism risk. Because clinical judgment (or a more subjective, impressionistic approach) has been shown to be inferior to actuarial decision making (or a more statistically based, formal approach) to risk assessment (Grove et al., 2000; Hanson & Morton-Bourgon, 2004), adherence to best practices implies the use of empirically validated risk tools. The development of these tools has relied on the work of Hanson and Bussiere (1998), Hanson and Morton-Bourgon (2004), Hanson et al. (2002), and others in identifying individual factors (e.g., age) or offense

characteristics (e.g., gender of victim, use of violence) that most strongly correlate with recidivism. Whereas some risk assessment instruments provide overall risk scores based on the combined weightings of a set number of risk factors, such as the Sex Offender Risk Appraisal Guide (Quinsey et al., 1998), Rapid Risk Assessment for Sex Offence Recidivism (Hanson, 1997), Minnesota Sex Offender Screening Tool–Revised (Epperson et al., 1999), and Static-99 (Hanson & Thornton, 2000), others, such as the Sexual Violence Risk–20 (Boer, Hart, Kropp, & Webster, 1997) and the Risk for Sexual Violence Protocol (Hart et al., 2003), use a structured professional judgment approach that provides decision makers with structured guidelines for considering a list of empirically validated factors but does not provide probabilistic estimates of risk based on the combination of such factors.

Comparative analyses of the utility of specific risk instruments have been undertaken elsewhere (see Barbaree, Seto, Langton, & Peacock, 2001; Harris et al., 2003), and although each instrument seems to have its particular strengths, as yet there appears to be no single instrument with a well-accepted superior predictive capability, although each has a demonstrated reliability and predictive validity that exceeds that of clinical judgment. Continued refinement of these instruments should enhance our predictive capabilities in the realm of recidivistic sexual violence, but at present such instruments seem to provide decision makers with the best available evidence regarding likelihood of recidivism. Indeed, Janus and Prentky (2003) highlight the transparency, accountability, and consistency that actuarial tools bring to the risk-finding process and suggest that actuarial risk assessment provides the most accurate indication of long-term reoffense risk.

INTIMATE VIOLENCE OFFENDERS

Intimate partner violence is an all too common social phenomenon, with a yearly average of approximately 511,000 women and 105,000 men reporting having experienced violence at the hands of an intimate between 2001 and 2005 (Catalano, 2007). Furthermore, 22% of women report experiencing intimate partner violence at some point in their lives (Tjaden & Thoennes, 1998). Intimate partner violence has serious psychological and physical sequelae for victims and has been estimated to cost the U.S. government approximately \$5.8 billion annually in direct (e.g., health care) and indirect (e.g., lowered productivity) costs (National Center for Injury Prevention and Control, 2003). It is clear that treatment and prevention programs targeting intimate violence are vital.

Assessment for Treatment

Research into the assessment of intimate violence offenders has not enjoyed the same allocation of resources often devoted to the study of other offender populations (Geffner & Rosenbaum, 2001), such as sex or violent offenders. However, the limited body of literature examining this issue suggests that the risk factors for intimate violence recidivism may be similar to those for peer violence, such as exposure to family and community violence, attachment difficulties, and child abuse (Moffitt, Krueger, Caspi, & Fagan, 2000; Wolfe & Feiring, 2000). A handful of risk assessment instruments have been specifically designed for use with intimate violence offenders. The three most widely used are the Spousal Assault Risk Assessment Guide (Kropp, Hart, Webster, & Eaves, 1999), a 20-item checklist of clinical variables comprising five broad risk domains (intimate violence history, criminal history, psychosocial adjustment, characteristics of index offense, and other); the Revised Conflict Tactics Scale (Straus, Hamby, Boney-McCoy, & Sugarman, 1996), a 36-item self-report measure that assesses the degree to which intimate partners attack each other, physically and psychologically, and their use of more adaptive methods of conflict resolution (e.g., reasoning and negotiation); and the Danger Assessment Scale (Campbell, 1986), a 14-item dichotomous yes/no scale assessing the presence of factors found to be empirically associated with battery-related homicide.

