Rehabilitative Strategies for Preventing Re-offending

Preface

The following two literature reviews were commissioned by the A.C.T. Department of Justice and Community Safety (Corrective Services) to assist in the planning of a new prison. The work for the reviews was undertaken between October and December 1999. We have attempted to identify findings and principles from the vast literature on rehabilitation and management of prisoners that are relevant to 'best practice'. The literature reviewed is international, though we have particularly emphasised important developments from the Canadian Correctional system.

The two reviews are the product of a 'team effort', involving Professor Kevin Howells, Dr. Andrew Day, Mr. Mitch Byrne, Dr. Jack White, Ms. Kart Hart and Ms. Josie Nakos. We would like to thank the large number of people who directed us to relevant information, publications and reports or helped in other ways:

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Introduction

More people than ever before are serving prison sentences. The 1998 National Prisoner Census showed that the national prison population increased by 62% from 1988 to 1998 to a figure of 19,906 (Australian Bureau of Statistics, 1999). Of these more than half (62%) were reported as having been previously imprisoned under sentence. In this report we review the evidence suggesting that recidivism can be significantly reduced through the provision of rehabilitation programs for offenders serving prison sentences.

Recent years have seen a re-awakening of interest in rehabilitating prisoners in correctional systems around the world. There is currently more optimism about the usefulness of working with offenders to reduce the likelihood of them re-offending than perhaps at any time in the last thirty years. In this review we have tried to examine the reasons behind this optimism. We start by outlining recent empirical studies pointing to the effectiveness of rehabilitation programs and what we (and others) believe to be some principles of good practice. We see this work as offering a framework for the provision of rational, evidence-based approaches to offender rehabilitation, with clear practical suggestions for the most promising ways forward. In the final sections, we review recent rehabilitation programs for different types of offender in the context of what we know generally about effective offender treatment. Our focus is on psychological rehabilitation programs rather than educational or vocational programs. Finally we look at the current situation in Australia, before identifying some key issues and recommendations for the ACT in developing best-practice offender rehabilitation programs.

The most common starting point for modern reviews of rehabilitation is the publication in 1974 of what proved to be a most influential paper by Robert Martinson. In this paper, Martinson (1974) attempted to draw together the results of evaluations of a wide range of offender rehabilitation programs conducted between 1945 and 1967. From his review of a total of 231 controlled outcome studies, Martinson's conclusions were pessimistic. To quote him: "with few and isolated exceptions, the rehabilitative efforts that have been reported so far have had no appreciable effect on recidivism" (p. 25). Whilst this conclusion was challenged on methodological grounds by some and later rejected by Martinson, the work was taken by many as proof that 'nothing works' in offender rehabilitation. Attempts at rehabilitation were regarded as too individualistic and reductionist to be useful, reflecting a change in correctional policy and service planning around the world.

It is only over the last 15 years or so that evidence has accumulated to challenge the 'nothing works' position. Firstly, Martinson's original study was itself criticised. A re-analysis by Thornton (1987) of the data used in the original review reached a different conclusion, that psychological treatment either had a positive effect on recidivism, or that no conclusions could be drawn from the data. Thornton maintained that it was not possible to conclude on the basis of Martinson's data that 'nothing worked'. Secondly, since 1967 there has been an accumulation of new outcome studies providing evidence that some rehabilitation programs do indeed work. There are currently more than 1500 published studies in the area of offender rehabilitation (Lipton et al, 1997) giving a substantial new database for further evaluations. Furthermore, the development of the statistical procedure of meta-analysis has enabled researchers to draw together findings from large numbers of evaluation studies in a way that is intelligible and easily interpreted. A number of meta-analytic reviews from around the world have been

published in the last ten years, consistently reaching the same two conclusions. Firstly that there is substantial evidence suggesting that interventions to reduce re-offending lead to an overall positive net gain when treated groups are compared to non-treated groups. Secondly that some interventions have significantly higher effects than others. Furthermore, recent evidence indicates that some types of program are much more effective than others, leading to a focus on identifying the characteristics of programs which produce the best outcomes. This work has, for the first time, allowed us to begin to articulate what we know about best practice.

The move back to rehabilitation has been supported not only by growing evidence of program effectiveness, but also by an increasing pessimism about the differential effects of other sentencing options. In the last few years the way in which the effectiveness of sentencing options is determined has changed from using large scale criminological data, (for example, showing rates of re-offending following different types of court disposal) to more refined methods where researchers control offenders' for risk of re-offending. This is important as those offenders sentenced to imprisonment, for example, are likely to be at higher risk of re-offending than those who receive community orders. Assessing the impact of different sentences in terms of changes that can be observed between predicted and actual rates of offending for large samples of re-convicted offenders takes account of differences between the groups in terms of risk and is, therefore, likely to lead to more meaningful comparisons (see McGuire, 1998) . Using this method, a Home Office study in the UK (Lloyd, Mair & Hough, 1994) compared the four main types of sentence used by criminal courts for more serious offences over a two year follow up period (imprisonment, community service orders, probation orders and probation with additional requirements). Lloyd and colleagues concluded that when aspects of criminal history were taken into account, most of the apparent differences between types of

sentence disappeared. McGuire (1998) following a re-analysis of more recent Home Office data replicated this finding. McGuire concludes from this work that:

"Overall the rates at which individuals re-offend is very close to the rate at which they were probably going to re-offend, regardless of the type of sentence imposed upon them. The sentence of the court has no obvious bearing on the outcome" (McGuire 1998, p. 5).

Assessing Best Practice

In this review, we aim to examine the notion of best practice as it applies to offender rehabilitation. Before describing some of the programs that may be regarded as best practice, it is important to first define what the term 'best practice' means, and how it relates to the research literature.

Three main methods have been used to review the literature on the effectiveness of psychological interventions (Kazdin & Kendall, 1998). Firstly there is the narrative or qualitative review, in which people with expertise in the field attempt to synthesise individual studies and summarise what can or cannot be supported. Generally, this type of review has not proved very useful when applied to rehabilitation programs, given the diversity of programs that are typically offered to offenders (Gendreau & Andrews, 1990). Programs which aim to reduce recidivism include deterrence programs, social casework, group counselling, psychotherapy, family therapy, probation, restitution and physical challenge programs (Palmer, 1996). As Hollin (1999) points out, attempting to draw together the results of studies examining this range of interventions is probably an impossible task (Hollin, 1999).

More recently, methods of quantitative review have been dominated by the statistical technique of meta-analysis. Meta-analysis involves “collecting relevant studies, using the summary statistics from each study as a unit of analysis, and then analysing the aggregated data in a quantitative manner using statistical tests” (Izzo & Ross, 1990, p.135). The application of this method to studies of offender rehabilitation has had a major influence on the field and provides a substantial database from which to evaluate program effectiveness. Recent meta-analytic reviews are discussed in more detail in the next section.

The third method of review examines evidence from the perspective of a common set of criteria to evaluate the extent to which a specific treatment is effective. In other words, the review focusses on what we know about treatment for a particular problem area. This method offers a model from which individual programs can be assessed, accredited and evaluated. With this method, the way in which the studies are reviewed (i.e., qualitatively or quantitatively) is less critical than the focus or purpose of the review. A typical question might be: what evidence is there to suggest that this particular program delivered to this population is likely to achieve its goals? In this review, we begin by describing previous meta-analytic reviews which offer general statements about program effectiveness, then go on to review literature about interventions for particular types of offending.

Meta-analytic Reviews

The popularity of meta-analyic reviews is, in part, due to an increase in the numbers of research studies employing recidivism as an outcome measure.

Meta-analysis offers an efficient way to aggregate data across large numbers of comparable studies and achieves three main objectives: (a) to obtain a global index of program effectiveness; (b) to determine the homogeneity of the results, related to this global index; and (c) if homogeneity is not met, to search for study characteristics that may explain the variability in effect size. By drawing together the results of studies involving large numbers of offenders such reviews have the potential to answer the general question of how effective rehabilitation programs are in reducing re-offending, whether some types of program are more effective than others, and finally to identify the characteristics of those programs which are related to their success. Meta-analysis has become a widely accepted way of making generalisations about outcomes, and produces an easily understandable overall estimate of program effect sizes. An effect size index can usually be directly interpreted as the percentage improvement of treatment groups compared to control groups.

In the last ten years a number of major reviews have been conducted in the UK, North America, Canada and Europe summarising the outcomes of rehabilitation programs involving thousands of offenders (see Hollin, 1999). Published meta-analytic studies include those of Garrett, (1985); Gottschalk, Davidson, Gensheimer and Mayer, (1987); Gottschalk, Davidson, Mayer and Gensheimer, (1987b); Losel and Koferl, (1989); Whitehead and Lab, (1989); Andrews, Zinger et al (1990); Izzo and Ross (1990); Antonowicz and Ross (1994); Lipsey (1995); Redondo, Garrido, Anguera and Luque, (1996); Cleland, Pearson, Lipton and Yee (1997); Pearson, Lipton and Cleland (1997). There have also been a number of overall reviews and syntheses (Gendreau & Andrews (1990); Hollin (1993; 1994); Lipsey (1995); Losel (1995a; 1995b; 1996); McGuire & Priestley (1995); Gendreau (1996); MacKenzie (1997); McGuire (1998), Hollin (1999) and Howells & Day (1999)).

Each of these reviews has reached broadly similar conclusions with Hollin (1999) estimating the average effectiveness of the programs to vary between 5% and 18%. If the recidivism rate for a group of offenders is 50%, this rate will be reduced to between 32-45% for those who receive a rehabilitation program. For example, the European meta-analysis of Redondo, Sanchez-Meca and Garrido (1998) integrating the results of 57 programs obtained a global effect size of r-.150 for all treatment and all outcome measures (including psychological adjustment, school adjustment and recidivism).

In the United Kingdom, James McGuire recently presented evidence to the Home Affairs Committee of the House of Commons on the effectiveness of rehabilitation programs. McGuire (1998) reviewed ten meta-analytic studies conducted between 1985 and 1996, based on a cumulative sample of over 50,000 offenders. McGuire reported that all of these studies (of rehabilitation programs) reported positive effect sizes (+0.10 to +0.36) in recidivism (i.e., those who have attended programs re-offend between 10% - 36% less than those who do not attend programs). McGuire argues that these effect sizes, although modest, compare favourably with the effect sizes for various pharmacological treatments (e.g., AZT or use of aspirin to prevent myocardial infarction), and would prove a cost-effective option for the criminal justice system.

Whilst the technique of meta-analysis has been influential in transforming the 'what works' debate, it has attracted some criticism (e.g., Sharpe, 1997; Weisz & Hawley, 1998). With any summarising technique, the output inevitably reflects the limitations of the input. The criteria used to select studies for inclusion in a meta-analysis are critical to the outcome. It is possible that by aggregating studies as diverse as educational programs, behavioural programs, therapeutic community and diversion programs, with an age range from adolescent to adult offenders (such as in the Redondo, Garrido & Sanchez-Meca 1998 review), important distinctions between different programs are masked.

Meta-analyses have thus far been applied to studies involving between-group comparisons, with a large body of evidence from within-group designs and single subject designs omitted. Another limitation is the unavoidable confounding among factors that may relate to outcome. In short, there is an array of potential limitations relating to the methodological decisions that must be made in any meta-analysis (e.g., methodological rigour, inclusion of unpublished studies etc.). Selection of the outcome variable is critically important in interpreting the results. Using recidivism as the main (though not sole) outcome variable across different studies raises reliability issues. In particular, care needs to be taken with issues such as length of follow-up and consistent definitions of recidivism both between jurisdictions and across studies (e.g., any re-offending, or re-offending of a similar nature to the targetted offence, length of time to re-offending). Measuring recidivism reliably has proven a difficult task (see Broadhurst & Loh, 1995; Lloyd, Mair & Hough, 1994, for a discussion of this area).

There is now a consensus that, when grouped together, rehabilitation programs are generally effective in reducing recidivism. Within these groupings, it is probable that some interventions are likely to be very effective, whilst others have a negligible effect on recidivism. The largest published meta-analysis to date by Lipsey (1995) reported that approximately 65% of interventions yielded reductions in recidivism. Others have reported that some 'treatments'(such as intensified criminal sanctioning or deterrence programs) which do not reduce recidivism at all, but actually increase it (Andrews, Bonta & Hoge, 1990; Lipsey, 1992;1995). Meta-analytic reviews are thus an important source of information in developing general statements about best practice.

Best Practice

It is only in the last five years that it has been possible to speak seriously of an evidence-based approach to rehabilitation. Whilst program efficacy and effectiveness can only be demonstrated by outcome evaluations of specific programs, Andrews (1998) argues that it is currently possible to derive some evidence based guidelines for offender rehabilitation from evidence regarding differential outcomes between studies of rehabilitation programs. Whilst some of the differences can be attributed to study characteristics other than treatment (Andrews et al, 1990), there is an emerging consensus about the characteristics of the most effective programs (i.e., those programs which are associated with an average effect size greater than the overall average of ten percentage points (Andrews, 1998)). In many respects, Canadian researchers have led the field in this area, presenting evidence that (according to their criteria) appropriately designed services produce an average reduction in recidivism of over 50%, compared with 'inappropriate services' which lead to increased recidivism. Of the 35 studies of 'appropriate services' reviewed by Andrews et al (1990), all but 2 found reduced recidivism. These researchers have developed a set of general principles for use in program selection and delivery, which can be applied to determine the general appropriateness of a particular program. For example, programs which select appropriate candidates for treatment have been shown to be more successful than those who do not. Secondly, better outcome have been shown for those programs which target areas for rehabilitation which are directly related to offending. In the next section we will outline some principles of effective program selection, developed by Canadian researchers such as Andrews, Bonta and Gendreau.

Principles of Rehabilitation

Bonta and Andrews have put forward five principles for rehabilitation: risk, need, responsivity, professional discretion and program integrity. The Risk principle suggests that higher risk offenders stand to benefit more from rehabilitation programs than low risk offenders; the Needs principle suggests that programs should meet individual offender Criminogenic Needs, and the Responsivity principle suggests that programs would be as responsive as possible to the characteristics of individual offenders, and, for example, assess motivation for treatment and target weak motivation. Bonta (1997) suggests that these five principles can be developed into some basic guidelines for matching offenders to programs. It is suggested that the most effective programs are those which match the intervention with the needs, circumstances, and learning styles of individuals (Andrews & Hoge, 1995; Andrews 1996).

