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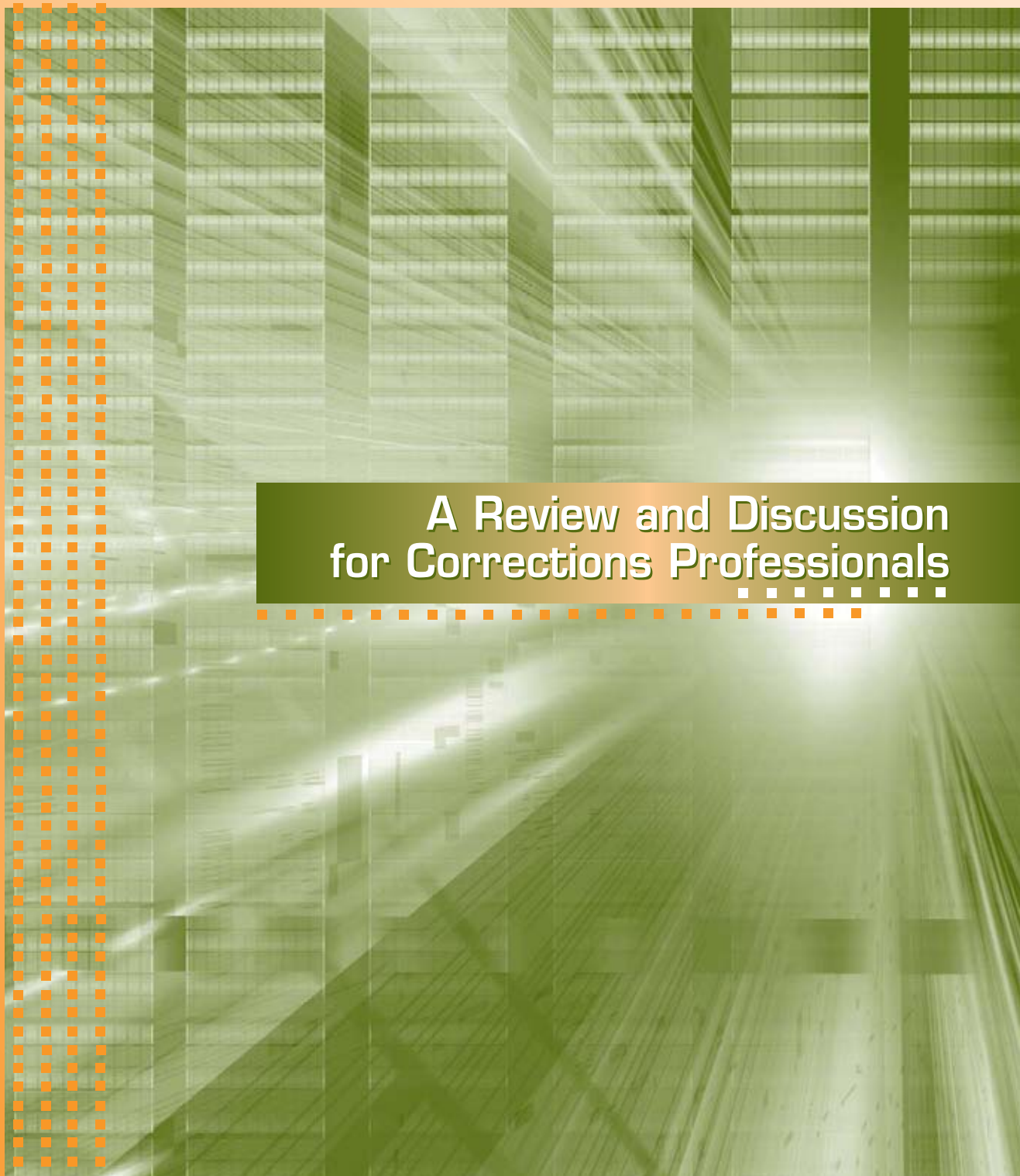
COGNITIVE-BEHAVIORAL TREATMENT



A Review and Discussion for Corrections Professionals

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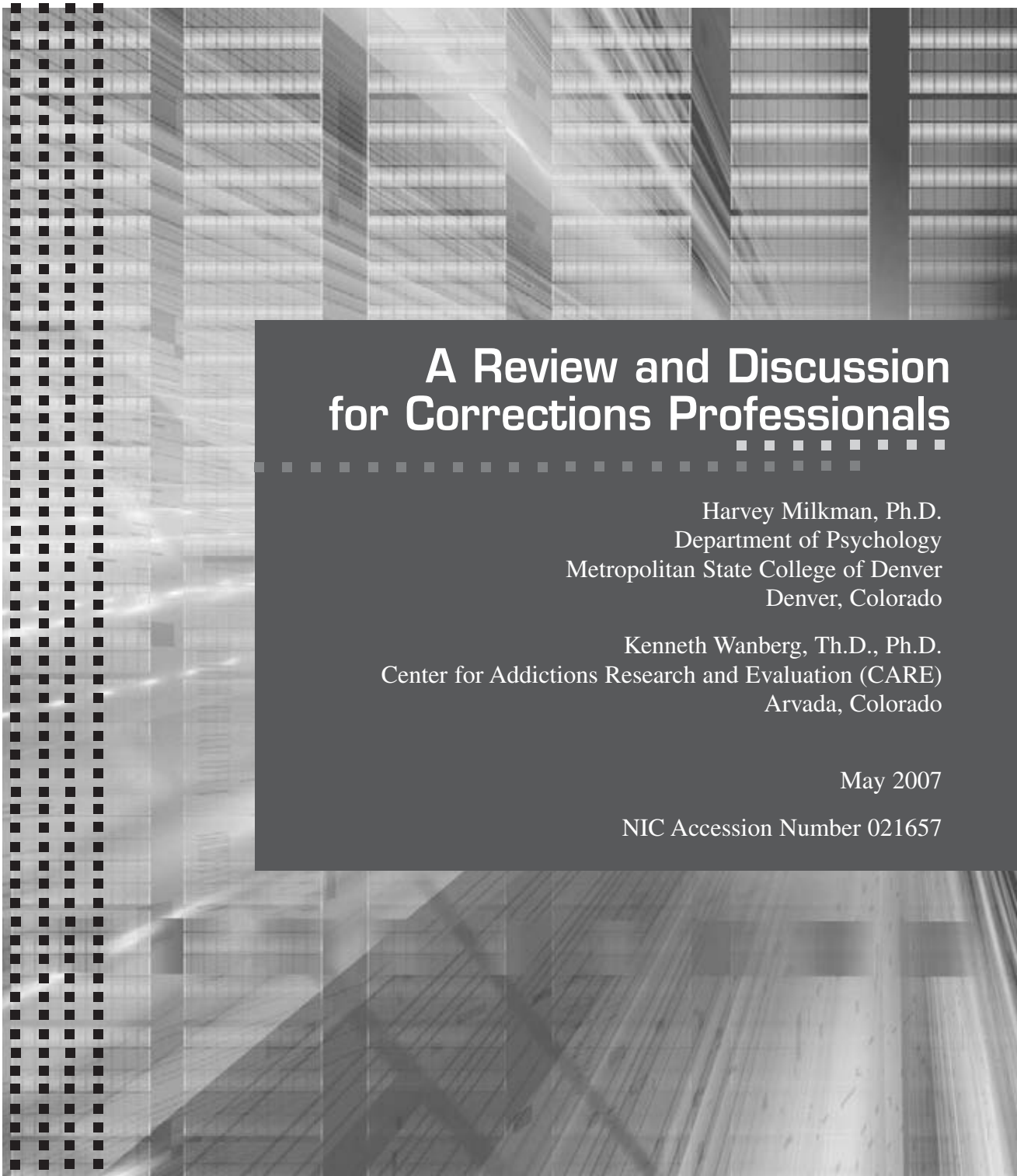