However, researchers have noted that risk assessment of intimate violence is an understudied area, and current instruments have questionable predictive validity and should serve only as adjuncts to a comprehensive clinical assessment (Geffner & Rosenbaum, 2001).

Treatment Techniques

The first intervention program for intimate violence offenders began in the mid-1970s, with the number of such programs proliferating in subsequent decades because of the growing awareness in the legal community of the need for such treatment programs (Geffner & Rosenbaum, 2001; Scott, 2004). However, despite such growth the scientific community did not become involved in the development, implementation, and evaluation of such programs until well into the 1980s (Babcock, Green, & Robie, 2004). Although there has been growing demand and interest in intimate violence offender interventions, many of the programs currently offered lack standardization and, unfortunately, lack sufficient empirical support to warrant their continued use

(Babcock et al., 2004). Among the most common intimate violence offender programs are those founded in feminist-based psychoeducation and cognitive-behavioral principles.

The bulk of programs offered as intimate violence prevention programs can be roughly categorized as following the feminist psychoeducational model, often referred to as the Duluth model after its originator, the Duluth Domestic Abuse Intervention Program in Minnesota (Babcock et al., 2004; Pence & Paymar, 1993). This paradigm, founded in social work theory, is often viewed as an educational rather than a true therapeutic approach (such as the cognitive-behavioral approaches) because of its avoidance of diagnostic labels and other psychological constructs. This model posits that intimate partner violence stems from an offender's patriarchal views coupled with the differential power dynamic between men and women (Dobash & Dobash, 1977; Pence & Paymar, 1993). The goal of this psychoeducational model, conducted almost exclusively in a group format, is to challenge the offender's existing views and replace them with more egalitarian beliefs, thereby effecting a reduction in intimate violent behavior (Babcock et al., 2004).

Less prevalent than the feminist psychoeducational intervention model are programs derived largely from cognitive-behavioral psychological theory. Like the Duluth model, cognitive-behavioral interventions are conducted almost exclusively in a group format and target the development of offenders' insight into the functional role that intimate partner violence plays in their lives (Babcock et al., 2004). Techniques that are commonly used in cognitive-behavioral interventions include skill training aimed at enhancing assertiveness, communication, social skills, and anger management strategies. However, critics point out that many intimate violence offender programs labeled as CBT use a range of techniques that would not be used in true cognitive-behavioral therapies and more closely resemble psychoeducational models, such as the Duluth model, rather than traditional CBT (Dunford, 2000). Indeed, many researchers argue that most programs offered to intimate violence offenders are paradigmatic hybrids, blending elements of feminist psychoeducational models and cognitive-behavioral approaches (Gregory & Erez, 2002; Whitaker et al., 2006).

Treatment Effectiveness

Historically, research regarding the effectiveness of intimate violence offender treatment programs has been hampered by several factors. First, before individual states mandated treatment for all intimate violence offenders, engagement in voluntary treatment programs was abysmally low (Geffner &

Rosenbaum, 2001). Furthermore, more recent research suggests that the intimate violence offender population is much more heterogeneous than previously believed. An identified subset of these offenders are viewed as highly treatment resistant because of their reluctance to initially engage in treatment and to remain in treatment once engaged, with some estimates suggesting that 50–75% of these offenders drop out early in treatment (Daly & Pelowski, 2000; Geffner & Rosenbaum, 2001). Only with the advent of mandatory treatment has enrollment in intimate violence offender treatment programs reached a level conducive to empirical scrutiny.

Second, early research on treatment effectiveness with intimate violence offenders has been plagued by methodological flaws including poor operationalization of outcome variables (Whitaker et al., 2006). In other words, measurement of treatment success has varied widely, precluding comparisons across studies. Typically, treatment effectiveness has been measured by a reduction in a partner's use of physical violence, through self- or partner report, criminal complaints, or offender rearrest (Gregory & Erez, 2002; Scott, 2004).