Risk

The meta-analytic research on differential outcomes suggests that two issues are central to effective offender assessment - the assessment of risk; and the assessment of what have been termed 'criminogenic' factors. Andrews and Bonta (1994) have formulated the risk principle for effective program delivery. This principle states that offenders identified as medium to high risk should be selected for intensive treatment programs. Effective risk assessment will allow accurate matching of the client group with the consequent level of delivery of the program (Brown, 1996).

Essentially, risk assessment involves attempting to predict human behaviour. There are two ways of doing this, the clinical and the actuarial. Clinical assessment is based primarily on professional judgement of an individual's likelihood of re-offending, from an individual practitioner's knowledge of the offender. Actuarial or statistical assessments

are based on empirically established correlations between a risk measure and recidivism. Research investigating the ability of both methods to predict recidivism (e.g., Goggin, 1994) has demonstrated conclusively the superiority of the actuarial model of prediction. In other words, clinical judgments of risk are significantly more unreliable than actuarial assessments. Gendreau, Goggin and Paparozzi (1996) conclude that there is simply no justification for the use of the clinical model of assessment, despite its continued popularity amongst professionals.

There are currently a number of risk assessment measures available, which vary in terms of their content and in the extent to which they have been validated for use with different populations. A commonly used instrument in Community Corrections settings in Australia is the Wisconsin Risk Assessment Scale (W.R.A.S., Baird, 1981). This is a clinical interview-based assessment which is used primarily to assess risk and determine the appropriate level of supervision for each client. The focus of the W.R.A.S. is on the assessment of static risk factors. While some dynamic risk / need factors are also identified, these are used primarily to inform the level of supervision, and not as targets for change or indices of program efficacy. Various studies have supported the use of the W.R.A.S. in a Community Correctional setting (N.I.C., 1981). Gendreau, Little and Goggin's (1996) meta-analysis reported that the W.R.A.S. was not significantly better or worse than other composite scales. The main difficulty with the W.R.A.S. lies in its reliance on static variables in predicting risk. Static variables by definition do not change over time, and, as such, the level of risk as measured by the W.R.A.S. rarely changes. Whilst the W.R.A.S. does measure some dynamic factors, there have been very few studies which report on their predictive validity (Bonta, 1996). The W.R.A.S. has also received criticism due to its potential for unreliability (Bonta, 1996), given that some of the items are scored according to clinical judgment, and staff can 'over-ride' assessed need when they deem it appropriate. While Cumberland and Boyle (1997) have reported

that professional over-ride has made a significant contribution to predictions of recidivism in a Queensland sample, the inclusion of an opportunity for an individual assessor to assert his / her (subjective) opinion is none-the-less methodologically problematic.

One of the most widely used measures of risk is the Level of Supervision Inventory which has been used extensively in Canada. The LSI was developed empirically and there is a wealth of data (primarily from Canada) supporting its ability to predict reoffending reliably (Andrews & Bonta, 1995, cited in Gendreau, Goggin & Paparozzi, 1996). This instrument is currently being trialed in New South Wales.

There are other risk assessment instruments and approaches. For example, psychopathy has been shown to be a strong predictor of recidivism. Psychopaths are characterised by their persistent disregard for social norms, impulsivity, unreliability, lack of empathy, and failure to maintain enduring attachments to people. It is therefore no surprise that the Hare Psychopathy Checklist – Revised (Hare, 1991) consistently predicted recidivism in a study by Hemphill, Hare and Wong (1998). They found that psychopaths were three times more likely to recidivate and four times more likely to violently recidivate than non-psychopaths. Furthermore, Hemphill et al found that the PCL-R scores were more strongly correlated with recidivism than standard risk scales constructed specifically for that purpose, such as the Base Expectancy Score (BES, Gottfredson & Bonds, 1961), the Level of Supervision Inventory (LSI, Andrews, 1982), the Salient Factor Score (SFS-81, Hoffman, 1983), Statistical Information on Recidivism scale (SIR, Nuffield, 1989) and the Violent Risk Appraisal Guide (VRAG, Rice & Harris, 1995). The PCL-R is not good at identifying specific areas of risk which might form the target of intervention and for that reason it is not a 'stand alone' instrument.

There are some ethical issues to consider with respect to risk assessments, which, fall broadly into the area of errors in prediction. Firstly there is the problem of false positives, for those individuals who do not re-offend, and yet are identified as high risk and subjected to more intensive (and unneccessary) restrictions. On the other hand, risk assessments can lead to false negatives where assessments do not identify those who do re-offend and cause harm to the community. These problems inevitably arise from attempting to apply statistically developed, generalised methods of classification to individual offenders. At present, perfect methods of measuring risk do not exist, although it seems likely that the field will develop in the direction of combining statistical data, clinical judgment and criminogenic needs in risk assessment (Monahan, 1996).

Needs

Actuarial risk assessment measures include items on age, gender, past criminal history, early family factors and criminal associates, which are all robust predictors of recidivism (Andrews & Bonta, 1994). Each of these factors is static (i.e., cannot be changed through intervention). Whilst static predictors may be of use in determining the intensity of intervention offered, they have no use in assessing changes in risk or program effectiveness. Andrews, Bonta and Hoge (1990) have argued that the focus of rehabilitation efforts should be on dynamic risk factors, the most important of which have been termed criminogenic needs. These are broadly defined as “those set of attitudes, values, beliefs, and behaviors held by an offender that support (a) negative

attitudes towards all forms of official authority and conventional pursuits, (b) deviant values that justify aggression, hostility and substance abuse, (c) rationalisations for anti-social behaviour that free one from moral constraints" (Gendreau et al 1996 p.8). A meta-analysis by Gendreau, Goggin and Little (1996) investigating the relationship between criminogenic needs and recidivism reported that criminogenic needs predicted recidivism (r=.17) equally as well as static predictors.

A list of typical offender needs which are related to recidivism (i.e., criminogenic needs) is shown in Table 1.

Table 1: Needs of Offenders (from Bonta, 1997)

Criminogenic	*Non-Criminogenic*
Pro criminal Attitudes	Self-Esteem
Criminal Associates	Anxiety

Substance Abuse	Feelings of Alienation
Antisocial Personality	Psychological Discomfort
Problem-Solving Skills	Group Cohesion
Hostility-Anger	Neighbourhood Improvement

The Correctional Service of Canada has recently published major reviews of the literature describing three domains of criminogenic need: substance abuse (Boland, Henderson & Baker, 1998), personal emotional factors (Robinson, Porporino & Beal, 1998) and criminal associates / social interaction (Goggin, Gendreau & Gray, 1998). These reviews offer strong support for rehabilitation programs focussing on criminogenic needs as targets for change.

In a narrative review and meta-analysis of studies looking at the relationship between criminal associates and recidivism, Goggin et al (1998) confirmed previous findings that the criminal associates domain is a powerful predictor of recidivism. They further identified three separate components - criminal companions, crime neighbourhood and criminal family, of which companions was the strongest predictor of recidivism. The personal / emotional domain represents a broad group of factors which are believed to be criminogenic. Robinson, Porporino and Beal (1998) group these factors into 4 principal components: self concept (e.g., self-esteem), cognition (e.g. impulsivity, problem solving, interpersonal skills, empathy), behavioural (e.g., assertion, neuroticism / anxiety, aggression / anger / hostility, risk taking and coping), and sexual behaviour, mental ability and mental health.

In Canada, all new reception prisoners go through a standardised method for assessing criminogenic needs. An initial assessment screens the offender for immediate physical health, security, mental health and suicide concerns. This is followed by a criminal risk assessment and a case needs identification and analysis or CNIA (Motiuk, 1998). The CNIA provides indicators on each of the seven dynamic risk or criminogenic need factors (employment, marital/family, associates, substance abuse, community functioning, personal/emotional and attitude). This assessment then forms the basis for sentence planning. We believe that if correctional systems are to embrace the 'what works?' literature, adoption of this type of assessment process linking criminogenic needs to rehabilitation programs, is essential.

Responsivity

The responsivity principle focuses attention on client and program characteristics that influence the offender's ability to learn within a therapeutic situation. Treatment is a learning experience and individual factors that interfere with, or facilitate, learning can be termed responsivity factors.

Responsivity factors can be understood as contextual variables that may have an influence on treatment outcome. These contexts make a difference both to the skills, strategies, or identities that individuals develop and to the support that is available when transitions are made. Factors such as ethnicity, gender, socio-economic status, anxiety, depression and mental illness can be considered key responsivity factors. For the most part, these factors might be considered as non-criminogenic factors in that they are not directly related to recidivism. Other responsivity factors may also function as risk factors. For example, a diagnosis of antisocial personality or psychopathy highlights the ways

risk, criminogenic needs and responsivity may operate together. Bonta (1995) suggests that “(N)ot only are such individuals more likely to re-offend (risk), but treatment may target aspects of the antisocial personality such as impulsivity (criminogenic need)' (p.37). Others have suggested that group work may not be the best approach for treating psychopaths (Ogloff et al, 1990).

Whereas some responsivity factors (e.g., anxiety, self-esteem, mental illness, gender, ethnicity) can be found in the general population, some responsivity factors are more common in offender populations (e.g., poor social skills, inadequate problem solving skills, concrete thinking styles, poor verbal skills) (Bonta, 1995). Examination of these factors makes it clear why some treatment modalities appear to produce better outcomes than others.

At present it is difficult to make any conclusive statements about responsivity factors. Research into this area is in its infancy, although work is in progress to develop methods of accurately assessing different responsivity factors (see Serin & Kennedy, 1997; Serin, 1998). The area of responsivity that has stimulated most work to date has been that of offender motivation to attend rehabilitation programs. Drawing on models developed primarily in the drug and alcohol field, it has been suggested that, in the course of resolving a problem, people pass through identifiable stages of change (see Prochaska & DiClemente, 1986, 1996; Prochaska, DiClemente & Norcross, 1992; McConnaughy, Prochaska & Velicer, 1989). For example, a person may start off being unmotivated and unaware of a problem, before beginning to contemplate making changes and actually doing something to bring about change. This approach has been used for assessing motivation in offenders with drug and alcohol problems (e.g. Bubner, 1999), with anger problems (Howells, Day, Bubner & Jauncey, 1999), and in offenders generally (McMurran et al, 1998). It has also been influential in the development of the intervention

technique of motivational interviewing (Miller & Rollnick, 1991), which is a method of working collaboratively with offenders to identify problems and increase motivation. Whilst the Prochaska and DiClemente model seems useful in assessing a major component of readiness to change in offenders, it does not take into account the secondary gains of engaging in treatment (Jones, 1997). For many offenders, the decision to enter treatment is influenced by the degree of coercion they feel to attend, the possibility that treatment will influence parole, home detention or release decisions, and their confidence in the particular program being offered. Recent work on responsivity factors in prison settings has attempted to include other aspects of responsivity pertinent to prison treatment.

For example, a promising scale developed by Baxter, Marion and Goguen (1995), measures not only offender motivation and perceived need for treatment, but four other aspects of responsivity (perceptions of treatment and the institution, perceptions of staff, optimism about treatment outcome and comfort regarding disclosure in groups) This scale has been shown to predict outcomes for prisoners attending drug and alcohol and anger management programs. Another format for assessing responsivity has been developed by Serin (1998). Serin divides responsivity factors into two broad categories, treatment readiness (including motivation and goal setting) and treatment performance that are assessed through a semi-structured interview. Taking a different approach, Jones (1997) applies a model of adaptation to organisations to map attitudes to treatment in a prison therapeutic community.

Much more work needs to be done to determine the utility of these measures in selecting offenders for programs and influencing program outcomes. Whilst some studies have recommended certain scales as potential predictors of offender treatment response, research in this area has produced conflicting results. For example, whilst offender

motivation to change has been viewed as important before placing people in drug and alcohol programs (Miller & Rollnick, 1991), others have argued that motivation is not as relevant to treatment outcome in sexual offender programs (Terry & Mitchell, 1999; Rittakertu, Laippala & Salonkangas, 1997).

An important area of responsivity, that has until recently received little attention in the literature, is that of cultural appropriateness of programs. Cultural inappropriateness may lie either in the total conceptualisation of a program or in the everyday routines that accompany its implementation. In Australia a large proportion of imprisoned offenders are from the Indigenous community, and programs are frequently conducted with populations in which minority cultural groups are over-represented. It is well established in the USA, however, that programs related to activities such as substance abuse need to be altered for various cultural groups (Wallace, 1999). The importance of culture as a responsivity factor, may be illustrated by anger and violence programs. The possibility that different expectations and norms about anger-expression and violence exist in such cultural groups needs to be considered, though empirical research in this area is sparse. Averill (1993) has similarly argued that anger, like other emotions, is a syndrome constituted according to social and cultural rules, of a constitutive, regulative and procedural kind. Thus cultures vary in their definitions of anger, in their notions of when it is legitimate / illegitimate, and in their expectations as to its appropriate expression. Anger-management theory and methods have been influenced largely by North American and European conceptions of anger. Kovecses (1986) has argued that North American and European cultures have distinctive implicit metaphors about the nature of anger (for example, as hot liquid contained under pressure in a vessel). It is not difficult to see how such metaphors would affect ideas about how anger should be controlled and ventilated. Burbank's (1994) anthropological studies of anger and aggression in women in an Aboriginal community suggest that a degree of cultural variability may exist in

perceptions and understanding of anger and its control. The issue of how violence programs might be adapted for Australian Aboriginal offenders has been discussed in detail by Mals, Howells, Chapman and Day (in press), although there has been little evaluation of such programs (e.g., Ferrante, Loh & Maller, 1999).

Underpinning the responsivity principle is the task of matching programs to individual needs. Unfortunately, individual differences are rarely addressed in intervention programs. The dominant model for many rehabilitation programs seems to be that of the treatment 'package', whereby a standard program is delivered to all identified offenders. This occurs in most Australian jurisdictions. The pragmatic decision to give the same treatment to all identified offenders is easy to understand, given the labour-intensiveness of assessing each offender and of varying the intervention conditions to accommodate individual differences in the population. The consequence of the standard treatment package approach is, inevitably, that participants in such programs are diverse in terms of their psychological and criminological characteristics and needs.

Program Integrity

In contrast to the demands made by the responsivity principle to individualise interventions, an important component of quality assurance has been to emphasise program integrity issues. Program integrity refers to the extent to which a program is delivered in practice as intended in theory and design (Hollin, 1995). Waltz et al (1993) suggest that assessing integrity involves two components: therapist adherence to the treatment protocol, and therapist competence in delivering the treatment.