A Review and Discussion for Corrections Professionals

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The decision to include the six cognitive-behavioral treatment programs chosen for this publication was based on a focused literature review of cognitive-behavioral treatments for individuals involved in the criminal justice system (see References section of this report). The review showed these to be some of the prominently discussed, implemented, and researched CBT programs used in correctional settings throughout the United States. These programs are not to be taken as exhaustive of effective CBT treatments for correctional clients, nor are they ranked in any order of impact on recidivism or number of clients served.

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Foreword

In the latter half of the 20th century, a trend began toward deinstitutionalization of persons with mental illness. At the end of 1988, more than 100,000 patients resided in state and county mental hospitals. By the end of 2000, fewer than 56,000 patients resided in these hospitals, a reduction of almost one-half. An increasing number of these individuals have become involved with the criminal justice system with no indication of a decline in the trend. The Bureau of Justice Statistics estimated that mid-year 1998, there were 283,800 mentally ill offenders in the nation's prisons and jails, representing 7 percent of federal inmates, 16 percent of state prison inmates, and 16 percent of those in local jails.

During those same decades, cognitive-behavioral therapy (CBT) emerged as the predominant psychological method of treating not only mental illness, but a broad spectrum of socially problematic behaviors including substance abuse, criminal conduct, and depression. CBT attempts to change negative behaviors by attacking, as it were, from both ends. Clients are not only taught more positive behaviors to replace their old ways of getting through life, they are also shown how to be more attuned to the thought processes that led them to choose negative actions in the past.

This publication, *Cognitive-Behavioral Treatment: A Review and Discussion for Corrections Professionals,* offers corrections personnel with various responsibilities an in-depth explanation of what CBT is and how it is being implemented in prisons and jails across the country. It explores the history and philosophies underlying CBT and gets right to the "nuts and bolts" of several promising CBT treatment programs. Users of this publication—from administrators to treatment professionals—will gain an understanding of what CBT can bring to their corrections facilities whether they have already implemented such a program and want to refine it or if they are just starting the process of determining which program might best meet their needs.

We hope this document will ultimately prove beneficial to inmates struggling with mental illness or drug addiction or simply lacking appropriate social skills as well as ease the way for corrections staff who must deal with these types of inmates on a daily basis.

Morris L. Thigpen
Director
National Institute of Corrections

Preface and Acknowledgments

This publication is intended to inform corrections and probation/parole professionals about the availability and benefits of cognitive-behavioral treatment (CBT) services geared toward the specific risks and needs of offender populations. The publication is also intended as a resource for mental health professionals seeking to evaluate or improve delivery of treatment services in correctional institutions, community corrections centers, and outpatient programs serving probation and parole clientele.

Chapter 1 discusses the increasing need for psychiatric and behavioral treatment in the nation's prisons and jails. Chapter 2 explores the history of cognitive-behavioral therapy and explains its principles.

Chapters 3 to 5 review the literature on cognitive-behavioral treatments for individuals who have come in contact with the criminal justice system. Six programs in general use are reviewed: Aggression Replacement Training®, Moral Reconation Therapy®, Thinking for a Change, Relapse Prevention Therapy, Reasoning and Rehabilitation, and Criminal Conduct and Substance Abuse Treatment: Strategies for Self-Improvement and Change (a program developed by the authors of this publication).

Chapter 6 covers "real world" issues that need to be addressed when providing CBT for offenders, such as diversity considerations and how to treat clients with serious mental disorders. The chapter concludes with a discussion of two strategies: targeting the appropriate treatment for the particular offender, and the "manualized" approach (giving practitioners a precise curriculum to follow). These strategies have been shown to greatly improve offender outcomes.

The authors would like to thank Karen Storck and David Fialkoff for editorial support and Karen Storck and Steve Fante for research assistance.

In addition, the authors would like to thank the National Institute of Corrections for its support. In particular, George Keiser, Chief, Community Correction/Prisons Division, and correctional program specialists Dot Faust, Rachel Mestad, and Michael Guevara were instrumental in bringing this project to fruition.

Executive Summary

This publication is intended to inform corrections and probation/parole professionals about the availability and benefits of cognitive-behavioral treatment services geared toward the specific risks and needs of offender populations. The publication is also intended as a resource for mental health professionals seeking to evaluate or improve delivery of treatment services in correctional institutions, community corrections centers, and outpatient programs serving probation and parole clients.

Chapter 1: The Increasing Need for Effective Treatment Services

Incarceration and Release

In 2000, 502,000 offenders were released from correctional facilities in the U.S., and the release estimate for 2004 is more than 600,000 (Bureau of Justice Statistics, n.d.; Petersilia, 2004). The increase in the number of releasees has stretched parole services beyond their limits, with increased concern about what assistance can be provided at release. One study concluded that released prisoners need more assistance than in the past, yet available resources have decreased.

The Need for Mental Health Services

Mental health services were offered in significantly more correctional facilities in 2000 than in 1988; however, the relative percentage of facilities that offered mental health services decreased overall. Growth in prison facilities and prisoner populations has outstripped the slower growth in mental health services, and service populations are becoming more concentrated in the facilities that do offer such services. Since the deinstitutionalization of persons with mental illness began, an increasing number of these individuals have been imprisoned, with no indication of a decline in the trend.

Cost-Benefit Analysis

A 2004 research project analyzed 14 studies that evaluated the impact of correctional treatment on reoffending in the community and carried out a

cost-benefit analysis. Thirteen had a positive cost-benefit outcome, with ratios ranging from 13:1 to 270:1 (Welsh, 2004). This means, for example, that in the study with the best outcome, for every $1 spent, a benefit of $270 was realized as a result of the program.