Despite these challenges, recent research has emerged elucidating intimate violence offender treatment program effectiveness, although the results have been less than optimistic. For instance, recent meta-analyses and other outcome studies have consistently found small effect sizes for such programs (Davis & Taylor, 1999; Dunford, 2000; Green & Babcock, 2001; Levesque & Gelles, 1998), regardless of the treatment modality, with average effect sizes of approximately 5% reductions in rates of recidivism (Babcock et al., 2004). Proponents of intimate violence offender treatment argue that although such a modest reduction in reoffense rates may seem inconsequential, a reduction of even 5% would equate to approximately 44,000 fewer women being physically abused each year. However, critics point out that even these modest treatment gains apply only to recidivism in terms of physical abuse, with other studies demonstrating that treatment is even less effective in reducing other forms of intimate partner violence such as psychological or verbal abuse (Gondolf, 2002). Taylor, Davis, and Maxwell (2001) provide more optimistic findings, concluding that when offenders are categorized and excluded from analysis based on low treatment motivation, a significant effect for treatment on reoffense rates does emerge. That is, for offenders who express interest in and actively engage in the treatment process, significant therapeutic gains can be made.

Risk Management

Currently, treatment programs for intimate violence offenders are designed to be universally applicable. With the surge of interest and research in the

development, implementation, and evaluation of such programs, there has been a move to assess and refer individual offenders to programs specifically designed to suit their individual capacities and criminogenic needs (Holtzworth-Munroe, 2001). It is believed that such a paradigmatic shift, consistent with the RNR model, would lead to better risk management services for intimate violence offenders.

JUVENILE OFFENDERS

With more than 2.2 million juvenile arrests in 2006, juvenile offenders are responsible for a significant proportion of criminal offenses, accounting for 17% of all violent offenses and 26% of all property crimes in the United States (Snyder, 2008). In the last 20 years, the rate of juvenile violent offenses, including homicide, has increased dramatically. Moreover, because of the current age distribution of the general population, it has been estimated that the juvenile arrest rate will have doubled in the 15-year period of 1996 to 2010 (Office of Juvenile Justice and Delinquency Prevention, 1996; Sickmund, Snyder, & Poe-Yamagata, 1997).

Assessment for Treatment

The assessment of juvenile offenders for risk of recidivism and treatment planning has been hampered by a disproportionate allocation of resources to the study of adult offender populations. Although the risk assessment of adult offenders has generally shifted from reliance on subjective clinical judgment to more objective actuarial methods, the risk assessment of juvenile offenders has been slow to follow suit (Hoge, 2002). Only recently has research into the development and validation of juvenile assessment instruments accelerated. In the last decade, numerous structured instruments specifically designed for use with juvenile offenders have been developed.

Among the more commonly used risk assessment instruments are the Youth Level of Service/Case Management Inventory (Hoge & Andrews, 2001), a structured clinical inventory consisting of 42 items and 8 subscales that can be administered with minimal training; the Child and Adolescent Functional Assessment Scale (Hodges, 1994, 1999), a structured instrument designed to ascertain impairments in emotional and behavioral functioning associated with recidivism; the Structured Assessment of Violence Risk in Youth (Borum, Bartel, & Forth, 2003), a 30-item structured instrument designed to assess four major domains (historical, social/contextual, and individual risk factors and

protective factors); and the Hare Psychopathy Checklist–Youth Version (Hare, Forth, & Kosson, 1994), a 20-item adaptation of the adult version designed to measure the presence of psychopathic traits in juveniles, particularly older juveniles. It should be noted that the use of this instrument with juveniles remains controversial because of concerns about the construct validity of juvenile psychopathy (Hoge, 2002).

Treatment Techniques

Numerous treatment modalities have been developed and implemented with juvenile offenders, but the bulk of empirical data appears to favor two approaches: treatments based in cognitive–behavioral and social learning theory and family system therapy.

Intervention programs grounded in cognitive–behavioral and social learning principles target maladaptive thought processes and impairments in social problem-solving skills found to be linked with the onset and maintenance of antisocial behavior (Tarolla, Wagner, Rabinowitz, & Tubman, 2002). Although the specific techniques used in any given cognitive–behavioral treatment program can vary somewhat, many programs use a number of the following techniques in a group therapy format: cognitive skill training, cognitive restructuring, interpersonal problem solving, social skill training, anger management, moral reasoning, victim impact, substance abuse counseling, behavior modification, and relapse prevention (Landenberger & Lipsey, 2005). Supplemental individual therapy is often offered to maintain active therapeutic engagement and to reduce attrition. Some researchers and clinicians have criticized the use of CBT-based approaches as too narrow in their focus, arguing that such treatment modalities ignore the role of dysfunctional family relationships, deviant peer groups, and negative school and neighborhood environments in the etiology and maintenance of juvenile antisocial behavior (Borduin et al., 1995).