Attempting to increase the integrity of programs has, in part, been behind the move towards standardised treatment manuals and protocols. These can be easily translated into checklists of treatment adherence for completion by a program facilitator and / or client in each program. Assessing competence is more problematic. Whilst facilitators are likely to have some biases in their perceptions of sessions, and clients may not have the level of knowledge required to accurately assess integrity, these sources of data are commonly utilised in checking for integrity (Moncher & Prinz, 1991).

Program integrity is of paramount importance in program evaluations which aggregate data collected from programs delivered across different sites by different therapists. For such evaluations to be meaningful, we need to be confident that the programs being evaluated are broadly consistent. A lack of detailed description of program delivery in many studies has meant that the independent variable in meta-analytic reviews may contain a considerable degree of error and insensitivity (Lipton et al, 1997). Additionally, missing or unreported information is a substantial problem. Many key variables which would inform policy makers' decisions, such as program cost, are consistently unreported.

Gendreau and Goggin (1997) suggest that therapeutic integrity is essential for prison programs to produce reasonably large effects on recidivism (20-35 percent reductions). They argue that programs with therapeutic integrity are designed and evaluated by well qualified individuals, hire staff with four year degrees in a helping profession, provide ongoing training and development to program staff and offer a very intensive service (p.272).

Professional Discretion

The final principle of Professional Discretion allows for professionals to make decisions on the basis of other characteristics and situations not covered by the other principles. It makes sense to build in scope for some professional judgement into any rehabilitation system, rather than to rely upon the administration of relatively static principles. For example, in working with a child sexual offender, who in other respects may not be identified as high priority for treatment (low risk, low need, low responsivity), a professional may have access to knowledge (e.g., the offender is entering high risk situations such as babysitting) that would be of concern and indicate further intervention.

Evidence Based Interventions

In psychology, there has been recent debate about the degree of evidentiary support required for determining that psychosocial interventions are of value for specific problems. Publication of the Task Force on Promotion and Dissemination of Psychological Procedures (1995) has inspired much discussion and debate in this area.

Applying evidence-based criteria to correctional programs is not easy. One of the clearest statements to help guide decisions as to the appropriateness of a particular program comes from Quinsey (1995). Whilst Quinsey is describing programs for sexual offenders,

the following general criteria can be applied to all areas of rehabilitation. Quinsey (1995) suggests that treatments should be selected that:

- "fit with what is known about the treatment of offenders in general
- have a convincing theoretical rationale
- have been demonstrated to produce proximal changes in theoretically relevant measures
- are feasible in terms of acceptability to offenders and clinicians, cost and ethical standards
- are described in sufficient detail that program integrity can be measured, and
- can be integrated into existing supervisory procedures" (Quinsey, 1995, p. 23).

What Do We Know in General About the Treatment of Offenders?

As discussed earlier, meta-analytic studies have consistently reported not only that correctional rehabilitation is effective, but that some interventions have significantly higher effects than others. A strength of meta-analytic reviews is that they draw upon large sample sizes, thus allowing for more specific comparisons of different studies. This has allowed researchers to demonstrate empirically that particular aspects of the program and the setting in which a program is delivered are associated with greater reductions in recidivism. These are described below.

Program Characteristics

In addition to targeting criminogenic needs, it is also possible to make some statements about the content of the more effective programs. There is now a consensus that cognitive and behavioural methods are more successful than other types of treatment approach with offenders. Cognitive-behavioural programs are structured, goal oriented and focus on the links between beliefs, attitudes and behaviour. Programs based on confrontation or direct deterrence have been consistently found to be less successful. Evaluations of social casework, physical challenge, restitution group counselling, family intervention, vocational training, employment and educational programs have all produced mixed findings (McGuire, 1995). McGuire (1998) has argued persuasively against the use of punishment in reducing recidivism. McGuire suggests that not only is there little evidence to suggest that programs based on punishment bring about long-term behaviour change, but also that, theoretically, we would not expect punishment to be effective in the criminal justice system. For example, for punishment to be effective, it has to be applied immediately after the undesirable behaviour occurs, it works best when applied at maximum severity and should be inescapable following the infraction of a rule. McGuire (1995) argues that these circumstances are unlikely to be met in correctional settings.

Secondly, programs should be of sufficient intensity to be expected to impact upon offending rates. For example, a six week course on anger management is unlikely to have a significant impact on offenders with 20 year histories of anger-related offences. Canadian researchers recommend that programs should be at least 100 hours and take place over a minimum of 3-4 months.

Finally, researchers have strongly recommended that the staff responsible for program delivery receive adequate training and supervision (e.g., McGuire, Andrews and others). Therapist skills should be matched with the type of program. It has been argued that therapists who have a concrete problem-solving style function best in highly structured

programs. Others, such as Gendreau, have suggested that therapists should have at least an undergraduate degree or equivalent, and receive 3-6 months formal on-the-job training in the application of interventions.

Whilst there have been few published attempts to audit rehabilitation programs, one study in North America by Gendreau and Goggin (1996) reported that only about 10% of existing rehabilitation programs could be regarded as satisfactory, and the Home Office in the UK reports a lack of appropriate selection for services and evaluation (Vennard, Sugg & Hedderman, 1997). The Correctional Program Assessment Inventory (CPAI) (Gendreau & Andrews, 1996) has been developed in an attempt to measure the extent to which programs typically delivered to offenders correspond to the research-derived suggestions for good practice. This evaluation tool assesses programs on six dimensions: program implementation, client pre-service assessment, program characteristics, staff characteristics and practices, evaluation, and an 'other' category. Of 101 programs assessed using the CPAI, only ten percent received a satisfactory score (Gendreau & Goggin, 1997). Whilst these programs are North American and Canadian, in many respects these jurisdictions lead the field in rehabilitation and could be expected to have the highest quality programs in the world. There is little reason to expect that Australian programs currently delivered would fare any better in an independent audit. The assessment also revealed that community based (rather than prison) and contracted out (rather than delivered by institutions) programs tended to score higher, with the best programs having a specialised focus (e.g., sex offender, substance abuse). Gendreau and Goggin (1997) describe those shortcomings found in at least half of the programs they surveyed.

Setting Characteristics

Successful rehabilitation depends not only on the type of treatment offered, but also upon the conditions under which treatment is delivered. Appropriate treatments delivered in community settings produce two to three times greater reductions in recidivism than prison based programs (Andrews et al 1990b). It has been suggested both that the social climate of prisons works against the effective delivery of programs, and that recidivism is related more to what happens in the community than what subsequently happens in institutions (Clarke, 1985). The available evidence suggests that, on average, programs delivered in community settings produce better outcomes than those delivered in institutions. Issues of organisational resistance and staff motivation may need to be addressed before implementing programs in prisons. At the same time, prisons are more likely to contain those offenders with a medium to high risk of recidivism and therefore have a potential for more effective rehabilitation outcomes.

Rehabilitation programs frequently involve discrete therapeutic sessions, whether individual or group based (e.g., the anger management programs described by Edmondson & Conger, 1996), with the participant returning to their natural environment on completion of sessions. Where this natural environment is a justice agency or institution, the issue arises of the compatibility between the lessons learned in the therapeutic setting and the lessons learned on a daily basis within the institution itself. There is, therefore, a need to integrate the goals of specific interventions with the formal care plan for the individual offender but also with the less formal and broader philosophies and expectations of the institutional environment. McMurran and Hollin (1997) have further suggested that a limited number of one hour intervention sessions are likely to be inadequate in addressing some of the more complex criminogenic needs (e.g., changing antisocial attitudes). They suggest that, for some offenders, more intensive

residential programs, using models of social therapy (such as those offered by therapeutic communities), may more be appropriate.

An important issue in ensuring therapy session-system integration is the staffing of therapeutic groups and programs. Howells et al (1997) argue that one of the lessons to be learned from the "nothing works" era in prison rehabilitation is the need to engage prison officers, and the whole prison culture, in the process of changing offending behaviour. In their view, one of the reasons for the perceived failure of rehabilitation was that treatments were delivered by the "new professionals"from psychology and social work, with prison officers being actively discouraged from involvement in treatment. Hall (1995) has argued that "in the absence of any rehabilitation role, and with the removal of many traditional duties ... the majority of officers were left with purely custodial roles. The dominant ideology of punishment (based on retribution and deterrence) remained unchanged for prison officers". Frizzell, the Chief executive Officer of the Scottish Prison Service concurs: "With the rejection of the rehabilitative ideal in the 1960s and 1970s the Prison Service was plunged into a philosophical vacuum. The prison officer's job ... became more difficult to define outwith [sic] the context of a "turnkey". The 1970s in the UK Prison Services were characterized by deteriorating industrial relations, which can in part be viewed as a consequence of a lack of direction" (Frizzell, 1993).

Howells et al (1997) argue that violence programs in prison settings should engage prison officers, working collaboratively with psychologists and other professionals. This development would go a long way towards ensuring the systemic integration of programs. They suggest that the credibility of programs such as anger management is considerably enhanced by the involvement of staff who are familiar with the trials, tribulations and annoyances of everyday life in prisons, as well as with the feasibility and impact of various strategies for dealing with day to day frustration. The greater

involvement of prison officers in violence programs, at least in an Australian context, would often require a "culture change" of the sort envisaged by Frizzell (1993). This change would include a fundamental shift in the direction of reaffirming the rehabilitative function in addition to the retributive and deterrent functions of prisons.

Links with Community Services

Finally, it is important that prison-based programs are integrated with community services, particularly in the period shortly following release. In a study following offenders after release from prison, Zamble and Quinsey (1997) found that recidivists reported more problems in the period after release, and had fewer or less effective skills for coping with them. Recidivists more often experienced difficulties and had poorer strategies for managing negative emotional states, such as anger, anxiety and depression. They also thought more frequently about substance abuse and possible crimes, and less often about employment and the future in an optimistic light. They experienced greater fluctuation in emotional states in the 48 hours preceding a re-offence.

Summary of What We Know About Effective Programs

Hollin (1999) summarises the above literature with six statements describing what we know to be the characteristics of effective treatment programs, which can be used as a basis for identifying examples of good correctional practice. The statements can be found in Table II below:

Table II: Components of Effective Treatment Programs (from Hollin, 1999)
1. Indiscriminate targeting of treatment programs is counterproductive in reducing recidivism: medium- to high-risk offenders should be selected and programs should focus on criminogenic targets
2. The type of treatment program is important, with stronger evidence for structured behavioral and multi-modal approaches than for less-focussed approaches
3. The most successful studies, while behavioral in nature, include a cognitive component to focus on attitudes and beliefs.
4. Treatment programs should be designed to engage high levels of offender responsivity
5. Treatment programs conducted in the community have a stronger effect than residential programs. While residential programs can be effective, they should be linked structurally with community-based interventions.
6. The most effective programs have high treatment integrity in that they are carried out by trained staff and the treatment initiators are involved in all the operational phase of the treatment programs.

To reiterate, programs which are well grounded in psychological theory and / or research are likely to produce better outcomes than those which are not. In particular, programs should be designed to target 'criminogenic needs', that is psychological factors which are amenable to change through treatment and have a functional relationship with offending. Programs based on psychological theory and research have been developed in the areas of drug and alcohol use, anger management and violent behaviour, sexual offending and general offending programs. All of these programs make sense in that the targets addressed (drug and alcohol use or anger problems) have high plausibility as contributors to offending behaviours. Whilst many of the programs were originally drawn from clinical treatments, they have been adapted to meet the specific needs of offender clients and have a growing empirical base to support their efficacy. In the following section we will describe some common rehabilitation programs, together with a review of the literature suggesting that they are both evidence based and can be considered as best practice.

Sexual Offender Programs

Rationale

Whilst there are enormous difficulties associated with obtaining reliable estimates of the extent of sexual abuse in Australian society, there is general agreement that sexual offending against both adults and children is a major social problem. Estimates of the incidences of sexual offences, drawn from community surveys and official records, highlight the significance of the problem. Rates of childhood sexual abuse within the Australian population have been estimated at between 5-28% for females and 1.5-9% for males (Goldman & Goldman, 1988). Koss (1993) suggested that approximately 20% of women will be a victim of rape at some time in their lives. A recent New Zealand study reported that 26% of women and 16% of men reported being sexually assaulted at least once in their lifetime (Young, Morris, Cameron & Haslett, 1997).

The rationale for offering treatment to sexual offenders is clear (Prentky, 1995). The sexual offending recidivism rates for untreated sexual offenders and abusers of children have been reported to be around 27% for untreated sexual offenders (both child sexual offenders and rapists)(see Hall, 1995). It therefore seems reasonable to suggest that if treatment programs are able to have any impact on reducing recidivism in even a few offenders, large numbers of further offences will be prevented.

Current statistics show that sexual offenders make up a significant proportion (13%) of the prison population (Australian Bureau of Statistics, 1999). An opportunity therefore

exists to offer treatment to a group who might otherwise not present voluntarily to a community service.

Whilst most observers would agree that treatment should be offered, decisions regarding the most appropriate methods of treatment have been the subject of considerable debate. This, perhaps, reflects competing theoretical understandings of why people offend.
A recent review of theories of sexual offending by Polaschek (1999) outlines a number of different theories of sexual offending (against both adults and children) that have been influential. Firstly, Polaschek describes a theory developed by Malamuth and colleagues (Malamuth, Heavey & Linz, 1996). These authors argue that in order for sexual aggression to occur a number of aetiological factors must converge. These might include motivation to commit the aggressive act, reductions in internal and external inhibitions, and the opportunity to aggress. This theory is similar to that proposed by Finklehor (1986) and can be easily translated into treatment goals for both adult and child sexual offenders. Treatment would address the individual motivational characteristics of a particular offender, in order to decrease the level of interest in abusive sexual contact. This would include methods designed to increase social and relationship skills, coping with aversive emotional events, behavioural techniques to modify deviant arousal patterns and possible marital / relationship counselling (McGregor & Howells, 1997).

The second theory described by Polaschek (1999) is Marshall and Barbaree's integrated theory (1990a, 1990b). In this theory, difficulties in the development of empathy and intimate relationships are emphasised as important causes of sexual offending. Marshall and Barbaree (1990a) propose a developmental model highlighting the role of disruptive and abusive childhood experiences in producing a severe lack of confidence in young males and failing to equip them with the skills necessary to develop quality relationships with other adults. This includes a failure to appreciate the distress of others (i.e., a lack of empathy) and an inability to form affectionate bonds with other people (i.e., a lack of

intimacy skills with the consequent experience of loneliness). Marshall and Barbaree (1990a) argue that these vulnerability factors reduce the chances of young men meeting their needs in prosocial ways, increasing the appeal of those ideas that emphasise male privilege and the use of coercive tactics (Parton, 1999). Reviewers such as Fisher and Howells (1993) regard this theory as highly plausible, as it is able to account for a large number of empirical research findings (e.g., Garlick, Marshall & Thornton, 1996). Treatment programs which draw heavily on these ideas tend to be more psychotherapeutic in nature, with a focus on increasing offender empathy for the victims of sexual assault, together with an increased sense of responsibility for their offending (Quinsey, 1995).