Focus on Community Reentry

In consideration of factors associated with the high number of individuals who are incarcerated and released, rates of recidivism, and costs to society, there has been an increased interest in the concept of prisoner reentry. Reentry programs have been defined as those that (1) specifically focus on the transition from prison to community or (2) initiate treatment in a prison setting and link with a community program to provide continuity of care. Between 2001 and 2004, the federal government allocated more than $100 million to support the development of new reentry programs in all 50 states (Petersilia, 2004).

With budget shortfalls at any level of government, the question soon becomes: Are prisoner reentry programs worth government investment? Sociologist Robert Martinson concluded in 1974 that most rehabilitation programs studied up to that point "had no appreciable effect on recidivism." However, in the 30-plus years since Martinson's scathing critique, the positive effects of offender treatment have been well documented and multiple studies have concluded that recidivism has significantly decreased. Moreover, several studies have indicated that the most effective interventions are those that use cognitive-behavioral techniques to improve mental functioning. Cognitive-behavioral treatments have become a dominant therapy in clinical psychology, and analyses of cognitive-behavioral programs for offenders have come to positive conclusions.

Chapter 2: What is Cognitive-Behavioral Therapy?

History and Background

Cognitive-behavioral therapy (CBT) comes from two distinct fields, cognitive theory and behavioral theory. Behaviorism focuses on external behaviors and disregards internal mental processes. The cognitive approach, by contrast, emphasizes the importance of internal thought processes.

In the early 1960s, therapies began to develop that blended the elements of behavioral therapy with cognitive therapy. Thus, although behavioral therapies and cognitive approaches seemed to develop in parallel paths, over time the two approaches merged into what is now called cognitive-behavioral therapy.

The Community Responsibility Focus of CBT

In the treatment of judicial clients, a third focus is added to the traditional CBT focus on cognitive functioning and behavior: developing skills for living in harmony with the community and engaging in behaviors that contribute to positive outcomes in society. Traditional psychotherapy is egocentric; it

helps individuals resolve their personal problems, feel better about themselves, and fulfill their inner goals and expectations. This egocentric psychotherapy, in and of itself, has failed to have significant impact on changing the thinking, attitudes, and behaviors of offenders. Therapy must also include a sociocentric approach to treatment that focuses on responsibility toward others and the community.

Counselor's Role

The two most important components of intervention programs are the provider (counselor, therapeutic educator, or therapist) and the relationship between the provider and the client. After 50 years of studies, core provider characteristics have been identified for effective delivery of psychosocial therapies. These include the communication of genuine warmth and empathy by the therapist.

A consistent finding in psychotherapy research over the past 20 years has been that, regardless of other factors, the strength of the therapeutic alliance has a strong impact on outcome. One study even concluded that a strong alliance is beneficial in and of itself, and that a client may find a well-established alliance therapeutic regardless of other psychological interventions. Similarly, there is evidence that a weakened or poor alliance is a good predictor of early, unilateral termination.

Clients within a correctional setting differ from noncorrectional clients in that they are required to attend education and treatment as part of their sentence. This means that counselors and therapeutic educators must integrate the therapeutic and correctional roles in delivering effective services to their clients.

Chapter 3: Prominent Cognitive-Behavioral Therapy Programs for Offenders

Traditional cognitive-behavioral approaches used with correctional populations have been designed as either cognitive-restructuring, coping-skills, or problem-solving therapies. The cognitive-restructuring approach views problem behaviors as a consequence of maladaptive or dysfunctional thought processes, including cognitive distortions, social misperceptions, and faulty logic. Most cognitive-behavioral programs developed for criminal offenders tend to be of this first type, focusing on cognitive deficits and distortions.

Six cognitive-behavioral programs are widely used in the criminal justice system:

- Aggression Replacement Training® (ART®).
- Criminal Conduct and Substance Abuse Treatment: Strategies for Self-Improvement and Change (SSC).
- Moral Reconation Therapy® (MRT®).
- Reasoning and Rehabilitation (R&R and R&R2).

- Relapse Prevention Therapy (RPT).
- Thinking for a Change (T4C).

Aggression Replacement Training®

Aggression Replacement Training® (ART®) is a multimodal intervention originally designed to reduce anger and violence among adolescents involved with juvenile justice systems. More recently, the model has been adapted for use in adult correctional settings.

Based on previous work with at-risk youth, ART seeks to provide youngsters with prosocial skills to use in antisocial situations as well as skills to manage anger impulses that lead to aggressive and violent actions. It has three components:

- **Social skills training** (the behavioral component) teaches interpersonal skills to deal with anger-provoking events.
- **Anger control training** (the affective component) seeks to teach at-risk youth skills to reduce their affective impulses to behave with anger by increasing their self-control competencies.
- **Moral reasoning** (the cognitive component) is a set of procedures designed to raise the young person's level of fairness, justice, and concern with the needs and rights of others.

Youth attend an hour-long class in each of these components (on separate days) each week for 10 weeks. ART is usually part of a differential program, prescriptively chosen to meet the needs of aggressive/violent youth.

Criminal Conduct and Substance Abuse Treatment: Strategies for Self-Improvement and Change

Strategies for Self-Improvement and Change (SSC) was developed by Kenneth Wanberg and Harvey Milkman (authors of this publication). It provides a standardized, structured, and well-defined approach to the treatment of clients who manifest substance abuse and criminal justice problems. It is a long-term (9 months to 1 year), intensive, cognitive-behavioral-oriented treatment program for adult substance-abusing offenders. The recommended client age is 18 years or older. However, some older adolescents may benefit from portions of the curriculum.

SSC can be presented in either a community or an incarceration setting. The treatment curriculum for SSC consists of 12 treatment modules that are structured around 3 phases of treatment. Each module is taught in a logical sequence with basic topics covered first, serving as the foundation for more difficult concepts covered later.

The phases of the program are as follows:

- **Phase I: Challenge to Change.** This phase involves the client in a reflective-contemplative process. A series of lesson experiences is used to build a working relationship with the client and to help the client develop motivation to change.
- **Phase II: Commitment to Change.** This phase involves the client in an active demonstration of implementing and practicing change. The focus is on strengthening basic skills for change and helping the client to learn key CBT methods for changing thought and behavior that contribute to substance abuse and criminal conduct.
- **Phase III: Ownership of Change.** This phase, the stabilization and maintenance phase, involves the client's demonstration of ownership of change over time. This involves treatment experiences designed to reinforce and strengthen the commitment to established changes.

An important component of SSC is the screening and assessment process. The client is engaged in the assessment process as a partner with the provider, with the understanding that assessment information is just as valuable to the client as to the provider and that change is based on self-awareness.