These critics argue that for juvenile offender treatment to be effective, treatment must be customized to fit the needs and capabilities of the individual offender, his family, and his environment (e.g., school, neighborhood); take a holistic approach, allowing the multiple determinants of juvenile antisocial behavior to be targeted for intervention concurrently; and be provided in a number of settings (e.g., home and community) to ensure optimal generalization of newly acquired skills and produce more stable therapeutic change (Tarolla et al., 2002; Tate et al., 1995). Treatment programs based in family system theory were developed to provide such a comprehensive approach to juvenile offender treatment. Although a variety of treatments fall under the

broad umbrella of family system therapy, all such treatment programs attempt to enhance family communication styles and use techniques such as behavioral contracting, rule clarification, and positive reinforcement to achieve desired behavioral outcomes.

Among the most successful family system treatment approaches is multisystemic therapy (MST), developed in the 1980s by Henggeler et al. (1986). This treatment seeks to keep the family intact while addressing a number of issues believed to be related to the juvenile offense cycle, such as maladaptive cognitive styles and attitudes, social and relational difficulties (at both the immediate micro and larger macro levels), and symptoms of mental illness (e.g., depression), if relevant. MST uses numerous empirically supported treatment approaches including techniques based in cognitive-behavior therapy, social learning, strategic and structural family therapy, and behavioral training for the juvenile's parents or primary caregivers.

Treatment Effectiveness

Research suggests that without treatment, 60–96% of juvenile offenders will reoffend within approximately 1 year of arrest (Jenson & Howard, 1998; Lattimore, Visher, & Linster, 1995; Lewis, Yeager, Lovely, Stein, & Cobham-Portorreal, 1994). Despite skepticism about the effectiveness of treatment with juvenile offenders, recent advances in intervention development and implementation have provided promising results for both cognitive-behavioral, social learning-based, and family system therapy.

Mounting literature supports the effectiveness of cognitive-behavioral approaches in enhancing social problem-solving skills and regulating impulsive behavior, reducing rates of reoffense among juvenile offenders (Andrews et al., 1990; Dowden & Andrews, 2003; Gendreau & Ross, 1979; Larson, 1990; Lipsey & Wilson, 1998; Redondo, Sanchez-Meca, & Garrido, 1999). Redondo and colleagues found that CBT programs, in general, produced a mean reduction in recidivism rates among treated juvenile offenders of 25%. Moreover, this effect resulted in a 50% reduction for treated offenders who received programs optimally configured to include the most effective components (i.e., those that included anger management and interpersonal effectiveness as targets). Interestingly, treatment programs that included victim impact and behavior modification components were found to be less effective. Furthermore, CBT-based approaches appeared to be most effective with higher-risk juvenile offenders, directly contradicting clinical lore suggesting that high-risk offenders are untreatable (Landenberger & Lipsey, 2005).

Similarly, a significant body of literature supports the use of more holistic family system approaches (Kazdin, 1987; Shadish et al., 1993), particularly MST (Borduin, 1999; Henggeler, 1996; Schoenwald, Ward, Henggeler, Pickrel, & Patel, 1996). MST has been demonstrated to produce both short-term and long-term reductions in recidivism among juvenile offenders, including persistent and seriously violent ones (Borduin et al., 1995). More specifically, it was found that 14 months after referral for MST services, juvenile offenders had been rearrested 50% fewer times than their treatment-as-usual counterparts (Henggeler, Melton, & Smith, 1992). Furthermore, MST-treated juvenile offenders had an overall reincarceration rate of 20%, compared with 68% for their treatment-as-usual counterparts. Finally, treatment effectiveness has been maintained for follow-up periods of up to 4 years, with MST-treated juvenile offenders being arrested at much lower rates than the offenders who received treatment as usual; when rearrest did occur, the MST-treated offenders committed significantly less serious crimes (Borduin et al., 1995).