The third major theory of sexual offending decribed by Polaschek (1999) is an integration of other theories presented by Hall and Hirschman (1991). This theory suggests that four factors are commonly implicated in sexual offending: physiological sexual arousal, cognitions justifying sexual aggression, affective dyscontrol, and developmentally deprived personality problems. Deviant sexual arousal and sexual preferences have been identified as one of the strongest predictors of recidivism (Hanson & Bussiere, 1996). Whilst cognitive-behavioural techniques have been used to modify deviant sexual arousal, a number of medical treatments have also been employed to reduce sex drive through hormonal or anti-depressant medications. Hucker (1995) suggests that, whilst such treatments should only be used as part of a more comprehensive treatment package, given the lack of empirical support for medical approaches, the combination of psycho-social therapies and medical treatment may be important in reducing recidivism for some offenders.

Sexual arousal is argued to be insufficient to produce sexual aggression in some offenders without the presence of the second factor, cognitive distortions. Whilst most treatment programs aim to identify and modify dysfunctional attitudes and cognitions, research in

this area has been hampered by the lack of a theoretical framework and a lack of attention to conceptual issues (Ward, Hudson, Johnston & Marshall, 1997). Thus whilst there has been some work on certain aspects of cognition, for example attitudes and beliefs (e.g., Ward, Hudson & Marshall, 1995), more theoretical work on this area is needed (see Ward et al, 1997 for a review of this area). The third aspect of the Hall and Hirschman model highlights the role of affective dyscontrol and how negative emotional states such as anger and hostility can play a role in reducing the normal inhibitors of sexual offending. The fourth factor, personality, encompasses Marshall's work on the role of childhood experiences in adult relationships (see Polaschek for a detailed discussion of these theories).

Description of Typical Program Content

There is a broad consensus that offender assessment should, as a minimum, cover deviant sexual preferences, choice of victim, early onset of sexual offending and prior sexual offences. Other areas that have been recommended for assessment include lack of victim empathy, denial and minimisation, deviant sexual fantasies, unfulfilled intimacy needs, association with other sex offenders and access to victims.

While many different treatment approaches have been used with this population, cognitive-behavioural programs have become the treatment of choice. Cognitive-behavioural therapies and relapse prevention strategies are used in approximately 94% of all treatment programs (Pithers, et al., 1995). Cognitive-behavioural programs aim to remedy skill deficits, alter cognitions that are believed to be related to sexual offending, and alter deviant patterns of sexual arousal or preference (Quinsey, 1995). Clearly cognitive behavioural programs aim to address each of the areas that are theoretically important to offending. Many programs also follow up treatment with a relapse

prevention program in which the focus is to help the individual avoid triggers or situations that are likely to lead to re-offending and improve self-management skills when such situations arise that are unavoidable (Barker, 1996; Pithers, 1990; Pithers, et al., 1995). Donato, Shanahan & Higgins (1998, 1999) suggest that cognitive-behavioural treatment for sexual offenders typically involve several weekly sessions over a period of up to twelve months.

Programs offered to child sexual offenders in Australia are described in the Wood Royal Commisssion report (1997). To illustrate, a New Zealand program for child sexual offenders has been described by Bakker, Hudson, Wales and Riley (1998). The program begins with a two week assessment leading to a clinical formulation of the offending behaviour. The assessment includes interviews, written reports from the offenders and a series of self-report scales including assessment of sexual attitudes, beliefs and behaviours, emotional functioning, interpersonal competence and personality. Treatment is entirely group based, with groups of eight offenders attending three two and a half hour sessions per week over thirty one weeks. Treatment modules are listed in the following order: norm building, understanding offending, arousal conditioning, victim impact and empathy, mood management, relationship skills, relapse prevention, relapse planning and aftercare (Bakker et al, 1997, p.8).

In the UK, the Home Office has introduced an intensive sex offender treatment program (SOTP) made up of four components: the Core program, the Extended program, the Booster program and the Thinking Skills program (Beech, Fisher & Beckett, 1998). The Core program comprises 35-40 two hour sessions delivered over around 86 treatment sessions. Those offenders who require further treatment are then invited to attend the extended program with additional modules on anger management, relationship skills, fantasy modification and further work on victim empathy and relapse prevention. The booster program is for offenders who are approaching release, but who completed the

core program some time previously. The main function of this program is to develop a realistic relapse prevention plan. Finally the thinking skills program is designed to improve general coping skills and it draws on cognitive skills programs described later in this review.

Evidence for Effectiveness

Evaluations of sex offender treatments have reported that programs are generally effective in reducing recidivism. Cognitive-behavioural treatment programmes, including a relapse prevention component, show rates of only 4 to 8 percent recidivism compared to 20 to 29 percent for untreated child sex offenders (Barker, 1996; Marshall & Barbaree, 1990b; Pithers, 1990). Marshall (1993) reported that, whilst 15% of treated offenders re-offended over a five year period, 60% of an untreated sample re-offended. In a review by Hall (1995) of recent outcome research, involving various treatment modalities (behavioural, cognitive-behavioural, family therapy, group psychotherapy, hormonal therapy, and individual psychotherapy), the recidivism rate for treated sexual offenders (both child and adult) was 19% compared to 27% for untreated sexual offenders. The results of Hall's (1995) meta-analysis suggest that treatment is most effective with outpatient offenders and when it consists of hormonal or cognitive-behavioural components. Whilst there is some evidence for the effectiveness of cognitive behavioural group-work with men who sexually abuse children, the evidence on outcomes for programs with rapists is less encouraging (e.g., Marshall & Pithers, 1994). An ongoing evaluation of the UK prison program has reported that treatment is effective in bringing about change in each of the key areas of intervention described above (denial, pro-offending attitudes, predisposing personality factors and relapse prevention skills) (Beech,

Fisher & Beckett, 1998). This evaluation also revealed that treatment gains were most pronounced for a low deviancy / low denial group of offenders.

We are aware of only one published Australian outcome study for a sexual offender treatment program - one conducted in Victoria (Lee et al, 1996), although this study did not look at recidivism as an outcome variable. A recent study in New Zealand by Bakker, Hudson, Wales and Riley (1998) reported a recidivism rate of eight percent for the treated group compared with twenty one percent for the untreated group.

Best Practice

It has been suggested that the models for assessing general criminal behaviour, using the risk, needs and responsivity framework, have been under-utilised in the area of sexual reoffending (Gendreau, Goggin & Paparozzi, 1996). This may be particularly true in regard to non-sexual offence recidivism (i.e. where a sexual offender reoffends, but the re-offence is not a further sexual offence), and in the assessment of rapists who have many similarities to other high-risk offenders (Quinsey, Lalumiere, Rice & Harris, 1995).

There are many methodological problems in estimating the recidivism rates for sexual offences. Most notably, observed recidivism rates are likely to underestimate actual recidivism rates, given that many sexual offences go undetected (Bonta & Hanson, 1994). However, as for other offences, there is strong evidence to suggest that actuarial measures of risk are more accurate than clinical judgement alone (Hanson & Thornton, 1999), and a number of new instruments for the prediction of violent or sexual re-offending among rapists and child sexual offenders have recently been developed (for a review and comparison of some measures of risk, see Hanson and Thornton, 1999). In

line with the risk principle, risk assessments should be used to determine the intensity of services for a particular offender, so that higher risk offenders are offered more intensive intervention.

Research would support the view that sexual offenders do not form a homogenous group. Different types of offenders have different probabilities of re-offending (Hanson & Bussiere, 1996). For example, rapists re-offend more than child sex offenders; sexual offenders against male victims have higher recidivism rates than those who offend against females; incest offenders have the lowest recidivism rates. Hanson and Bussiere's (1998) meta-analytic review of risk factors identified a number of risk factors reliably associated with sexual recidivism. Most of these factors were static in that the probability and type of recidivism was strongly affected by victim, age, sex, and relationship to the offender, the seriousness and nature of the sex offence, and the number of previous sex offences.

Research on the criminogenic needs related to sexual offending is not well developed, but plausible dynamic risk factors include deviant sexual preferences, sexual fantasies or arousal (which can vary markedly between offenders), relationship and social skills problems, intimacy deficits (e.g., Seidman, Marshall, Hudson & Robertson, 1994; Garlick, Marshall & Thornton, 1996) and emotional identification with children (Wilson, 1999). It is widely believed that offenders need to take responsibility for abusive behaviours, and pro-offending attitudes and beliefs are frequently idenitifed as important criminogenic needs (e.g., Hanson & Harris, 1998; Ward, Hudson & Marshall, 1995).

It is unlikely that a general statement about the criminogenic needs of sexual offenders can be made, given the marked heterogeneity of offenders. In general, child sexual offenders have been viewed as having different needs from rapists (Grubin & Kennedy, 1991), and others have distinguished between familial and non-familial child sexual

offenders (Miner & Dwyer, 1997). However there have been attempts to classify offenders within these groups through the use of typologies rather than risk / needs assessments. In theory, typologies can be used to classify offenders in order to determine the most appropriate treatment, in much the same way as a needs assessment. The danger of this approach is that individuals can become stereotyped and that important individual factors are overlooked. Knight et al, (1985) review different typologies and suggest that they involve four major components - the amount of aggression involved, sexual motivation, antisocial personality and finally whether or not sadism was a feature. Examples of other classification systems that have been influential include that of Groth and colleagues (e.g. Groth & Birnbaum, 1979) and Prentky, Knight and Lee (1997). However classification systems have been viewed by some as limiting, rather than extending, assessments. For example, Cossins (1999) argues that the use of a classification system in the recent Royal Commission into New South Wales led the commission to focus on homosexually fixated offenders, and to significantly under-emphasise familial sexual abuse and offending against female children. A recent review of classification systems by the Home Office in the UK concluded that none of the classification systems they looked at were "reliable, efficient, pertinent to a large number of offenders and simple to administer" (Fisher & Mair, 1998, p.1). The important issue is that of the use of any system of classification or diagnosis. If a key objective for classification systems is to assess risk of further offending, a more productive way forward appears to be through the use of empirically based risk assessments rather than theoretically driven classification systems.

One way of making programs more responsive to the needs of individual offenders is to match type of offence with the intervention offered. There is some evidence that offering the same program to both child sexual offenders and rapists is ineffective. Marshall and Barbaree (1990b) report that programs that reduce risk in child molesters have little impact on rapists and exhibitionists. Other treatment approaches have been reported to

be more successful with rapists than child molesters (Marques, Day, Nelson & West, 1994).

Secondly, many existing programs are delivered in a group rather than on an individual basis. Groups are thought to facilitate the breakdown of denial and increase the motivation to change (Barker, 1996; Clark & Erooga, 1994). However, it is possible that some offenders (e.g., the socially anxious) may find group treatment unproductive and require individual treatment. Programs have also been modified or developed to be more responsive to the needs of Aboriginal sex offenders (Ellerby, 1995), and intellectually disabled offenders (Boer et al, 1995).

An important responsivity factor in sexual offender treatment is the level of denial and motivation for treatment (Terry & Mitchell, 1999). Whilst it has been argued that that some acceptance of responsibility for offending is required for treatment to be effective (Prendergast ,1991), others have suggested that length of time in treatment is a more important predictor of outcome, particularly for more serious offenders (Beech, Fisher & Beckett, 1998).

Problems and Issues

A major problem in the treatment of sexual offenders lies in the interpretation of the evidence about the effectiveness of treatment programs. It is often argued that the immense costs of further sexual offending make it unethical to withhold treatment from a control group. As such, there are very few studies which make direct comparisons between a matched treatment and no-treatment group. This and other methodological problems (such as treatment drop-outs) suggest that optimism about the effectiveness of treatment programs should be tempered with caution.

A second area of controversy relates to how sexual arousal and sexual preferences should be assessed. Whilst self-report is likely to be unreliable for some offenders, the use of physiological assessment measures has also been criticised. Those who caution against the use of phallometry (a physiological measure of sexual arousal), such as Marshall (1996), argue that such assessments are of limited value in that they may be unreliable, easily faked and lack discriminant validity. In addition, others have questioned whether the use of such procedures is ethical (McConaghy, 1997).

Perhaps the most salient treatment issue facing those who work with sexual offenders centres around the issue of denial and the extent to which offenders feel coerced into treatment. Many, if not most, sexual offenders present for treatment denying that the offence took place, or minimising their responsibility for the offence. Engaging these offenders in treatment is a complex task, requiring clinical expertise. Whilst there has been recent work investigating the impact of coercion on treatment outcomes (e.g., Kaltiala-Heino, Laippala & Salokangas, 1997), this remains an important area for further research.

Finally, it is worth re-iterating that many jurisdictions focus their treatment efforts on child sexual offenders. To some extent, treatment programs for adult sexual offenders (such as rapists and exhibitionists) are less common and less well developed. Further work in this area is warranted.

Conclusion

Despite difficulties in reliably assessing program outcomes, sex offender treatment programs are, at the very least, promising in terms of being effective in recidivism. Whilst the development of sex offender programs has been largely in response to a perceived social need, in many respects programs have developed in ways that are consistent with the 'what works?' literature. More work is currently underway linking the two areas more closely (for example in the area of specialist risk assessment for sexual offenders). Furthermore, integrative theories such as Hall and Hirschmann's (1991) have helped fuel a developing consensus regarding the most appropriate method of treatment (cognitive-behavioural with relapse prevention), treatment targets and length of treatment (up to 12 months). As such, the provision of a prison-based sexual offender program would be regarded as an important priority in many jurisdictions.

Anger and Violence Programs

Rationale

Violent crime is often seen as a social problem requiring retribution rather than rehabilitation and psychological management. While it may be true that not all violent offenders will benefit from a therapeutic or rehabilitative approach, some have problems which, at face value, may be amenable to rehabilitation. Howells, Watt, Hall and Baldwin (1997), for example, describe an offender worthy of consideration:

John B. has lived a life which has been shaped and largely spoiled by his propensity for violence. Unusually for a violent man, he was raised in a family where violence was not the norm. He neither observed nor experienced violence on the part of his mother or father. His early years, by his own account, were largely uneventful though he always had a "quick temper". His achievements at school were limited, though a number of teachers observed that he showed signs of high ability. His early teenage years were marred by the social consequences of a disfiguring condition of his spine. His unusual posture and bearing led to teasing and ridicule which, in turn, further damaged his self esteem and social confidence. Two developments provided a lifeline out of his unhappiness. The first was his rapid physical development. During these years he became one of the tallest and strongest in his class. The second was his learning to cope with teasing by becoming aggressive and violent. He quickly discovered that such behaviour stopped and prevented his victimization and earned what he perceived as the "respect" of his peers and others in his environment. This lesson was quickly generalized, and he acquired a reputation as a violent individual in his community.