Moral Reconation Therapy®

Developed by Greg Little and Ken Robinson between 1979 and 1983 for use in prison-based drug treatment therapeutic communities, Moral Reconation Therapy® (MRT®) is a trademarked and copyrighted cognitive-behavioral treatment program for offenders, juveniles, substance abusers, and others with "resistant personalities." Although initially designed specifically for criminal justice-based drug treatment, MRT has since been expanded for use with offenders convicted of driving while intoxicated (DWI), domestic violence, and sex offenses; parenting skill and job attitude improvement; and to address general antisocial thinking.

The term "moral reconation" was coined in 1972. "Conation" is an archaic term that was used in psychology until the 1930s, when the term "ego" replaced it. It refers to the conscious, decisionmaking portion of one's personality. "Reconation" implies a reevaluation of decisions. "Moral" indicates the process of making correct, prosocial decisions about behaviors.

MRT is based on the experiences of its authors, who noted that offenders were often highly functional during stays in therapeutic communities, but returned to criminal behaviors after release. They felt that the offenders' character and personality traits that led to failure were not being addressed.

Nine personality stages of anticipated growth and recovery are identified in the program:

- **Disloyalty:** Typified by self-centered behavior and a willingness to be dishonest and blame and victimize others.

- **Opposition:** Includes the same behaviors as "disloyalty," only occurring less often.
- **Uncertainty:** Person is unsure of how he or she stands with or feels about others; these individuals still make decisions based on their own pain or pleasure.
- **Injury:** Destructive behavior still occurs, but recognition of the source of the problem also occurs; some responsibility for behavior is taken and some decisions may be based on consequences for others.
- **Nonexistence:** Person feels alienated from things but has a few satisfying relationships; these individuals sway between making decisions based on formal rules and decisions based on pleasure and pain.
- **Danger:** Person commits to goals and makes decisions primarily on law and societal values; when regression occurs, these individuals experience anguish and loss of self-esteem.
- **Emergency:** Social considerations are made, but "idealized ethical principles" influence decisionmaking.
- **Normal:** These individuals are relatively happy, contented people who have chosen the right goals for themselves and are fulfilling them properly; decisionmaking based on pleasure and pain has been virtually eliminated.
- **Grace:** The majority of decisions are based on ethical principles; supposedly, only a small percentage of adults reach this stage.

MRT is conducted in open-ended groups that may meet once a month or up to five times per week. MRT does not require high reading skills or high mental functioning levels, as participants' homework includes making drawings or writing short answers.

Reasoning and Rehabilitation

Developed by Robert Ross and Elizabeth Fabiano in 1985 at the University of Ottawa, Reasoning and Rehabilitation (R&R) is a cognitive-behavioral program that, like MRT, is based on the theory that offenders suffer from cognitive and social deficits. Ross and Fabiano's research that stands as the basis for the principles of R&R was published in the text *Time to Think: A Cognitive Model of Delinquency Prevention and Offender Rehabilitation* (1985). The techniques used in this program were modified from techniques used in previous correctional programs as well as methods that the authors found to be of value when used with offenders. They were field tested in an experimental study with high-risk probationers in Ontario, Canada.

The authors attempted to provide a program that can be used in a broad range of institutional or community corrections settings as well as one that can be used concurrently with other programs in which offenders may participate.

The authors encourage significant individuals in the offender's life to be familiar with the program principles so that they can reinforce and encourage the offender in skill acquisition.

This program focuses on enhancing self-control, interpersonal problem solving, social perspectives, and prosocial attitudes. Participants are taught to think before acting, to consider consequences of actions, and to conceptualize alternate patterns of behavior. The program consists of 35 sessions, running from 8 to 12 weeks, with 6 to 8 participants.

R&R's authors believe that highly trained professionals (e.g., psychiatrists, psychologists, social workers) may not always be the ones implementing rehabilitation programs, and therefore took steps to ensure that line staff would also be adept at implementing the program. Trainers are encouraged to add to or modify the program to best serve specific types of offenders. The authors make note of the importance of trainers presenting the material just above the functioning level of the offenders so as to be challenging, yet not overwhelming or discouraging.

A shorter version of R&R, known as R&R2, is a program specifically for adults that was developed by Robert Ross and Jim Hilborn in 1996. This is a specialized, 15-session edition that seeks to target those over age 18 whose antisocial behavior led them to social services or criminal justice agencies.

The authors of R&R2 believe that long-term intervention can both "tax the motivation of many offenders and [be] associated with high attrition rates"; it can also tax the motivation of trainers and overburden agency budgets. R&R2 is also designed to correct a shortcoming of previous versions that did not allow the program to be tailored to the needs and circumstances of the group recipients. The new program offers specialized versions specific to age, sex, nature of the antisocial behavior, risk of recidivism, and culture.

Relapse Prevention Therapy

As described by authors George A. Parks and G. Alan Marlatt (2000), Relapse Prevention Therapy (RPT) was originally developed to be a maintenance program to prevent and manage relapse following addiction treatment. Designed to teach individuals how to anticipate and cope with relapse, RPT rejects the use of labels such as "alcoholic" or "drug addict," and encourages clients to think of their addictive behavior as something they *do* rather than something they *are*.

RPT uses techniques from cognitive-behavioral coping-skills training to teach clients self-management and self-control of their thoughts and behavior. This approach views addictive behaviors as acquired habits with biological, psychological, and social determinants and consequences.

RPT proposes that relapse is less likely to occur when an individual possesses effective coping mechanisms to deal with high-risk situations. With this, the individual experiences increased self-efficacy and, as the length of abstinence

from inappropriate behavior increases and effective coping with risk situations multiplies, the likelihood of relapse diminishes.

RPT clients are taught to:

- Understand relapse as a process, not an event.
- Identify and cope with high-risk situations.
- Cope effectively with urges and cravings.
- Implement damage control procedures during lapses to minimize their negative consequences and get back on the road to recovery.
- Stay engaged in treatment, particularly after relapses occur.
- Create a more balanced lifestyle.

Thinking for a Change

In December 1997, the National Institute of Corrections introduced a new integrated cognitive-behavioral change program for offenders and sought a limited number of local, state, or federal correctional agencies to serve as field test sites for the program, Thinking for a Change (T4C). An overwhelming response from the corrections community requesting participation in the project necessitated immediate program expansion and the inclusion of a much broader scope of participation for the field test. Since its introduction, correctional agencies in more than 40 states have implemented T4C with offender populations. These agencies include state correctional systems, local jails, community-based corrections programs, and probation and parole departments. The offender populations included in the project represent both adults and juveniles and males and females. More than 5,000 correctional staff have been trained to facilitate offender groups. Nearly 500 individuals have participated in Thinking for a Change: Advanced Practicum (Training of Trainers), which enables participants to train additional facilitators at their agencies to deliver the program. As research of the effectiveness of the program continues to mount, so does the interest from the correctional community to adopt a quality, evidenced-based cognitive-behavioral change program.