Risk Management

As with treatment of all offenders, treatment of juvenile offenders should be viewed as an ongoing, dynamic process following the RNR paradigm. That is, intensity of treatment should be matched to the perceived risk of the juvenile offender, and criminogenic factors should be targeted for treatment, with the assumption that they may change as the juvenile develops (Borum & Verhaagen, 2006). Furthermore, only empirically supported treatments should be implemented, treatment should be customized to suit the unique capabilities and characteristics of the individual juvenile offender and his or her environment, and both treatment providers and community supervision agents should continually monitor, reassess, and modify intervention programs to ensure that treatment gains are maintained.

FEMALE OFFENDERS

Little research has focused on the treatment of female offenders, which may stem from the fact that females offend at much lower rates than do males, making up 8–18% of the total population of offenders (Bonta, Pang, & Wallace-Capretta, 1995). Given their lower rates of offending, research has either neglected female offender populations or treated them similarly to male offender populations, with little attention paid to whether motivations for

offending or crime patterns and recidivism are distinct for female offenders. Therefore, it is not known whether the needs and patterns of female offenders are unique.

Assessment for Treatment

Given that female offenders may have unique life experiences and responsibilities (e.g., pregnancy, childcare) (Koons, Burrow, Morash, & Bynum, 1997) and may be affected more frequently by certain life events (e.g., child sexual abuse, domestic violence, adult sexual assault) and clinical syndromes (e.g., depression or posttraumatic stress disorder) (Poels, 2007), it stands to reason that gender-specific issues warrant attention in a clinical evaluation. Indeed, although measures of personality, cognitive functioning, substance abuse history, or mood dysfunction are likely to be the same as those used with male offenders, a full and comprehensive evaluation should consider the unique needs and obstacles that female offenders may face both in accessing treatment and in benefiting from services offered. Although gender-specific measures are seldom used, at least some evidence suggests that economic disadvantage and social relationships may have differential impact on risk for offending among men and women (Heilbrun et al., 2008).

Treatment Techniques

Given the aforementioned unique needs of female offenders, some suggest that more gender-responsive treatment services be offered (Koons et al., 1997; Morash, Bynum, & Koons, 1998). For example, like their male counterparts, female inmates may be cut off from family and supportive networks. However, this separation could be particularly difficult for mothers with young children, and maintaining family contacts and connections may be an especially important treatment target for females (Monster & Micucci, 2005). However, some evidence suggests that specific programming for causes of female criminality may not be offered in correctional settings (Monster & Micucci, 2005), although there is a shift toward offering more gender-specific programming (Heilbrun et al., 2008). Moreover, evidence suggests that most treatment programming may be based on patterns of male offending (Monster & Micucci, 2005). However, little is known about whether the existing treatment literature or existing treatment programs can be simply extended to female offenders or whether different models of treatment should be used with this population.

Treatment Efficacy

Little research has specifically examined the effectiveness of treatment for female offenders. Using meta-analytic techniques, Dowden and Andrews (1999) examined 26 studies that investigated the effectiveness of corrections-based treatment for female offenders, finding support for the RNR model of treatment. Indeed, Dowden and Andrews found larger treatment effects for programs that directed more treatment services to higher-risk (rather than lower-risk) female offenders and larger treatment effects in programs that focused on criminogenic (vs. noncriminogenic) needs. Specifically, focus on interpersonal criminogenic needs (family process or antisocial associate variables) was most strongly associated with reduced reoffending. Program focus on antisocial cognition and self-control deficits also had a significant association with reduced reoffending (Dowden & Andrews, 1999). Notably, although substance abuse and basic education may intuitively appear to be important treatment targets, Dowden and Andrews did not find these variables to be associated with treatment outcomes in female offenders. Importantly, no research has looked specifically at treatment responsiveness in female offenders, specifically whether women may have particular learning or interpersonal styles that affect recidivism rates (Dowden & Andrews, 1999). Although what works with female offenders may in many ways be an extension of what works with male offenders, more research attention, particularly with regard to issues of treatment responsiveness, is needed in this area.