Gradually, his life increasingly centred around violent encounters with others, in a range of settings, including public houses, nightclubs, workplaces, football matches, and driving , as well as in relationships with women and with his family.

The escalation in the frequency and seriousness of his violent acts led, inevitably, to criminal convictions and to a three year term of imprisonment. Within prison he become involved in a large number of violent incidents with prison officers, leading to him losing all remisssion. When he was eventually released, he made the decision to try to change his behaviour, largely by avoiding risky situations. This worked at first, but his previous pattern of behaviour re-emerged and intensified. The negative social consequences of his violence began to be more apparent to him, including the breakdown of several valued relationships with women, the deterioration of his relationship with his family, problems at work, and the real risk of further convictions and imprisonment. He feared that his control was increasingly erratic and that he might end up killing someone. These fears led to him requesting “help”.

In recent years, correctional administrations have increasingly identified violent offenders as a key target group for rehabilitation programs. The reasons for this are clear:

Violent crime is a source of great social concern in Australia.

Whilst there is limited evidence to suggest that violent crime is increasing (Indermaur, 1996), the numbers of offenders imprisoned for violent offences has risen over the past few years. Whilst it has been well established that violent offences are not necessarily angry offences (e.g. Mills, Kroner & Forth, 1998), it has been argued that poor anger control often plays a role in violent offending and can be considered a criminogenic need

for many violent offenders (Howells et al, 1997). Similarly Novaco (1995) suggests that anger can be used as a risk factor for the prediction of violence.

As a group, violent offenders commonly experience difficulties with anger. On average, prison inmates score substantially higher on measures of anger arousal and expression than other populations (Spielberger, 1991), with violent offenders scoring higher than non-violent offenders (Mills, Kroner & Forth, 1998).

Treatment programs developed in clinical settings have been shown to be applicable to criminal justice settings

The experience and expression of anger has been studied in a wide range of clinical and non-clinical populations, including students (Deffenbacher et al 1988,1990), clients in community, health-care and psychiatric/residential settings (Stermac, 1986) and adolescents in residential settings (Swaffer & Hollin, 1997). Cognitive-behavioural anger management programs have been developed for use with many of these populations and initial research suggests that they are effective in reducing problems with anger expression (Beck & Fernandez, 1998). There is reason to believe that similar cognitive-behavioural programs may also be appropriate for offender groups. A number of studies have highlighted the role of cognitive factors in anger arousal and expression in offenders. For example, Gembora (1986) found that inmates with chronic anger control problems perceive and interpret anger provoking situations differently from those without anger problems. Similarly Ford (1991) found that anger in inmates was related to cognitive variables in anger arousal and expression, a finding supported by Copella and Tata (1990) and McDougall, Venables and Roger (1991).

Findings such as these have lead to the widespread implementation of anger management programs in prison settings around the world. These programs tend to be brief (up to 10 sessions) cognitive behavioural programs designed to reduce anger arousal and improve anger control (e.g. Novaco, 1994; 1997). Anger Management programs take a skills approach and attempt to help program participants develop alternative strategies in the control and expression of angry impulses (for a discussion of the rationale for anger management with violent offenders see Levey & Howells, 1990; Novaco, 1997; Howells, 1998). Whilst these programs have been shown to be reasonably effective with different clinical populations (Beck & Fernandez, 1998; Edmondson & Conger, 1996), there has only been limited research investigating program outcomes with offender groups (e.g. Watt & Howells, 1998; Day, Maddicks & McMahon, 1994).

Offenders with anger problems tend to be more difficult to manage than other offenders

Anger appears to be a particularly important emotion in residential settings with offenders. Anger problems have been linked with prison adjustment, disciplinary problems, assaults and violence. Anger is a strong predictor of aggression amongst incarcerated adolescents (Cornell, Peterson & Richards, 1999) and has been shown to be associated with physical assault on care staff (Gentry & Ostapuik, 1989). Institutional staff rate anger as the primary problem in secure psychiatric facilities (Rice, Harris, Quinsey & Cyr, 1990). Kroner and Reddon (1995) found that interpersonal problems in prisoners were strongly related to anger expression and arousal, and the inward expression of anger was significantly related to dimensions of psychopathology.

Whilst research on prison adjustment suggests that negative emotions (such as anxiety and depression) decrease over time, this does not appear to be the case for anger. In one study, prisoners reported two episodes of anger per week during the initial stages of their incarceration. The frequency of anger experiences increased, the longer they were in

prison (Zamble & Porporino, 1988). The finding that anger is a stable and present feature of long term imprisonment appears to be robust.

Violent offenders are a major group

There are good reasons for suggesting that intervention programs for violence deserve far more attention from rehabilitators and a much greater investment of resources by criminal justice systems. In many countries, violent offenders form a large proportion of the prison population and constitute a group that causes considerable public disquiet because of perceived and real "risk" to the community on release.

Much is known about anger and violence

Another reason for targetting violent offenders is the relatively large theoretical and research literature that the practitioner can use to inform his or her rehabilitative efforts. Anger, aggression and violence have long been a central area for psychological enquiry, resulting in sophisticated theoretical models of the causes of these behaviours (e.g., Wyer & Srull, 1993). This can be contrasted with the rapid growth and implementation of sex offender treatment programs, which has occurred with far less substantial research and theoretical literature illuminating the causes of this behaviour. Theoretical bases are discussed in more detail below.

Theoretical Basis

In recent years there has been a proliferation of interventions for violent offenders in correctional settings, many of them labelled as "anger-management", "violence-prevention" or "alternatives to violence". The theoretical basis for some programs offered may be unclear or non-existent. As previously suggested (Howells, 1996), there is a danger that "common-sense" is perceived as an adequate basis for devising the content of such programs, even though common sense can suggest contradictory and incompatible analyses and strategies for dealing with anger and aggression.

A rich and potentially useful theoretical and empirical knowledge base appears to exist in relation to aggressive and violent behaviour. The theoretical analyses of anger and angry aggression by Novaco have been particularly influential in informing practice in this field (Levey & Howells, 1990; Novaco, 1993, 1994, 1997). Such analyses suggest the need for wide-ranging, multimodal rehabilitative programs in which the environmental, cognitive, physiological, affective and behavioural components of the anger syndrome are assessed and remedied (Howells, 1989, Deffenbacher, 1999).

Novaco's analyses have emphasized the importance of the cognitive dimension of angry experience and behaviour. Indeed, cognitive perspectives have dominated the theoretical analysis of anger and of emotion in general in recent years. It is now clear that the process of appraisal forms a major part of most contemporary theories of anger and other emotions (Clore et al., 1993; Forgas, 1993; Ortony, Clore & Collins, 1988). For these reasons a major cognitive component is required in anger and violence rehabilitation programs. Current models suggest the need to assess and target a range of cognitive processes in anger-management therapy, including social cognitions relating to freewill, factors which reduce freewill, cognitions of negligence, the structure of standards (rules and moral imperatives) that guide the client's actions, the rigidity of moral imperatives

and the goal structure of the person. The practice of anger management will clearly need to develop in order to accommodate the more sophisticated theoretical models that are now available.

In recent years a number of challenges have been mounted to the cognitive perspective, particularly the claim of "excessive cognitivism" (Berkowitz, 1993; Izard, 1993). Izard proposes a range of routes to emotional activation. It follows that there would be a variety of routes to anger, including a neural route, a sensorimotor route and a motivational route.

Bekowitz's cognitive-neoassociationist perspective suggests several different emphases for anger-management therapy, including greater attention to environmental features (e.g., weapon and temperature effects, Anderson et al., 1996) and to the effects of low mood on subsequent anger. Additionally, Berkowitz's stress on the cognitive inhibition and regulation of the anger-aggression syndrome draws attention to the need to address such processes in therapy. In summary, it is essential that anger-management and related interventions for violent offenders are firmly rooted in an established and developing theoretical framework. Anger-management should not "stand still" but should derive new methods from, and contribute to, broader psychological theories.

Assessment

An obvious and frequently used discrimination within the violent offender population is that between individuals whose violence is "angry" or "hostile" and those whose behaviour is more "ïnstrumental" in function (Buss & Durkee, 1957). Angry violence is

instigated by an annoyance or frustration, is, by definition, emotionally mediated, and produces the behavioural intention to harm the source of annoyance or frustration. Instrumental violence, on the other hand, need have no frustrating or emotional antecedents. The distinction between the two types of violence is not entirely clear-cut in that the expression of anger may itself have instrumental functions (e.g., a boss who learns to ventilate anger because it is successful in intimidating his / her employees). Equally, behaviours that appear, superficially, to be instrumental can, on more detailed investigation, have angry features. This latter point has been lucidly explicated by Indermaur (1995).

One obvious and apparently easy way to subdivide a population of violent offenders would be to identify violent property offenders from their criminal records (previous violent offences in the course of robbery or housebreaking, for example). It might be assumed that the violent acts of such offenders are clearly instrumental (using violence to obtain financial reward). It would seem to follow that violent property offenders would be unsuited to anger-management or similar interventions. Indermaur's analysis casts doubt on the validity of such an assumption. Indermaur quotes Katz's (1988) conclusion that "the contrasting characterizations of homicides as impassioned acts among acquaintances and violent robberies as coldly instrumental acts against strangers has been exaggerated because of methodological limitations with the data" (p. 180). Indermaur stresses that a crime such as robbery may have the function of establishing dominance and that violence is triggered when the experience of dominance is denied the offender by the victim. Such research reinforces the need to conduct an analysis of the individual's violent behaviour , in terms of its antecedents and consequences, rather than assume that broad categories of crime (property crime) reflect unitary psychological mechanisms and motives.

The core task of the Crimogenic Needs perspective, is to conduct a thorough assessment of the individual and his/her violent behaviour, and from this assessment to derive a formulation of the factors that have led to the development of and maintenance of violence. Such a formulation establishes the "needs" of the person in terms of difficulties that need to be addressed to prevent recurrence of violent behaviour. The case formulation approach has similarities to clinical formulation in psychiatric and other medical settings, except that the end point is not a diagnosis but a hypothesis or series of hypotheses about the causation and maintenance of the violent behaviour. The formulation needs to be multimodal, including environmental and intrapersonal variables. Amongst the environmental variables will be the immediate and contextual antecedents for violent acts, as well as the functional consequences. Intra personal variables will include dispositions and traits (e.g., impulsivity, anger proneness and psychopathy), as well as patterns of cognition, appraisal, belief and interpersonal behaviour. Variables such as mental disorder and substance abuse will also need to be included in the formulation, given the evidence (e.g., Hodgins, 1996) that these are implicated in the causation of violence.

Howells (1998) has proposed that a needs assessment for violent offenders would include the following:

- Frequency, intensity, duration and form of aggression
- Environmental triggers
- Cognitive antecedents (biases in appraisal of events, dysfunctional schemata, underlying beliefs and values supporting aggression)
- Affective antecedents (emotions preceding violent acts)
- Physiological antecedents
- Coping/problem-solving skills
- Personality dispositions (anger-proneness, impulsivity, psychopathy etc)
- Mental disorder variables

- Consequences / functions of aggressive acts
- Buffer factors (good relationships, family support, achievement in some area)
- Opportunity factors (weapons, victim availability, restrictions)
- Disinhibitors (alcohol, drugs etc.)

The above discussion and, indeed the contents of this review in general, suggest the need for allocation to an anger management or violence program (or any other program) to be preceded by an assessment of the individual offender. This assessment would need to include an assessment of risk (as suggested by the Risk Principle). More importantly, the individual offender will require a criminogenic needs assessment, to determine the nature if the offender's anger or violence problem. One important consideration in anger management programs, for example, is whether a violent offender actually has an anger problem (above average trait anger). An extensive needs assessment may be required for offenders deemed to be of very high risk (see above), a more lightweight assessment may be sufficient for offenders of lower risk.

Description of Program Content

The content of cognitive behavioural therapeutic interventions for anger and aggression has been described in a substantial number of clinical accounts, research reports and reviews (Becker 1997; Feindler & Ecton, 1986; Howells. 1988, 1989, Levey & Howells, 1990; Novaco, 1997; Towl, 1994). It is clear that anger management training has a number of possible components, including relaxation training, social skills training and cognitive restructuring, and that these various components may have differential effects on the different dimensions of anger (Edmondson & Conger, 1996).

Arguments have previously been put forward for a comprehensive approach to rehabilitation for anger and violence problems, derived from theoretical models and empirical research (Howells, 1989; Howells et al, 1997). Some examples of basic intervention methods are summarized below. The choice of strategy depends on the assessment and analysis of the offender's anger / violence problem:

- Improving client's understanding of nature of problem
- Identifying and modifying immediate triggering event
- Identifying and modifying contextual stressors
- Changing cognitive inferences and dysfunctional schemata
- Improving control of physiological arousal
- Broadening the repertoire of coping responses
- Prevention of escalating social behaviour
- Strengthening commitment to change

Evidence for Effectiveness

Programs for violent offenders have been provided in a variety of forensic and clinical settings and a number of workers have described the rationale for, and content of, anger / violence reduction programs (Napolitano & Brown, 1991; Serin & Kuriychuk, 1994; Smith & Beckner, 1993; Towl, 1994) but the evaluation of effects of interventions has been limited (Ward, 1996).

Attempts have been made to modify violent behaviour by devising environments within correctional facilities (Coyle, 1987). Walmsley (1991), for example has described a special unit at Parkhurst prison in England for violent offenders, and Cooke (1989) has described and evaluated the famous Barlinnie Special Unit. The evaluation by Cooke found a reduction in assaults and problem behaviours.

A relatively large number of outcome studies have been reported for anger management programs. However some of these studies, have been conducted with university students with anger problems or similar groups, rather than with offenders (for example, Deffenbacher, McNamara, Stark & Sabadell, 1990; Deffenbacher, Thwaites, Wallace & Oetting, 1994. It cannot therefore be assumed that the findings from these studies can be generalized to offender populations.

A few studies have been conducted with offenders, but many of the studies have methodological problems, including lack of control groups, absence of behavioural measures or poorly specified comparison groups (Rokach, 1987; Valliant & Antonowicz, 1991; Dixon & Polascheck, 1992; Faulkner, Stoltenberg, Cogen, Nolder & Shooter, 1992; Smith & Beckner, 1993; Valliant & Raven, 1994; Valliant, Jensen & Raven-Brook, 1995).