T4C uses a combination of approaches to increase offenders' awareness of self and others. It integrates cognitive restructuring, social skills, and problem solving. The program begins by teaching offenders an introspective process for examining their ways of thinking and their feelings, beliefs, and attitudes. This process is reinforced throughout the program. Social-skills training is provided as an alternative to antisocial behaviors. The program culminates by integrating the skills offenders have learned into steps for problem solving. Problem solving becomes the central approach offenders learn that enables them to work through difficult situations without engaging in criminal behavior.

The broad spectrum of the program's sessions makes T4C meaningful for a variety of offenders, including adults and juveniles, probationers, prison

and jail inmates, and those in aftercare or on parole. A brief 15-minute prescreening session to reinforce the participant's need for the program and the necessity of positive participation is the first step in T4C. Small groups (8 to 12 individuals) are encouraged in order to facilitate interactive and productive feedback. The program can be used concurrently or consecutively with other treatment programs.

The curriculum is divided into 22 lessons, each lasting 1 to 2 hours. No more than one lesson should be offered per day; two per week is optimal. It is recommended that at least 10 additional sessions be held using a social skills profile developed by the class. Lessons are sequential, and program flow and integrity are important; however, in situations of high turnover or movement to other facilities, some sessions can be used as points to reorganize or combine existing groups, freeing up one facilitator to work with a new set of offenders.

Chapter 4: Measuring the Effectiveness of Rehabilitation Programs

Recidivism and CBT

Because most outcome evaluations are based on recidivism, there are many positive treatment outcomes that are rarely measured. For example, one of the positive results of a female offender's engagement in treatment is that her children are much less likely to be born drug-addicted. However, from a research standpoint, the broader definitions are too conceptual and all-encompassing to be of much use in evaluating program success. A narrower definition of program success (i.e., reduced recidivism) makes the evaluation task manageable, even if it fails to capture the range and diversity of assistance to the offender and benefit to the community.

An abundance of research shows positive effects of cognitive-behavioral approaches with offenders. At the same time that cognitive-behavioral treatments have become dominant in clinical psychology, many studies report that recidivism has been decreased by cognitive-behavioral interventions.

A meta-analysis of 69 studies covering both behavioral and cognitive-behavioral programs determined that the cognitive-behavioral programs were more effective in reducing recidivism than the behavioral programs. The mean reduction in recidivism was about 30 percent for treated offenders (Pearson et al., 2002). Other meta-analyses of correctional treatment concluded that cognitive-behavioral methods are critical aspects of effective correctional treatment. Yet another study similarly determined that the most effective interventions are those that use cognitive-behavioral techniques to improve cognitive functioning.

Factors That Determine Effect Size

Multiple factors that determine effect size have been identified within program evaluation designs. For example, the definition of recidivism can significantly

determine statistical outcomes. If one defines recidivism as rearrest after intervention, the effect size will be significantly lower (i.e., treatment appears less beneficial) than it would be if recidivism were defined as reconviction or reincarceration.

Other factors relate to variation in recidivism effects. When offenders who were defined as being at high risk to reoffend were treated through CBT, they actually reoffended less after treatment than low-risk offenders. The number of sessions and fewer dropouts due to quality control monitoring created more effect size. Further, for treatment of high-risk offenders, treatment providers received greater levels of CBT training, which were associated with larger effects.

CBT programs designed for research or demonstration purposes (in contrast to "real world," routine-practice programs) were also associated with larger effects. Research and demonstration programs included smaller sample sizes, providers with mental health backgrounds, greater monitoring of quality control, and greater monitoring of offender attendance and adherence to treatment. Another critical factor in the evaluation of program efficacy is whether the program includes anger control and interpersonal problem solving.

Chapter 5: Evaluating Specific CBT Curricula

While there are too many moderating variables (e.g., staff training and supervision, length of contact in treatment, aftercare provisions, quality control) to identify a specific CBT program as superior in achieving measurable treatment outcomes, there have been significant efforts to demonstrate the effectiveness of standardized CBT curricula.

Studying the Effectiveness of Aggression Replacement Training®

Ramsey County Juvenile Probation and Uniting Networks for Youth collaborated to improve outcomes for those in the juvenile justice system, specifically those with a medium to high risk of reoffending. The Wilder Research Center conducted an evaluation summary of Aggression Replacement Training (ART) between the fall of 2002 and the fall of 2004 with 295 youth who received ART (Hosley, 2005). Four agencies provided the services, including a residential program, a school-based program, and two community-based programs. The youth were racially and culturally diverse (39 percent black, 28 percent white, 24 percent Asian, 6 percent Latino, and 3 percent of another or mixed race). Ninety-two percent were male, mostly between the ages of 14 and 17. Two-thirds had received previous interventions.

Hosley (2005) points out that while 77 percent of the youth had an offense in the year prior to entering ART, only 31 percent had an offense in the year after participating. Although this reoffense rate is described as similar to the overall rate of reoffending among all Ramsey County youth, those who participated in ART were described prior to participation as being generally at a higher risk for reoffending. Even though many participants were reported to

have continued problems at school, between 80 and 90 percent were still in school 3 months after the ART program. Eighty percent of the youth also reported at 3 months post-ART that it had made a positive difference in their lives (Hosley, 2005, p. 2).

Hosley (2005) reported positive feedback from youth and their families concerning their satisfaction with the services and staff who provided ART. Twenty-five items showed statistically significant increases, with the largest improvements in the following areas:

- Understanding someone's anger.
- Handling it well when accused.
- Figuring out methods other than fighting.
- Thinking of one's abilities before beginning a new task.
- Apologizing to others.
- Staying out of situations portending trouble.
- Asking permission when appropriate.
- Handling complaints fairly.
- Figuring out what caused a problem.

Hosley (2005) points out that research with comparisons to control groups will be necessary to more strongly correlate the use of ART with a reduction of aggressive behavior; improved emotional, behavioral, and cognitive health; and, ultimately, a decrease in recidivism with juvenile or adult offenders.

Studying the Effectiveness of Criminal Conduct and Substance Abuse Treatment: Strategies for Self-Improvement and Change

There has been a highly successful initiative to establish a statewide SSC provider base in Colorado. As of December 2001, a total of 483 providers representing 153 sites and 137 agencies have been trained in the delivery of SSC. An SSC program delivery effectiveness study was completed using client and provider self-reported data (Wanberg and Milkman, 2001). Important findings include the following:

- Providers reported that from 50 to 56 percent of outpatient clients maintained substance abstinence during SSC, and 60 percent of outpatients were rated as abstaining from any criminal conduct during SSC.
- Providers rated 80 percent of the SSC clients as having "fair" to "very good" prognosis in the areas of alcohol and other drug use and criminal conduct.
- SSC clients assigned positive ratings of program effects; an average of 75 to 80 percent reported their cognitive and behavioral control over

alcohol and other drug use as well as criminal thinking and conduct improved during SSC.