Risk Management

Because their pathway to crime may be different, it stands to reason that risk assessment should also consider unique risk factors predictive of future offending among women who commit crime. Unfortunately, given a dearth of research identifying risk correlates for female offenders, little is known about whether there are specific and unique risk factors for this population. Therefore, risk assessment tools may lack predictive utility if applied to female offenders. Although identified factors that predict future offending for male offenders may be similar to those that predict future offending for female offenders, this is not necessarily the case. Moreover, even if the factors are similar, their levels of association with future offending and combinations may be quite different. Although at least some evidence suggests that risk factors may be generally similar for male and female offenders (Heilbrun et al., 2008; Loucks & Zamble, 2000), there do appear to be at least some distinctions in pathways to and

maintenance of offending (Heilbrun et al., 2008). As with any population or subgroup not well represented in the developmental samples on which risk assessment tools are based, it may be premature to extend risk estimates to female offenders without a more established normative comparison group (Poels, 2007). Clearly, more research is needed that establishes how males and females differ, and this research can be used to extend or develop genderspecific assessment tools and develop or enhance more gender-responsive programming.

OFFENDERS WITH SERIOUS MENTAL DISORDERS

Mental illness is prevalent among forensic populations. Since the deinstitutionalization movement of the latter half of the 20th century, a significant increase in the number of people with severe and persistent mental illness in the prison system has been observed (Lamb & Weinberger, 2008). These mental illnesses include bipolar disorder, major depression, and psychotic disorders such as schizophrenia (American Psychiatric Association, 2004). In the United States, the numbers of people with mental illness in prisons vary according to the method used to assess prevalence. For instance, the Bureau of Justice Statistics (2006) reported that approximately 55% of male offenders and 73% of female offenders in state prison had a diagnosable mental illness based on self-report, and others have estimated the prevalence of mental illness among prison inmates to be approximately 16% based on mental health service records (Ditton, 1999). However, it is believed that only about one third of offenders with mental illness receive any treatment for their mental illness while they are incarcerated (Bureau of Justice Statistics, 2006).

Assessment for Treatment

Inmates are generally screened for mental illness at intake (Beck & Maruschak, 2001). Currently there appears to be no standard approach for assessing mental illness among offenders. Practices include clinical interviews and assessments and actuarial approaches (Adams & Ferrandino, 2008). The overarching goal of these assessments is to identify offenders who need mental health treatment and to assess their needs and security level.

Several measures have been used to assess need based on the RNR model. One such measure is the Level of Service Inventory–Revised (Andrews & Bonta, 1995), a rating scale designed to assess the risk for general recidivism. However, this instrument was designed for use with the general prison population

and not specifically for mentally ill offenders (Long, Webster, Waine, Motala, & Hollin, 2008). More recently, scales specifically designed to assess treatment needs (Camberwell Assessment of Need; Thomas et al., 2003) and security needs (Operationalized Risk Factors; Brown & Lloyd, 2008) among mentally disordered offenders have been developed. Both scales have been found to be useful and improve mentally ill offenders' access to care (Brown & Lloyd, 2008; Long et al., 2008).

Treatment Techniques

The primary line of treatment for mentally ill offenders is psychotropic medication. It is estimated that 73% of state prisons distribute medications to offenders in their facilities, resulting in 114,400 inmates receiving psychotropic drugs during their incarcerations (Beck & Maruschak, 2001).

Recently more focus has been placed on psychological interventions for mentally ill offenders with the passage of the Mentally Ill Offender Treatment and Crime Reduction Act of 2004 in the United States. This act provides funding to train correctional and mental health staff to treat mentally ill offenders and provides mentally ill offenders with greater access to mental health treatment both while incarcerated and when released into the community (American Psychological Association, 2004). Such interventions include in vivo training of goal-directed actions for offenders with treatment-resistant schizophrenia (Hodel & West, 2003), CBT for long-term inpatients with psychotic disorders and forensic histories (Garrett & Lerman, 2007), dialectical behavior therapy for offenders with borderline personality disorder characteristics (Linehan, 1993), and the Dangerous and Severe Personality Disorder Programme (Mullen, 2007).