The following controlled studies were conducted with offenders:

Stermac (1986) evaluated the effects of a program including cognitive skills, relaxation and assertiveness training, with 40 forensic psychiatric patients. Participants with a history of anger control problems or aggressive behaviour were randomly assigned to treatment or to a control group. In comparison to the control group, at post-test the treated group reported less angry feelings, more cognitive change and less self-denigration in response to provocation.

McDougall, Barnett, Ashurst and Wills (1987) have reported the effects of a 6-week anger management program at a Youth Custody Centre in England. Pre / post intervention changes were shown in disciplinary reports, suggesting improved anger control. Treatment was for 6 sessions of 1.5 hours.

McDougall and Boddis (1991) evaluated a brief anger management program for offenders with anger-control problems, as identified by prison staff.. Participants were randomly assigned to either a treatment or control group. Greater improvements were found for the treated group on self-reported aggression, anger and governor's reports.

Dixon and Polascheck (1992) included recidivism data in their evaluation of a cognitive-behavioural intervention for violent offenders in New Zealand. A reduction in recidivism followed completion of the program, but no control group was included in the study.

One of the best evaluated aggression control interventions is that reported by Goldstein and Glick (1996) with juvenile delinquents. Their Aggression Replacement Training (ART) has been developed and evaluated over a 10 year period, with encouraging results. This is a multimodal intervention including "skillstreaming", moral education and anger control training components. A series of controlled evaluations, using a range of treatment outcome measures, have provided evidence that ART is more effective than no treatment and other control conditions. Goldstein and Glick's own conclusion is that ART: "appears to promote skills acquisition and performance, improve anger control, decrease the frequency of acting-out behaviors and increase the frequency of constructive, prosocial behaviors. Beyond institutional walls, its effects persist, less fully perhaps than when the youth is in the controlled institutional environment, but persist none the less, especially when significant others in the youth's real world environment are simultaneously also recipients of ART. In general, its potency appears to us to be sufficiently adequate that its continued implementation and evaluation with chronically aggressive youngsters is clearly warranted" (Goldstein & Glick, 1996, p. 164).

Dowden, Blanchette and Serin (1999) have recently reported a substantial study of the effectiveness of an anger-management program with offenders in Canada. The program itself was a reasonably substantial one – 25 two-hour sessions. The program was shown to have an impact in reducing recidivism over a three-year period, though this improvement was found only for high-risk offenders. It is noteworthy that this program is far more intensive than anger-management programs offered in many jurisdictions. In Western Australia and South Australia Correctional Systems, for example, a typical anger-management program lasts for only 20 hours.

In brief, although anger-management and violence-reduction have developed and proliferated with violent offenders, the empirical and controlled evaluation of the effectiveness of such programs is at a very early stage. Beck and Fernandez (1998) recently conducted a meta-analysis of the effectiveness of cognitive-behavioural programs for the treatment of anger. Six of the fifty studies reviewed included offender inmates. An average weighted effect size of .85 was found. This suggests that inmates receiving cognitive-behavioural treatment did better than approximately 80% of those not receiving treatment. Large scale outcome studies are needed in which high risk, seriously violent offenders are exposed to anger management and similar programs and comparisons are made with no treatment and other conditions. Comprehensive outcome measures are needed, which would include self-reports, psychometric measures, behavioural observations and recidivism.

None of the studies reviewed above was conducted in Australia, though Dixon and Polascheck (1992) did their work in New Zealand. Two recent controlled studies published by Watt and Howells (1998) were conducted in Australia (WA) and suggest a need for caution before applying anger management indiscriminately with violent prisoners. These studies are of particular interest in that the anger management programs

evaluated were of a type and format common in various jurisdictions in Australasia. In two separate samples of violent prisoners undergoing anger management therapy, these authors found no difference between the treatment groups and untreated controls on a range of dependent measures, including anger experience, anger expression, prison misconduct and observational measures of aggressive behaviour. Watt and Howells suggest several reasons for these findings, including poor motivation of participants, the high complexity of the program content, low program integrity and limited opportunities to practice the skills learned. It is also clear from Watt and Howells' account that the participants were not subjected to a pre-treatment assessment to establish whether their violent offending was actually anger-mediated (discussed in more detail below).

Best Practice

A large number of anger and violence programs are being conducted internationally with offenders. It is likely that the quality and effectiveness of these programs varies considerably. An important consideration, therefore, is the identification of the characteristics of effective programs, with a view to ensuring these characteristics are built into any new program that is developed. The general features of effective and ineffective programs are discussed elsewhere in this review. Such features are also likely to be important for anger and violence programs. In addition, Howells (1996) and Howells et al (1997) have proposed a series of necessary conditions for worthwhile violence programs, including the following:

Andrews et al. (1990) have identified risk (along with need and responsivity) as being important in devising effective treatment services in correctional settings. It is likely to be

cost-effective to target violence interventions on individuals with a high risk, risk being defined in terms of both the frequency of, and harm caused by, the violent behaviour. It follows that the development of intervention programs for violent offenders should be preceded by some form of risk assessment.

Previous risk assessment research has often found that factors which predict future violence in community samples differ from the factors that predict violence among offender populations, thus selection of an instrument to identify previous offenders with a high risk of future recidivism needs to be based on research with offender populations and not in the general community. Even the more promising risk assessment instruments (e.g., Harris, Rice and Cormier, 1991) have only modest predictive accuracy.

The range of variables that may contribute to aggressive and violent behaviour is wide. Therefore aggressive behaviours that are topographically similar may be functionally dissimilar. Two men may each have committed a homicidal assault. For one, it is the product of a broadly antisocial personality, poor impulse control and a hostile appraisal of the world in general. For the other, the relevant antecedents are an intense crisis in a relationship, unexpressed anger, fantasized retaliation and disinhibition by alcohol. It is clear that the treatment needs of these two individuals are very different. It has been argued elsewhere (Howells, 1996, Howells et al, 1997) that, due to the varied analyses, it is often inappropriate to offer a generic "package' program for perpetrators of violence. Group treatment is still viable, but it needs to be sufficiently intensive and extended to allow for individualized formulation and treatment. Given that anger is not a necessary condition for aggressive behaviour, not all aggression perpetrators should be offered anger management as the primary treatment method.

Problems and Issues

Many anger-management interventions are very brief. Edmondson and Conger's (1996) analysis of 18 studies of anger-management intervention revealed a range of number of sessions from 1 to 15 (mean = 6.2). For the same studies the session length, where recorded, varied between 15 and 80 minutes (mean = 53 minutes). It is clear, therefore, that the brevity of such interventions precludes a detailed analysis and formulation of the problems of the individual within the therapeutic session, particularly as group, rather than individual treatment is the norm (Edmondson & Conger, 1996). It may be that the brevity of the programs described by these authors is a function of the (not seriously violent) populations being treated. It is likely that in forensic and clinical settings group participants will have serious and complex problems of anger and violence, often in the context of personality and other mental disorders, which will require a more comprehensive and time-consuming analysis (Howells, 1998).

It is not difficult to see how the package approach can involve interventions which may be unhelpful for individual offenders. The affectless "psychopath", for example (Hare, Strachan and Forth, 1993), whose violent behaviour is cold, calculated and instrumental, is unlikely to receive benefit from relaxation methods aimed at assisting him to control his temper. The inappropriate application of anger-management methods to those for whom it is contra-indicated is likely to bring such methods into disrepute.

There has been an attempt to devise a violence intervention program in Australian Corrections, firmly based on risk/needs principles. The Violent Offender Treatment Program has been developed in Western Australia for violent offenders (Hall, 1998; Chapman, 1998). This program specifically recruits participants at high risk of violent re-offending. Thorough, individualized criminogenic needs assessments are conducted for all participants to allow targetting of individual needs in a 400 hour program.

Preliminary, unpublished outcome data (Hall, 1999) suggests significant improvements were achieved by the program.

Problems arise in cognitive behavioural treatment of anger and violence in offenders, which are more acute than for other disorders, such as anxiety and depression. Anxiety and depression are distressing states for the person, who is, thereby, often motivated to change their affective state. Anger, and even aggression and violence, on the other hand, are not necessarily problematic for the person and this is almost certainly the case for many offenders. It has been suggested previously (Howells, 1989) that they may be either **ego syntonic** or **ego dystonic**. For example, one person views their anger as legitimate, useful and even enjoyable (Hodge, 1997) while for another it is a scourge, a cause of unpleasant physical states and an instigator of behaviours they subsequently regret.

The implication of this analysis is that methods such as motivational interviewing (Miller & Rollnick, 1991 have an important part to play for some clients, particularly in a prison or community corrections setting, where problems of low motivation and rejection of the skills model appear to be common.

As anger management and related methods begin to be implemented in criminal populations, with individuals who have serious. complex problems of violence, personality disorder and outright mental illness (Becker, 1997; Howells et al, 1997; Renwick et al; 1997), it is becoming apparent that many difficulties arise for the rehabilitator. These difficulties are likely to be far less common in clients in the general community, who have generally been the focus of anger-management interventions (Edmondson & Conger, 1996).

Renwick et al (1997) point to the therapeutic pessimism felt by both clients and therapists in such settings and to enduring problems of low motivation, treatment resistance and avoidance. These authors note the resentful, distrustful and even combative style of some offender participants in therapeutic groups. Additionally, the clients had realistic concerns about the effects of disclosure of their emotions and past behaviour on release or parole plans. Novaco (1997). similarly, highlights the long histories of failure, institutionalization and social rejection that characterize such clients and which entrench their anger and aggression.

Establishing a working alliance with the client, a prerequisite for cognitive behavioural therapy, is likely to be a challenging task in such settings. It may be that these difficulties in establishing engagement are a general feature of working with ego syntonic (low motivation to change) problems.

Conclusion

For the reasons outlined above, programs to address violent behaviour are required in the correctional system. The intensity of the program delivered needs to be calibrated to the level of risk of the violent offender. High risk individuals will need to be offered intensive programs (see Hall, 1999) while medium risk individuals will require less therapeutic input. Allocation to programs needs to be based on an assessment of the criminogenic needs giving rise to violence, rather than on the basis of the offence type alone. Anger-management programs have a part to play in the rehabilitation of violent offenders, provided allocation to such programs is needs based. It is likely that the typical anger-management program offered in Australian corrections will be too brief and insufficiently

intensive to produce significant change in high or medium risk offenders. Levels of treatment motivation and readiness will need to be assessed prior to programs.

Drug and Alcohol Programs

Rationale

Research from around the world has consistently reported a relationship between drug use and offending (e.g., Weekes, Moser & Langevin, 1997; Hammersley, Forsyth & Lavelle, 1990; Kevin, 1992a, 1992b). Criminal behaviour and drug and alcohol use share many common antecedents (McMurran, Hodge & Hollin, 1997) and research has shown that heavy drinking at age 18 predicts the continuity of crime into adulthood (Farrington & Hawkins, 1991). There is convincing evidence that crime rates are higher among drug-dependent offenders than non-using offenders, that a substantial proportion of offenders are dependent on drugs, and that most drug using offenders have significant life-style problems associated with substance abuse (Wexler & Lipton, 1993). Furthermore, as the extent of abuse increases, the frequency and severity of crime escalates (Chaiken, 1986). Studies have shown that active heroin use accelerates the users' crime rate by a factor of 4-6. Similar findings have been reported for those using crack (see Ball, 1986; Brownstein & Goldstein, 1990). There is also evidence of a significant association between alcohol use and crime. Makkai (1998) reports that around 17% of an Australian community sample report committing some form of alcohol related disorder or crime in the past 12 months, with other studies showing a relationship between the acute effects of alcohol and incarceration for violent offences (Collins & Schlentger, 1984).

Given the close relationship between alcohol and other drug use and criminal behaviour, it seems plausible that programs targeting these areas will be effective in reducing re-offending rates. However the precise nature of the relationship between alcohol, drugs and crime remains unclear; many people who use illicit drugs or consume alcohol do not

commit any crimes other than through the use of illicit substances. The two most plausible theories linking alcohol and crime are a disinhibition model (where the pharmacological properties of alcohol lower criminal and other inhibitions that normally restrain an individual from antisocial behaviour (Makkai, 1998); and social learning models, which argue that individuals learn to behave in certain ways when intoxicated (Barnett & Fagan, 1993). Others argue that substance abuse is the result of a deviant criminal lifestyle or that a third factor, such as genetics, causes both criminality and substance abuse.

It is clear however, that drug and alcohol problems are prevalent in correctional populations indicating a high degree of need for treatment. In the USA, the Department of Justice and National Center on Addiction and Substance Abuse (CASA) estimate that 60-80% of the correctional population have used drugs at some point in their lives, twice the estimated drug use of the total US population (ONDCP, 1998). 55% of jail prisoners were reported to have used drugs in the month before their offence, with 35.6% using drugs at the time of offence. Polysubstance use, both prior to and within prison, is a characteristic of incarcerated adult offenders (Kassebaum & Chandler, 1994). Further, intervention for drug problems is an identified area of need for many offenders. The Department of Justice (1997) reported that 21% of adults on probation were sentenced for a drug offence. Of those sentenced with special conditions, drug or alcohol treatment was a condition for 41% of adults on probation, and 33% were subject to mandatory drug testing. It has been estimated that between 70-85% of inmates need some level of substance abuse treatment (US General Accounting Office, 1991).

It seems likely that these figures would be reasonably representative of the situation in Australia. In South Australia, Department for Correctional Services statistics reveal that 32% of prisoners have committed an alcohol or other drug related offence (DCS, 1998).This figure does not include offences to finance drug use or offences committed

whilst under the influence of alcohol or illicit drugs. Dobinson and Ward (1984) reported that 90% of a sample of New South Wales prisoners with identified drug problems reported committed their offence to finance drug use. A recent study in New Zealand (Bushnell & Bakker, 1997) reported that half of the new arrivals in prison met the criteria for an alcohol dependence syndrome, estimating that alcohol disorder was twice as common, and drug use disorder eight times as common in prisoners than in the general population (see also McMurran & Hollin (1993) for UK data). Many authors have suggested that prisons are the logical place to start treatment. given the high proportion of non-violent drug offenders serving relatively short sentences (Platt, 1995). Lipton (1994) argues that imprisonment presents an important opportunity for treatment, given that many drug users are unlikely to seek treatment by themselves, and that drug use and criminality is likely to continue after release. Another study by Brooke, Taylor, Gunn and Maden (1998) reported that 24% of drug users on remand requested treatment at interview.