Studying the Effectiveness of Moral Reconation Therapy®

Greg Little, a founder of MRT who has been involved in much of the MRT outcome research, has reported that outcome data on MRT include almost 88,000 individuals (14,623 MRT-treated individuals and 72,898 individuals in control and comparison groups) (Little, 2000). He notes that few treatment approaches have been researched as extensively as MRT.

According to Little (2001), studies show that adult offenders who attend MRT treatment during incarceration have significantly reduced recidivism rates for 1 year after release. MRT leads to a 23-percent decline in expected recidivism which, Little explains, is substantial, because the expected rate of recidivism is 48 percent 1 year after release. MRT, therefore, cuts the expected 1-year recidivism rate in half. Little's 1999 research at the Shelby County Correction Center showed an 8.4-percent reincarceration rate for MRT-treated individuals as opposed to 21 percent for nontreated controls.

Little also conducted a 2005 meta-analysis of nine MRT outcome studies (only one of which was associated with the developers of MRT). The conclusion of this meta-analysis was that MRT outcome research has shown to be consistent in findings. As the use of MRT extends beyond incarcerated populations to probation and parole, outcome research continues to show a host of beneficial effects.

Studying the Effectiveness of Reasoning and Rehabilitation

In their 2005 review, Wilson and colleagues examined seven evaluations of R&R programs, three of which were true experimental studies. They reported that results were mixed, with the scientifically higher quality studies finding that R&R resulted in lower rates of reoffense. Although the three true experimental studies found positive results in recidivism rates, one was not statistically significant, with R&R participants' recidivism rate at 26 percent compared with a rate of 29 percent for non-R&R participants.

John Wilkinson, at the University of Surrey, England, conducted a quasi-experimental design that targeted repeat offenders who were at high risk of reoffending and had the thinking styles and attitudes that R&R was intended to change. His findings showed that 67 percent of the R&R group were reconvicted within 2 years as compared to 56 percent of untreated offenders. "It would seem . . . R&R did not reduce offending" (Wilkinson, 2005, p. 81). However, the author offers the alternative fact that 5 percent fewer R&R participants were reconvicted after release than was predicted on the basis of age and previous convictions, compared with the custody group, which had 14 percent more reconvictions than predicted. This, he states, could be taken as indicating success.

Wilkinson concluded that the effectiveness of the R&R program has yet to be demonstrated and that his findings are "broadly in line" with other studies that show R&R did not bring about significant reduction in recidivism.

Studying the Effectiveness of Relapse Prevention Therapy

A meta-analytic review of RPT confirms the "overall efficacy of RP[T] in reducing substance use and improving psychosocial adjustment" (Irvin et al., 1999, p. 569). Although treatment outcomes varied among the moderator variables (i.e., treatment modality, theoretical orientation of prior therapy, treatment setting, type of outcome measures used to determining effectiveness, medication used, and type of substance use disorder treated by RPT), the overall results showed that RPT was effective across the board and did not appear to vary with treatment modality or setting. The authors' review of 26 published and unpublished studies concluded that RPT is highly effective for alcohol and polysubstance use disorders when administered along with the use of medication and when evaluated immediately following treatment with the use of uncontrolled pre- and posttests.

A review of 24 randomized controlled trials of the effectiveness of relapse prevention (Carroll, 1996) suggests "that relapse prevention is better than no treatment, equal to or better than 'placebo' control groups, and at least equal to the best available active substance abuse treatments that the field has to offer" (George A. Parks, 2006, personal communication). Carroll's choice of studies included those randomized control trials that were defined as "relapse prevention" and that "explicitly invoked the work of Marlatt" (Carroll, 1996, p. 51).

Carroll (1996) also points out that relapse prevention therapy might not prevent relapse better than other therapies, but suggests that relapse prevention is more effective than alternatives, in that it reduces the intensity of lapses when they occur. As described by Parks (2006, personal communication), the basis of RPT is teaching cognitive and behavioral coping skills. Slip-ups by clients occur more often in the early stages of treatment. With continued RPT, clients learn to anticipate high-risk situations and become better equipped to deal with them as they occur. In summary, relapse prevention is a promising intervention in substance abuse treatment.

Studying the Effectiveness of Thinking for a Change

Two evaluations of Thinking for a Change were found. The first is a doctoral dissertation from the University of Texas Southwestern Medical Center at Dallas (Golden, 2002). This study centers on 42 adult male and female medium- and high-risk offenders on probation. Completers and dropouts from the T4C program were compared with those not assigned to the program, with procriminal attitudes, social skills, and interpersonal problem-solving skills as the studied factors. Ratings were based on self-report measures, applied-skill tests, and facilitator ratings as well as recidivism during the 3-month and 1-year postprogram completion time periods.

The study found that new criminal offense rates for those who completed the T4C program were 33 percent lower than for the comparison group. No differences were found between groups for technical violations of probation. On attitudinal measures of procriminal sentiments, again no differences were shown between the groups. Social skills did improve for completers and dropouts, but remained the same for the comparison group. Completers of the program improved significantly in interpersonal problem-solving skills, while dropouts and comparisons showed no change.

The author points toward the shortcomings of her study, including the small sample size, noting that the trend observed toward reduced offenses would have been statistically significant with a larger sample size. Also, generalization of the results is difficult because the sample consisted mostly of young, unmarried, black males of lower socioeconomic status in a large urban setting.

The author further notes that the study showed that new criminal charges, as well as technical violations, typically had occurred at least 3 months after completion of T4C for program participants, while those for comparisons and dropouts occurred within the first 3 months of the probationary period. Thus, she recommends "booster sessions" or an aftercare group to assist in relapse prevention.

The second study, of 233 probationers, was conducted in Tippecanoe County, Indiana (Lowenkamp and Latessa, 2006). It showed a significant reduction in recidivism (defined as arrest for new criminal behavior) over an average of 26 months (ranging from 6 to 64 months) for those who participated in the T4C program. Of the 136 treatment cases, the 90 who were "successful T4C participants" had a recidivism rate of 18 percent; the recidivism rate of the 121 probationers who participated in T4C was 23 percent. The recidivism rate of the 96 probationers in the control group was 35 percent.

Chapter 6: "Real World" Program Applications

Treatment Dimensions

The following are principles for successful CBT treatment:

- Services should be behavioral in nature.
- Interventions should employ cognitive-behavioral and social learning techniques such as modeling, role playing, and cognitive restructuring.
- Reinforcement in the program should be largely positive, not negative.
- Services should be intensive, lasting 3 to 12 months (depending on need) and occupying 40 to 70 percent of the offender's time during the course of the program.
- Treatment interventions should be used primarily with higher risk offenders, targeting their criminogenic (crime-inducing) needs.

- Less-hardened or lower risk offenders do not require intervention and may be moved toward more criminality by intrusive interventions.
- Conducting interventions in the community as opposed to an institutional setting will increase treatment effectiveness.