Some prisons have developed therapeutic communities (TCs). Generally TCs in prisons are usually separate from the general population and are considered therapeutic milieus. In this environment offenders develop prosocial skills that can be used to transition back into the community (Adams & Ferrandino, 2008). Although TCs traditionally have been used to treat offenders with substance use disorders (see Linhorst, Knight, Johnston, & Trickey, 2001), these programs also have been modified to treat other types of offenders, including those with mental illness (Saum et al., 2007). Staff in the TC environment receive specialized training on how to deal with mentally ill people, and many TC programs have elements of aftercare to help offenders with mental illness in the community (Wormith et al., 2007).

Another form of treatment for people with mental illness is the mental health court. These courts were established in an effort to divert people with serious

mental illness from prisons and jails (Slate & Johnson, 2008). The goal of these programs is to provide these people with the treatment and services they need in an effort to prevent recidivism (Lamb & Weinberger, 2008). Traditionally, mental health courts heard cases of mentally ill people who were accused of misdemeanor crimes, but some courts are also hearing cases of mentally ill people who have been charged with violent felonies (Fisler, 2005). Mental health courts differ from traditional courtrooms in that all those involved (such as the judge, prosecutors, and defense counsel) have had training and experience in working with people with mental illness. Furthermore, they are familiar with community mental health resources, and they make every attempt to provide mental health treatment and support to offenders once they are released from jail and reenter the community (Lamb & Weinberger, 2008).

Treatment Efficacy

Evidence suggests that people with severe mental illness benefit from treatment, which lowers their recidivism rate (Swanson et al., 2006). However, a substantial proportion of people with mental illness who commit crimes are resistant to psychiatric treatment (Draine, Solomon, & Meyerson, 1994; Laberge & Morin, 1995). For example, they may refuse referrals, miss appointments, refuse to take medication, and abuse substances. The failure to participate or adhere to treatment can substantially interfere with treatment success (Lamb & Weinberger, 1998). Therefore, programs that meet the specific needs of those with mental illness are likely to have the greatest success. For example, Griffith, Hiller, Knight, and Simpson (1999) found that TCs were the most cost effective for those at highest risk for recidivism, such as those with mental illness. Furthermore, Lees, Manning, and Rawlings (1999) found that TCs significantly decreased recidivism rates for offenders with borderline personality disorder and other mental disorders. The outcome research on mental health courts is still in its infancy, but preliminary studies have found that mentally ill offenders who successfully completed mental health court programs were less likely to recidivate and engage in future acts of violence than those who did not participate in mental health court programs (McNeil & Binder, 2007).

Risk Management

A recent development in risk management for offenders with mental illness is the emergence of assertive community treatment for forensic populations

(FACT). FACT is based on assertive community treatment (ACT), with the primary goal of preventing reincarceration. ACT is designed to prevent repeat hospitalizations for mental illness by providing a clinical team to help these people in the community around the clock (Morrissey, Meyer, & Cuddeback, 2007). Whereas ACT programs target clients of local hospitals and mental health agencies, FACT teams target county jails. The effectiveness of ACT has been well established (see Bond, Drake, Mueser, & Latimer, 2001). In theory FACT should operate on the same premises as ACT but with mentally ill forensic outpatients; however, in practice, resources are not available for FACT programs to adhere to ACT guidelines. Preliminary uncontrolled findings suggest that FACT programs decrease arrests and hospitalization and reduce yearly service costs (see Morrissey et al., 2007, for review).

COMMUNITY REINTEGRATION AND RISK MANAGEMENT

Each year, more than half a million offenders are released back into the community (Office of Justice Programs, 2004); however, many of these offenders eventually relapse and return to prison (Langan & Levin, 2002). A question that is frequently asked of researchers and policymakers is, "How can we stop this revolving door?" Although there are no easy answers to this question, one solution appears to lie in the RNR model. Offender treatment based on the principles of the RNR model has been found to reduce recidivism. Not only can these principles be used in prison-based programs, they can also be applied to relapse prevention and community reentry programs. For example, information garnered from intake screenings such as offender risk level, mental health status, and level of need can inform discharge planning and ensure that appropriate resources are available to the offender upon release (Hammett, Roberts, & Kennedy, 2001). This information can then be used to tailor reentry programs to coincide with offenders' periods of increased risk (Motiuk & Serin, 1998). Agencies should work together with the criminal justice system to more seamlessly provide services to meet the needs of released offenders (Wormith et al., 2007).