Description of Program Content

Correctional services have responded in different ways to the problems presented by drug and alcohol use. Westmore and Walter (1993) have described programs offered in Australian correctional services. In South Australia, the Department for Correctional Services have identified four categories of intervention: system wide harm minimisation; supply reduction; demand reduction and problem reduction. This review focusses solely on the fourth of these categories by looking at those interventions and rehabilitation programs designed to reduce the problems caused by alcohol and other drugs.

The diversity of alcohol and drug programs that have been offered to offenders makes it difficult to describe typical programs. In this respect, alcohol and drug programs differ

from some of the other interventions described in this review. In many ways this reflects an attempt by service providers to recognise the different causes and patterns of use by offenders. Prison drug use is generally regarded as a continuation of similar pre-prison behaviour and not an adaptation response to the problems and pressures of imprisonment (Thomas & Cage, 1977). Multimodality programs offer a combination of services including inpatient treatment, medical care, vocational and educational training, family therapy, therapeutic communities, methadone maintenance, group psychotherapy, individual psychotherapy, drug education and stress-coping techniques (see Inciardi, 1993; Inciardi, Lockwood & Quinlan, 1993; Incorvaia & Baldwin 1997; Peters & May, 1992).

In the USA, the Bureau of Prisons has developed a four-tier system to describe different interventions of increasing intensity, from education services, nonresidential drug abuse treatment, unit based residential treatment, and transitional services (Weinman & Lockwood, 1993). Education programs have been the most common form of intervention (Incorvaia & Baldwin, 1997), which typically focus on the physiological effects of drug use, high risk behaviours for HIV, hepatitis, tuberculosis and other diseases, and discuss the benefits of drug treatment and behaviour change. Through a group process, education programs aim to increase motivation to continue treatment. For example, an alcohol education program offered by the Ministry of Justice in Western Australia (see Papandreou, 1999), comprises three sections: knowledge of alcohol and its contribution to offending; information on alcohol, the law and problem drinking, focussing on alcohol related offences; identifying problem drinking; and education about the physical and psycho-social effects of alcohol.

Non-residential programs or outpatient treatment includes a range of protocols from highly professional psychotherapy to informal peer discussions. for those either unable or unwilling to enter residential treatment. Counselling services vary considerably and

include individual, group or family counselling, peer group support, vocational therapy and cognitive therapy. Medical and pharmacological treatments have been used in prisons for prisoners experiencing withdrawal. One of the most common treatments, methadone substitution, has been effective in prisons (Hser, Yamaguchi, Chen & Anglin, 1995).

A common form of residential treatment in prisons is the therapeutic community (Walker, Falkin & Lipton, 1990). Therapeutic communities are intensive long term, self-help, highly structured, residential treatment modalities for chronic drug users. Programs have been adapted for prison settings and vary according to the extent to which they adhere to community therapeutic community treatment philosophies. Wexler (1995) reports that they also tend to be shorter (6-12 months) and to emphasise self-help and relapse prevention methods. An alternative type of residential program, drug-free units tend to operate on behavioural principles, using a system of punishment and reward (Incorvaia & Baldwin, 1997). Transitional programs, or half-way houses, are designed to help reintegrate the offender back into the community

In Australia, the National Drug Strategy developed by the National Campaign Against Drug Abuse (NCADA) has adopted the concept of harm minimisation as an underlying basis of the strategy. Whilst definitions and meanings vary, harm minimisation has been defined broadly by Single and Rohl (1997) as: "(A)ny policy or program aimed at reducing drug-related harm" (p. 45) together with a number of strategic principles. These principles include: first, do no harm; focus on the harms caused by drug use rather than the use per se, maximise the intervention options, choose appropriate outcome goals; and respect the rights of persons with drug-related problems.

Assessment

Assessment instruments for substance abuse can be grouped into screening instruments; specific instruments for establishing treatment targets and monitoring change, and broad assessment tools that assess functioning in a number of areas to determine multiple needs. A review of assessment measures by Boland et al (1998) concluded that there are a number of brief and reasonably accurate screening measures available together with some valid and reliable measures for assessing the severity of substance abuse problems. Kevin (1992a) and Incorvaia and Baldwin (1997) recommend the use of screening tools to assess all new reception prisoners to identify those in need of further assessment and service priorities.

Other measures have been designed to assess specific treatment targets such as identifying high risk situations and self-efficacy. Boland et al (1998) argue that clinical ratings of whether someone abuses alcohol or drugs may be unreliable and they recommend the use of instruments which operationalise definitions.

Evidence for Effectiveness

Despite a pervasive belief that prison-based rehabilitation is ineffective and that treatment efforts should be reserved for post-release in the community, the evidence pointing to a reduction in reoffending, following participation in prison treatment programs, is encouraging (McMurran, 1995). However we have been surprised by the lack of large scale evaluation and reviews of the outcome research in this area (see Wexler, 1996). Whilst we understand that a major meta-analytic review of interventions

with substance abusing offenders is currently in progress (Lipton et al, 1997), our review of the literature is restricted to a description of individual evaluations.

In general these have suggested that a number of different treatment programs can have positive effects on recidivism (e.g., Millson, Weekes & Lightfoot, 1995; Wexler, Falkin & Lipton, 1990). McMurran (in press) reviews a number of studies which have used re-offending as an outcome measure. For example, Peters and May (1992) report a reduction in reoffending rates at one year follow up for drug users who attended a six week cognitive-behavioural program delivered in a prison. Platt, Perry and Metzger (1980) report lower reconviction rates for imprisoned young male heroin users following behavioural group programs. Shewan, MacPherson, Reid and Davies (1996) evaluated a residential prison reduction program reporting that those who completed the program used fewer drugs than those who did not. Another study provided evidence that methadone treatment greatly reduces crimes associated with heroin addiction and increased social productivity (Magura, Casriel, Goldsmith & Lipton, 1987).

Some of the strongest evidence for program effectiveness comes from evaluations of intensive residential programs, such as therapeutic communities. In the USA, the first large scale federally funded evaluation of prison drug treatment (the Stay 'n Out prison therapeutic community) reported a significant reduction in recidivism rates for the program contrasted with several comparison groups. In 1991 these findings were reinforced by a 5 year evaluation of a different therapeutic community (the Amity TC) (see Wexler, 1997). The US Department of Justice reports that for inmates who completed a prison residential treatment program, only 3.3% were likely to be arrested in the first six months after release, compared with 12.1% who did not receive treatment. Similarly among those who received treatment, 20.5% were likely to use drugs in the first six months after release compared with 36.7% without treatment (US Dept. of Justice, Bureau of Prisons, 1998). Wexler, Falkin and Lipton (1990) reported that the percentage

of therapeutic community males rearrested (27%) was significantly lower than for the no-treatment control (41%), and comparison treatment groups (35% milieu group, 40% counselling group). A recently published study by Hiller, Knight and Simpson (1999) examined the impact of residential aftercare on recidivism following completion of a prison-based therapeutic community treatment. A group of 293 treated prisoners were compared with a matched group of 103 prisoners who did not receive treatment. Hiller et al (1999) reported that the prison based treatment both lowered the risk of re-offending after release and prolonged the length of time until re-arrest. They reported that reductions in recidivism were increased when treatment was supplemented with residential community-based aftercare. They suggest that the first 90 days after release are likely to be a dangerous time for relapse and considered that aftercare facilities could significantly reduce this risk. Hiller and colleagues conclude that correctional treatment should follow a through-care model linking services from prisons through to the community. These evaluations and others of prison therapeutic communities (e.g., Wexler, DeLeon, Kressel & Peters (in press) and Knight, Hiller & Simpson, 1999) consistently suggest that this form of intervention is effective in reducing re-offending. Studies of therapeutic community programs conducted in community settings also suggest that drug use and criminality decline after treatment (e.g., Brook & Whitehead, 1980).

An important variable influencing treatment outcome for residential programs appears to be the length of time spent in treatment. Wexler, Falkin and Lipton (1990) found a strong relationship between time in the program and treatment outcomes, with the percentage with no parole violations rising from 50% for those who remained less than 3 months to almost 80% for those in the program for between 9 and 12 months. Similar results are reported by Field (1989; 1992). A recent study by Siegal et al (1999) reported that prisoners who spent at least 180 days in a therapeutic community were significantly less likely to be re-arrested or charged with violent drug related crimes.

There do not appear to be many evaluations of programs targeting alcohol use which have reported on recidivism as an outcome variable. Baldwin et al (1991a) reported that an alcohol education group for young offenders was effective in reducing the alcohol use of participants, but no data were reported on whether this affected subsequent offending. This UK program has been subsequently adapted for use in South Australia, Queensland and the Northern Territory (see Baldwin et al, 1991b). An evaluation by Crundall and Deacon (1997) with a largely Aboriginal sample, reported similar benefits from a prison based alcohol education program.

Best Practice

Suggestions as to what constitutes best practice in the drug alcohol field are broadly consistent with the 'what works' literature (McMurran, in press). For example, Wexler and Lipton (1993) recommend the following: an isolated treatment unit, motivated participants, committed and competent staff, adequate treatment duration, an array of treatment options, cooperative and supportive relationships with correctional staff and administrators and continuity of care that extends into the community. In South Australia, the Department for Correctional Services (DCS, 1998) argues that best practice characteristics of prison based programs include, prisoners assigned to programs on the basis of offending history, high integrity programs, confidentiality, a focus on relapse prevention, and the development of an individual's ability to take responsibility. There is also a consensus that intensive relapse prevention strategies need to be incorporated into programs for substance abusing offenders with ineffective coping skills (Incorvaia & Baldwin, 1997). However, at present, many of these suggestions for best practice, although highly plausible, remain largely unsupported by empirical research.

There is less emphasis in the literature on targeting intervention at higher risk offenders in accordance with the risk principle, despite Wexler and Lipton's (1993) conclusion that there is "convincing evidence that a relatively few severe substance abusers are responsible for an extraordinary proportion of crime" (p212). Gendreau, Goggin and Annis (1990) in a survey of 170 substance use programs operating within the Correctional Service of Canada, found that only 26% of respondents summarised assessment results in a way which would give some indication of risk. A majority (61%) did not vary the intensity of the treatment with the risk level of the client. They suggest that several areas should be given greater emphasis in offender assessment, including criminogenic needs such as cognitive skills, peer group associations, antisocial attitudes and psychopathy.

Risk assessments can be used to determine the most appropriate intensity of program. The Gendreau, Goggin and Annis (1990) survey of Canadian programs revealed that programs varied considerably in terms of intensity, ranging from one day to one year. Contrary to the literature suggestive that programs should be relatively intense, Annis (1990) in a review of drug treatment studies largely conducted outside of prison settings, reported that there is no evidence for more intensive programs producing better outcomes. For example, Annis suggests that residential treatment lasting 1-2 weeks produced results comparable with programs lasting several months. Furthermore, Annis argues that day-treatment programs may be equally as effective as residential programs. We await the results of meta-analytic reviews allowing for more direct comparisons of different treatment modalities, before drawing any firm conclusions about program intensity

With regard to the principle of responsivity, drug and alcohol services have led the rehabilitation field. The range of programs offered to offenders represents attempts by

service providers to develop programs that meet individual needs and are matching clients to treatment to improve outcomes (Annis, 1990). Annis suggests that the severity of the problem and the degree of motivation to address the problem should be matched to the intervention offered. Motivation to attend for treatment is widely regarded as a key issue if prison programs are to be effective (Gorta, 1992; Hall, 1997). One study reported that almost one third of pharmacologically dependent offenders did not want in-prison treatment for their drug problem (see Incorvaia & Baldwin, 1997). A significant contribution to the field has been in the development of models suggesting that people move through a predictable series of stages as the costs and benefits of their drug use varies (e.g., Prochaska & DiClemente, 1986, 1996). These models of change suggest that rehabilitation efforts should be targeted at the individual's location in this cycle of change. For example, educational programs aimed at improving motivation may be most appropriately aimed at those offenders who are reluctant to enter more formal treatment programs. An alternative strategy has been to develop different types of intervention designed specifically to encourage participation in treatment. The technique of motivational interviewing (Miller & Rollnick, 1991) has been particularly influential in this area. The extent to which these efforts to match clients to treatment are successful in leading to further reductions in recidivism, remains an important area for further research (Annis, 1990).

Problems and Issues

Despite the considerable need for treatment, there is evidence to suggest that existing programs tend to be over-burdened, and most offenders received either very limited treatment or none at all. In the USA, National Institute of Justice statistics show that although drug and alcohol counselling was available in nearly 90% of state and federal facilities, only 10-20% of prison inmates participated in treatment during their

incarceration. Baldwin et al (1991) argue that substance abusing offenders have not traditionally been seen as a high priority in service planning, with "service provision being characterised by poor quality and intermittent delivery" (p 13).

A clear issue in the management of drug using offenders is how best to coordinate the reception process. Prisoners undergoing withdrawal will have special needs, to which the prison needs to respond. Screening for drug and alcohol problems on arrival in prison will help identify immediate needs for medical treatment, as well as assisting with sentence planning and treatment recommendations. There is no clear model for most effective delivery of services. At present services are offered by a combination of prison staff, community drug agencies and volunteer groups. The provision of specialist units, such as therapeutic communities, seems to be indicated by the available outcome literature. Kevin (1992a,b) argues that treatment should be delivered in a detached unit, away from the general prison population. An important component of treatment is linking closely with community services to ensure support following release.

Conclusion

There is strong evidence of a clear association between substance use and crime, and it seems reasonable that effective treatments for drug and alcohol use will impact positively upon subsequent offending. A range of programs developed in clinical and community settings has been adapted for use with offenders. Whilst many programs have yet to be evaluated, evaluations of some programs, particularly therapeutic communities, support the idea that intervention can reduce rates of further offending. In addition, cognitive-behavioural and relapse prevention interventions show promise. Further evaluation of programs specifically targeting alcohol use in offenders is required. The provision of

through-care models linking prison treatments to post-release programs seems important in achieving optimal outcomes.

Cognitive Skills Programs

Rationale

The term "cognitive", as used in Cognitive Skills (CS) or similar programs has a wide range of meanings in the field of correctional rehabilitation (Porporino, 1999). The rationale for stressing cognitive processes as rehabilitation targets is that biases and deficiencies in cognition appear to contribute to the development and maintenance of criminal behaviour (Zamble & Porporino, 1988). Porporino (1997), for example, suggests: "Offenders will think about the world and about themselves in a certain way, and it is these cognitive characteristics that need to be targeted in any effective cognitive program" (page 6). Zamble and Porporino (1988) have analysed the cognitive deficits found in offender groups, including impulsivity / lack of reflection on consequences, poor

planning, concrete thinking, rigid and absolutist thinking, poor problem-solving, deficient reasoning skills and an inability to take the perspective of others.