Motivation Effects

Offenders vary greatly in terms of their motivation to participate in treatment programs. Policymakers and practitioners often feel that providing services to those who want them is money well spent, while forcing services on a resistant group of individuals is a waste of resources. Evidence shows that behavioral change is more likely to occur when an individual has the self-motivation to improve. Feelings of ambivalence that usually accompany change can be explored through "motivational interviewing," a style and method of communication used to help people overcome their ambivalence regarding behavior changes. Research shows that motivational interviewing techniques, rather than persuasion tactics, effectively improve motivation for initiating and maintaining behavior changes.

Risk Factors

"Static" and "dynamic" risk factors can be differentiated as intervention targets. *Static risk factors,* rooted in the past and therefore unalterable and inappropriate targets for change, include:

- Early involvement in deviance and acting-out behavior.
- Emotional, psychological, and family disruption in childhood and adolescence.
- Involvement with an antisocial peer group as a youth and school problems or failure.
- Alcohol and other drug use in childhood and adolescence.

Dynamic risk factors are parts of the offender's daily experience and are more amenable to change. These factors do more than simply forecast criminal events. They actually influence the chances of criminal acts occurring through deliberate intervention. Some dynamic risk factors are more appropriate and promising targets for change than others. Following are ways providers can work with dynamic risk factors:

- Changing antisocial attitudes.
- Changing antisocial feelings.
- Reducing current antisocial peer associations.
- Promoting familial affection and communication.
- Promoting familial monitoring and supervision.

- Promoting child protection (preventing neglect and abuse).
- Promoting identification and association with anticriminal role models.
- Increasing self-control, self-management, and problem-solving skills.
- Replacing the skills of lying, stealing, and aggression with more prosocial alternatives.
- Reducing chemical dependencies.
- Shifting the balance of personal, interpersonal, and other rewards and costs for criminal and noncriminal activities so that the noncriminal alternatives are favored.
- Providing the chronically psychiatrically troubled with low-pressure, sheltered living arrangements.
- Ensuring that the client is able to recognize risky situations and has a concrete and well-rehearsed plan for dealing with those situations.
- Confronting the personal and circumstantial barriers to service (e.g., client motivation, background stressors with which clients may be preoccupied).
- Changing other attributes of clients and their circumstances that, through individualized assessments of risk and need, have been linked reasonably with criminal conduct.

Clients With Serious Mental Disorders

The change in social policy regarding the institutionalization of the severely mentally ill has influenced the populations within the criminal justice system. Ideally, psychiatric patients would be at no higher risk for arrest and incarceration than the rest of the population. This unfortunately is not the case, as individuals with severe mental disorders have a substantially greater risk of being incarcerated. Offenders with a serious mental disorder are poorly compliant with treatment regimens and have a high level of substance abuse.

These offender subpopulations commonly require strategic, extensive, and extended services. However, too often, individuals within this group are neither explicitly identified nor provided a coordinated package of supervision and services. The evidence indicates that incomplete or uncoordinated approaches can have negative effects, often wasting resources.

Some researchers have argued that cognitive-behavioral approaches are not universally applicable to all groups of offenders, including the mentally ill. They stress that the effectiveness of rehabilitation depends on the application of treatment matched to the needs of the person. They determined that the efficacy of cognitive-behavioral approaches when applied outside the mainstream of adult offenders was questionable.

Other researchers identified a group of "exceptional offenders" who are psychopaths with mentally disordered thought patterns. Group-based cognitive-behavioral treatment shows promise for these types of offenders, but only if matched to offender need and the responsiveness of the offender to the treatment. This is especially the case when impulsivity is assessed in an antisocial personality disorder with psychopathic features.

Diversity Considerations

"Clinically relevant treatment" holds the best promise for reduced recidivism. It can be defined as those interventions that maintain respect for, and attention to, diversity in both people and programming.

Gender, age, and ethnic origin intersect to produce consistent statistical patterns of offending. According to the U.S. Department of Justice, in 2004, in both jails and prisons, there were 123 female inmates per 100,000 women in the United States, compared with 1,348 male inmates per 100,000 men. An estimated 12.6 percent of black males, 3.6 percent of Hispanic males, and 1.7 percent of white males in their late twenties were in prison or jail. Female populations in state and federal prisons are growing at a rate approximately 45 percent greater than that for male populations (2.9 percent for females versus 2.0 percent for males). At midyear 2004, 34,422 federal inmates were noncitizens, representing more than 20 percent of all prisoners in federal custody. Nearly 6 in 10 persons in local jails were racial or ethnic minorities. Whites made up 44.4 percent of the jail population; blacks, 38.6 percent; Hispanics, 15.2 percent; and other races (Asians, American Indians, Alaska Natives, Native Hawaiians, and other Pacific Islanders), 1.8 percent.

Given these fairly consistent statistics, it is surprising that programs and treatment generally have not taken into consideration ethnicity, race, sex, age, and degree of violence as they relate to the therapist and the treatment program. Most research in these areas is published in specialty journals, and there is a paucity of research in prestigious journals, which makes access to this information more difficult.

Appropriate Offender Selection

Appropriate offender selection for treatment is predicated upon making the distinction between *offense* criteria versus *offender* criteria for program eligibility. The offense is often used as the selection criterion because it is readily available through official criminal justice documents. The offender perspective, on the other hand, focuses on dynamic factors (traits that are current and subject to change) such as frequency of drug use during the past 30 days, amount of consumption per episode, or adequacy of housing and living conditions. An assessment of dynamic factors allows the system to match offenders to treatment programs that can target crucial psychological and social needs that influence criminal conduct.

One study used dynamic assessment tools to distinguish between two broad categories of alcohol and other drug-involved criminal justice clients: *criminal*

(those with an entrepreneurial involvement in the drug trade) and *addict* (those who compulsively used drugs and used crime as a means to obtain drugs). CBT outcomes for the two populations were markedly different. The addict population showed a reduction in rearrest rates from 41 percent without treatment to 26 percent with treatment. Most striking, however, is the finding that the rearrest rates for the treated criminal group were similar to those of matched samples of criminal offenders who did not attend treatment (approximately 44 percent). Drug treatment programs typically do not address the criminogenic values of an offender, and thus did not target those in the criminal category. Thus, it was shown that assigning appropriate offenders to treatment programs by using dynamic assessment tools (and avoiding offense-specific treatment assignments) can lead to improved treatment outcomes and better utilization of limited treatment resources.