In addition to assessment, correctional treatment must be connected to reintegration efforts so that skills that are learned in prison can be practiced and reinforced in the community. Furthermore, changes that may occur within correctional treatment should be assessed and incorporated into the release plan (Serin & Kennedy, 1997).

Taxman, Young, and Byrne (2004) developed a list of six principles for successful reentry based on the most current research literature on the RNR model:

- Emphasizing informal social control such that family, friends, and community members are enlisted to prevent the offender from reoffending
- Ensuring sufficient duration of the intervention, because behavior change takes a long time, and continuing prison-based initiatives in the community can give offenders the 12–24 months they need to learn new skills and behaviors
- Providing sufficient dosage of the intervention so that the intensity and frequency of the programming meet the offender’s risk level and needs
- Providing comprehensive, integrated, and flexible services designed to address the psychosocial needs of the offender
- Ensuring continuity in behavior change interventions such that interventions that are started in prison are continued into the community with aftercare programming
- Providing clear communication of offender responsibility and expectations so that the offender is involved with the development of rules and sanctions, thus ensuring more accountability

Offenders should be active participants in the development of the treatment and reintegration plan, and adherence to these principles decreases the risk of recidivism (Taxman, 2004).

Although most current reintegration programming is based on the RNR model, several reentry programs based in the restorative justice movement have gained prominence recently. One example is the Options to Parole Suspension project in Canada, whose goal is to prevent offenders released on parole from returning to prison. This program enlists professionally supported volunteers in the community to work with high-risk sex offenders. The goal of these types of reintegration programs is to empower stakeholders (Wilson, Huculak, & McWhinnie, 2002; also see chapter 9, this book).

POLICY IMPLICATIONS

At present, a large portion of the burden of preventing recidivism falls on the criminal justice system through the use of sanctions and monitoring. However, treatment removes some of this burden because unlike all other methods of containing offenders, treatment prevents recidivism by making the offenders responsible for their own actions, providing them the tools to restrain themselves from committing further crimes (Beck & Klein-Saffran, 1990; Levenson, 2003). This benefits offenders as they learn new skills and become more self-sufficient, and it also alleviates some of the financial, physical, and psychological

burdens caused by repeat offenders. Many researchers advocate active participation by offenders in their rehabilitation and reintegration plans (Taxman, 2004). It is assumed that if offenders are stakeholders in their treatment, they will assume a greater level of accountability.

Currently, treatment for many offenders is not a mandated component of incarceration. Consequently, offenders may complete their sentences without addressing any of their criminogenic needs. Additionally, for many offenders treatment is not designed to adhere to the principles of the RNR model. Numerous studies have demonstrated that treatment based on the RNR model can decrease recidivism (see Andrews et al., 1990, for review), and therefore it is unclear why some offenders are not participating in treatment at all or are participating in treatment programs that have no empirical support.

Many of the laws pertaining to offenders that have been enacted in recent years were developed in response to public pressure and outcry (Petrunik, 2002). Most of these laws are designed to contain and monitor offenders, not to provide treatment. However, several studies have found that the public is supportive of rehabilitation efforts (Brown, 1999; McCorkle, 1993; Valliant, Furac, & Antonowicz, 1994). For example, Gideon and Loveland (chapter 2) found in a public opinion survey of residents in New York and the Tri-State Region that about 80% of respondents supported the Second Chance Act and thus are supportive of rehabilitation initiatives. Although the public and policymakers may support treatment in theory, very few people are vocal advocates for it. Therefore, researchers must educate stakeholders about the importance of empirically supported treatment methods in the reduction of recidivism so that these types of rehabilitation and reintegration programs are provided to all offenders.

DISCUSSION QUESTIONS

1. Why do you think that not all rehabilitation programs adhere to the RNR model?
2. What would be the advantages and disadvantages of a generic rehabilitation program that could be adapted to meet the needs of various offender populations?
3. How can the transition from prison to the community be made in such a way as to minimize the risk of recidivism?
4. What facets of treatment are most important for risk management?
5. How can we use assessment to facilitate offender reentry?

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