Cognitive Skills programs are based on an obvious corollary of the above findings – the notion that offending can be prevented by teaching offender clients the cognitive skills they lack.

Description of Program Content

The program has been run throughout the Correctional Service of Canada since 1990, having been initially developed by Ross and Fabiano in 1985. The CS program has been described as the cornerstone of Correctional Service of Canada's Living Skills Programs. The program is intended to run for 36 sessions over 8 to 12 weeks and to be delivered in small groups of 6 to 8.

The content and structure of Cognitive Skills ("Reasoning and Rehabilitation") programs has been described by Porporino and Robinson (1995) by Robinson and Porporino (1998) and by Ross and Ross (1995). The cognitive deficits outlined above are addressed in a highly structured way within the program, which stresses systematic skills-building and a focus on the process as well as the content of thinking. The program targets the following: self-control (thinking before acting), interpersonal problem-solving skills, social perspective-taking, critical reasoning, cognitive style and values (Robinson & Porporino, 1998). A number of methods and modalities are used in the training, including role-playing, dilemma games, cognitive exercises, behavioural components and audio visual inputs (Robinson & Porporino, 1998).

A comprehensive and detailed Trainer's Manual describes all exercises and procedures. There is a clear sequence to the program, with a progression from an initial focus on problem-solving, through skill acquisition in areas such as assertiveness, social skills, negotiation and anger-management and finally on to the consolidation of skills and the development of higher-level thinking skills.

Evaluation of Effectiveness

The outcome literature relating to CS programs has been summarized and reviewed by Robinson and Porporino (1998). Some of these studies have measured reconviction rates as an outcome indicator (Fabiano, Robinson & Porporino, 1991) where others have reported 'clinical' outcomes honed on pre-test / post-test companions or specific program targets (Fabiano, Robinson & Porporino, 1990).

Outcome studies have also been conducted in Britain (Raynor & Vanstone, 1994) in the United States (National Council on Crime and Delinquency, 1997; Johnson & Hunter, 1992) and Spin (Garrido & Sanchez, 1991). Some of these studies have been conducted with generalist offenders, while others have focussed on particular groups, such as, substance-abusing offenders. In general, such studies have reliably reported greater improvements in CS participants than in controls (Robinson & Porporino, 1998), though in the longer-term, for example over 2 years, effectiveness remains uncertain. No published outcome studies appear to be available for Australian populations.

The single biggest evaluation of the effectiveness of Cognitive Skills has been reported by Robinson (1995). In this important study the author describes the results of a project investigating the effects of Cognitive Skills on post-release outcomes, including re-admission and reconviction rates, for federal offenders in the Canadian Correctional

system. The Cognitive Skills (CS) participants were compared with a control group who did not receive the program (waiting list). One of the strengths of this study is the large number of participants (over 4000) in the CS program.

Overall, Robinson found reductions in recidivism of between 11% and 20%, depending on what measure of recidivism was used. Outcome was found to be dependent on initial risk-status. High risk offenders showed little benefit from the program, while low risk offenders showed a 20% improvement. At face value, this finding contradicts the general proposition in the risk literature that greater rehabilitation gains are found in high risk groups. Robinson points to an important caveat, that the low risk group in his study was still relatively high in risk compared to offenders in general. This may mean that the low risk group can be more appropriately labelled a medium risk group.

Effects for criminogenic needs were also found in this study. Medium and high criminogenic needs offenders showed greater gains than the low need group. The reduction in recidivism was particularly large (52.5%) for the medium need group.

This study produced a number of other results with relevance for the planning of programs in correctional services. Greater improvements were demonstrated in community as opposed to institutional groups. Because of the strikingly good effects for community programs, Robinson recommends that high-risk offenders who have already received the program in institutions should then receive booster sessions in the community to further reduce their risk. Large differences also emerged between offender types. Sex offenders showed particularly large reductions in recidivism. This is a surprising finding, given the absence of significant content relating to sexual deviance in the program.. Violent offenders and drug-related offenders also showed good outcomes, with both groups doing better than acquisitive offenders.

An important finding, from an Australian perspective, was that Aboriginal offenders showed no benefits from participating in the CS program.

Robinson himself (1995) is quick to point out that the CS program is not a cure –all:

> "The findings permit greater confidence… that the Correctional Service of Canada offers programs that help reduce recidivism… the data also suggest that the program is not a panacea…….the pattern of findings (involves) modest effects in the full sample with larger and smaller effects across various sub-groups…….impressive reductions in recidivism were recorded for some offender sub-groups who represent substantial proportions within the federal offender population" (page 39).

Best Practice

The findings discussed in the previous section give some guidance as to the settings and populations in which CS is likely to prove most effective. Additionally, the originators of the CS program themselves identify features of the program they believe contribute to its effectiveness. Whilst no comparison studies appear to be available which compare outcomes for CS programs with and without these features, these characteristics have high face validity as contributing to success. Porporino (1997) suggest the following as important:

- Extensive staff training
- Delivery by the right staff to the right offenders
- Attention to sustaining program integrity
- A "building block" approach

- Line-level ownership of innovations
- Clear lines of authority for program management
- Secure and effective administrators, low staff turnover and sufficient resources
- Vision and values which provide a rationale and purpose for the program

It is clear that many of these characteristics are congruent with what are emerging as the general features of good practice in offender rehabilitation, as reviewed elsewhere in the present report.

An interesting feature of CS is that the program is designed to be delivered not by mental health professionals but by correctional officers, case managers and related staff. This feature is intended to promote broad ownership of the program within the correctional system.

The developers of CS also point to what they believe to be characteristics of effective coaches (trainers). Their list includes above average verbal skills; ability to balance empathic skills and authority demands; sensitivity to group dynamics, ability to confront without demeaning; good interpersonal skills and successful experience with difficult groups of clients. It is striking that these features are similar to those stressed as required for therapeutic intervention in general outside of the correctional setting.

One of the impressive aspects of the CS approach is the attention given to the steps of program implementation, from the initial selection of the program site through to the final steps of maintaining research and further development of the program itself.

Problems and Issues

One of the strengths of the CS program is that it has been presented in a near-identical format in a range of countries, including Canada, the United States, England, Scotland, Scandinavia, Spain, Portugal, Germany, Australia and New Zealand (Robinson & Porporino, 1998). This contrasts with many other offender rehabilitation programs where program content and structure may be highly variable, despite the programs sharing the same name (for example, "Anger Management" or "Sex Offender Treatment").

The program has been successfully established in Australia (South Australia). To date, little has been published about responsivity aspects of the program. How the program might need to be adapted for specific offender populations (for example, those with intellectual disability, those from different ethnic groups) is unclear.

Conclusion

One of the impressive aspects of the CS program is that the general principles of good rehabilitation practice discussed elsewhere in this report are explicitly incorporated into the program's design and implementation. For this reason, Robinson (1995) suggests CS is a "state of the art" correctional intervention.

More specifically, the program directly targets established criminogenic needs. Brown (1993) (quoted in Robinson, 1995) found that cognitive deficits were among the needs

that were the most highly correlated with recidivism among offenders. The program is also multi-modal, cognitive-behavioural in orientation and highly structured in the ways generally recommended within the rehabilitation outcome literature (Hollin, 1999). The substantial use of the program within the Canadian Correctional Services means that relatively high risk offenders have been targeted (Robinson, 1995) . The referral and selection process adopted in Canada also suggests that offenders of high need and risk are the focus for intervention. All these aspects, again, are consistent with the Risk Principle. Finally, program integrity has been specifically addressed, through initial and follow-up training of coaches and through detailed manuals. It might be added that the existence of Robinson's substantial report (1995) provides evidence of built-in evaluation and research in the Canadian Correctional system.

Other Programs

In addition to the programs described above, which constitute the rehabilitation programs most commonly offered to offenders, there are a number of other programs that warrant discussion. Perhaps the most significant of these are programs aimed at reducing marital or family violence. Whilst these can be considered a subset of broader programs to address violence, family violence programs have a number of distinguishing features. The rationale for many of these programs is drawn from social learning theory which suggests that we often model behaviour to which we have been exposed as children, in our own families (Mihalic & Elliott, 1997). Cognitive and behavioural factors are therefore important areas of assessment and treatment (as for violent and sexual offenders) (Tonizzo et al, in press). Others have fiercely criticised the use of such methods for family violence problems, arguing that abusers need to be re-educated regarding male ideologies of power and control (Pence & Paymar, 1993). These approaches rely on a high level of confrontation and place emphasis on abusers taking responsibility for violent behaviour. In general, research would suggest that excessive confrontation is ineffective (Murphy & Baxter, 1997), and there is scope for both philosophies to be incorporated into programs. This occurs to some extent in sexual offender treatment programs where cognitive targets for change (such as responsibility and denial) are emphasised within models that recognise the broader social context in which offending takes place. Whilst it makes sense for most family violence programs to take place in community settings, offering a prison based program may be appropriate for some offenders.

Offenders may also be offered program designed to target problem gambling. Gambling, for many offenders, could reasonably be regarded as a criminogenic need and therefore a

legitimate target for intervention. At present however many programs are offered in community rather than prison settings.

A second type of program has been developed out of the restorative justice perspective, which is becoming increasingly influential in Australia. Restorative justice programs generally bring all parties together to attempt to find collective ways to deal collectively with an offence. Whilst such mediation programs have been influential in offering sentencers alternatives to imprisonment, the Department for Correctional Services in South Australia has recently developed a program (the Victim Awareness Program) for use in prison. This program has been designed to increase levels of cognitive empathy across a broad range of offenders (Thomson, 1999).

Conclusions

We conclude this review with a positive statement about the effectiveness of rehabilitation programs for offenders. There is now a significant body of evidence demonstrating the rehabilitation programs offered to offenders in prison can be effective in reducing recidivism. When programs are well designed and well delivered, it is reasonable to expect reductions in recidivism in the range of 20-35 percent (Gendreau & Goggin, 1997). Programs addressing the areas of offending described in this review (sexual offending, violent offending, drug and alcohol related offending, and cognitive skills) are particularly promising. We recommend that programs in these areas form the basis of any rehabilitation efforts for offenders in prison.

In addition to the general conclusion that rehabilitation 'works', for programs to be truly evidence based they need to be matched, both in terms of content and intensity, to the risk and needs of offenders. It seems sensible to offer a range of programs, varying from brief psycho-educational programs for large numbers of low to medium risk offenders, through to intensive, perhaps residential, programs run in specialist units for very high risk / high need offenders. One theme that has emerged in the review is that for many offences there is a small proportion of offenders who are responsible for a significant proportion of crime. Targeting these very high risk offenders with relatively intensive services would seem to be a sensible use of resource.

Unfortunately, reviews of existing correctional programs suggest that they often do not apply in practice what we know about effective rehabilitation. Gendreau and Goggin (1997) argue that there is only one way to alleviate these shortcomings - by better education and training. We agree substantially with this view. All program staff should

receive training in assessment and treatment methods. This could be offered to existing staff through programs such as the Criminogenic Needs Assessment course recently run for prison social workers and community corrections officers in South Australia. To ensure that training is current and ongoing, all staff involved in programming should receive regular input from professionally trained staff with extensive knowledge in the area. Clinical and forensic psychologists have been highly influential in the development of many offender programs and would be an obvious professional grouping from which to select program managers and trainers. We believe that the programs themselves can often be delivered by staff from a range of backgrounds, and in principle, support the greater involvement of custodial staff in delivering programs. The sex offender treatment program in the UK and the cognitive skills programs offered around the world have adopted this model, and it seems an appropriate way of ensuring that treatment gains are generalised to a prisoner's living environment.

It is important in the success of an evidence-based approach that management systems are in place. Case management is an important process in planning rehabilitation efforts over the course of a sentence and in linking through to services in the community. A system of assessment also needs to be developed. The evidence suggests that screening instruments should be used with *all* new receptions as part of the reception process to identify risk, need and responsivity issues. Those identified as high in risk and / or high in need can then be assessed more thoroughly using both specific instruments to assess treatment targets and monitoring change, and broad assessment tools to assess functioning in a number of areas to determine multiple needs. A coherent assessment process is essential in matching the offender to the most appropriate service, thereby optimising program outcomes and saving resources.

A strong conclusion of this review is that staff training models should be based on the programs that have been evaluated and shown to be effective. A common shortcoming of many programs is a lack of evaluation. Some programs are either not evaluated or evaluation methods fail to meet the conventional requirements of research design. Our literature search, produced only three recently published studies of offender treatment in Australia; none of which would meet the criteria for inclusion in a meta-analysis. One study was an evaluation of a community based treatment program for sex offenders (Lee et al, 1996). Whilst this study did report some data on recidivism, it did not adopt a control group design. The other two studies were small scale evaluations of prison-based anger management programs (in Western Australia and Victoria), which did not report follow-up data on recidivism (Watt and Howells, 1999, Miller, 1996).

This finding is disappointing - the psychological literature on offender rehabilitation relies heavily on empirical data. Along with the 'what works' approach comes a commitment to evaluation. At the present time, virtually all of the available evidence upon which programs are based comes from international sources. There is no way of assessing how well the 'what works' approach applies to Australian correctional systems, or to groups such as women or Aboriginal and Torres Strait Islander offenders. If correctional departments are serious about implementing a 'what works' approach to rehabilitation, there should be a greater commitment to evaluation. We recommend that all programs are designed with in-built evaluation and quality assurance processes to enable ongoing accreditation.

Recommendations

Our review of the literature leads us to suggest the following as being consistent with best practice:

- A range of rehabilitation programs should be implemented in the prison system based on the 'what works' literature.
- Offender risk, needs and responsivity should be routinely assessed and form the basis for allocation to programs.
- Relevant staff should receive formal and ongoing training in 'what works' principles and methods, particularly in the criminogenic needs approach.
- Program integrity should be addressed in program development and should be monitored for all programs.
- Evaluation of rehabilitation programs and of their effectiveness should be routine.
- Programs of varying intensity should be provided with brief programs for offenders of low risk / needs and more intensive programs for offenders with medium or high risk / needs.
- Programs are required, as a minimum, in the areas of sex offending, anger / violence, drugs and alcohol use and cognitive skills.
- Other programs will need to be developed. Development should be on the basis of relevance to demonstrated needs and evidence as to effectiveness.
- New programs should be subject to an accreditation process based on the 'what works' literature.

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