Manualized Treatment Curricula

The emphasis of cognitive-behavioral treatment for substance abuse and criminal conduct is on acquiring new skills to improve resiliency in three focal areas: intrapersonal (safe regulation of thoughts, feelings, and impulses); interpersonal (adaptive communication, negotiation, and boundary setting); and community responsibility (empathy and adherence to community norms, morals, and ethical standards). Principle issues of misunderstanding and other elements that undermine the delivery of effective CBT treatment for judicial clients have been outlined as follows:

- Purpose of the treatment unclear.
- Goals of the services unclear.
- Whether services can be provided in a correctional setting.
- Appropriateness of the content of the therapy to change offender behaviors.
- Ability of the treatment staff to work with offenders.

Significant progress toward the remediation of the above-listed concerns has been made through the evolution of specialized curriculums that serve as a guide for content and style of treatment delivery. This "manualized" approach to treatment provides an operational design that has been shown to improve offender outcomes. From a management perspective, programs that adopt empirically validated, manualized curriculums have greater confidence in the quality of treatment services. Idiosyncratic treatment methods deployed by counselors with a broad range of personal and professional treatment experiences are controlled through an administrative mandate for standardized treatment services. Manualized curriculums allow program managers to be aware of the nature of treatment sessions so that programs can achieve continuity of services in the wake of staff absences and staff turnover. Additionally, program managers can develop objective means to assess treatment progress by developing indices to measure increments in cognitive restructuring and coping skills development.

CHAPTER 1

The Increasing Need for Effective Treatment Services

Incarceration and Release

The total number of people incarcerated in the United States grew 1.9 percent in 2004 to 2,267,787 (Harrison and Beck, 2005b). This number includes 1,421,911 federal and state prisoners plus 713,990 more assigned to local jails, 15,757 in United States territorial prisons, 9,788 in immigration and customs facilities, 2,177 in military facilities, 1,826 in Indian jails, and 102,338 in juvenile facilities. The state and federal prison population (which excludes federal and state prisoners held in local jails) grew 2.6 percent in 2004, while the number of women incarcerated in state and federal prisons was up 4 percent compared with 2003. Women accounted for 7 percent of inmates in state and federal prisons in 2004 and for nearly 1 in 4 arrests. At the end of 2004, 1 in every 1,563 women and 1 in every 109 men in the United States were incarcerated in state or federal prisons (Harrison and Beck, 2005b).

A continuing philosophical debate centers on the responsibilities of the correctional system. Is the correctional system responsible for rehabilitation or simply for incarceration and punishment? Compounding the philosophical issues are the practical concerns associated with the costs of housing offenders and the costs to society as offenders are released. In 2000, 502,000 offenders were released (Bureau of Justice Statistics, n.d.), and the release estimate for 2004 is more than 600,000 (Petersilia, 2004). Researchers have found that victimizations (including crimes by former inmates) generate $105 billion annually in property and productivity losses and outlays for medical expenses. This amounts to an annual "crime tax" of approximately $425 per man, woman, and child in the United States (Miller, Cohen, and Wiersema, 1996).

The increase in the number of releasees has stretched parole services beyond their limits, with increased concern about what assistance can be provided at release. One study concluded that released prisoners need more assistance than in the past, yet available resources have decreased (Petersilia, 2004). Compared with the 1990s, returning prisoners will have served longer prison sentences, be more disconnected from family and friends, have a higher prevalence of untreated substance abuse and mental illness, and be less

educated and employable. Legal and practical barriers facing exoffenders have also increased, affecting their employment, housing, and welfare eligibility. Without help, many released inmates quickly return to crime.

The Need for Mental Health Services

Public policy regarding mental health services in correctional facilities affects the capability of the facility to offer adequate services. One study that compared mental health services in state adult correctional facilities from 1988 to 2000 (Manderscheid, Gravesande, and Goldstrom, 2004) found that between those years, the number of correctional facilities increased 44.9 percent, from 757 to 1,097. The state prison population grew 114.5 percent from 505,712 to 1,084,625. Mental health services were offered in significantly more facilities in 2000 than in 1988; however, the relative percentage of facilities that offered mental health services decreased overall. At the same time, the percentage of inmates who used the services increased overall. The study authors concluded that growth in prison facilities and prisoner populations has outstripped the slower growth in mental health services, and that service populations are becoming more concentrated in the facilities that do offer such services. These results suggest that mental health services are becoming less available to the prison population in general.

Since the deinstitutionalization of persons with mental illness began, an increasing number of these individuals have been imprisoned, with no indication of a decline in the trend. At the end of 1988, more than 100,000 patients resided in state and county mental hospitals. By the end of 2000, fewer than 56,000 resided in these hospitals, a reduction of almost one-half (Atay, Manderscheid, and Male, 2002). These hospitals were also admitting only half as many patients in 2000 as they were in 1988, which may have played a role in the increasing number of persons with mental illness who appeared in the criminal justice system. In addition, throughout the 1990s, prison populations and prison construction increased (Beck and Maruschak, 2001). This escalation would also lead to an increase in the number of inmates in need of mental health services, because a disproportionate number of inmates are likely to be mentally ill compared with the general population. A report from the Bureau of Justice Statistics estimated that midyear 1998 there were 283,800 mentally ill offenders in the nation's prisons and jails, representing 7 percent of federal inmates, 16 percent of state prison inmates, and 16 percent of those in local jails (Ditton, 1999).

Cost-Benefit Analysis

An economic perspective such as cost-benefit or cost-effectiveness analysis is a tool used to determine policy given alternative uses of resources or alternative distributions of services (Knapp, 1997). The most common unit of measurement in determining benefit is efficiency, or achieving maximum outcomes from minimum inputs. Although there are many important noneconomic benefits by which intervention programs should be judged, measurement of these is difficult if not impossible.

Many different criteria can be used in measuring costs and benefits. Some cost-benefit analyses attempt to include a societywide perspective; others narrow their scope to include only one or a few elements, such as effect on taxpayers or effect on program participants. A 2004 research project analyzed 14 studies (12 in the United States and 2 in the United Kingdom) that evaluated the impact of correctional treatment on reoffending in the community and carried out a cost-benefit analysis (Welsh, 2004). Of the 14 studies, 13 had a positive cost-benefit outcome, with ratios ranging from 13:1 to 270:1. This means, for example, that in the study with the best outcome, for every $1 spent, a benefit of $270 was realized as a result of the program.

Determination of social policy and decisions regarding allocation of resources to correctional treatment is not as simple as cost-benefit analysis. Even if a cost-benefit analysis shows that additional dollars should be spent on correctional treatment, government priorities and politically based policies can overshadow the benefits shown.

Focus on Community Reentry

A study that tracked two-thirds of the former inmates released in the United States in 1994 for 3 years following their release found that 29.9 percent of the released inmates were rearrested within the first 6 months and 59.2 percent were rearrested within the first year; within 3 years, approximately 67.5 percent of the 272,111 inmates had been rearrested at least once (Langan and Levin, 2002). These data are consistent with more recent numbers from the Bureau of Justice Statistics (n.d.).

In consideration of factors associated with the high number of individuals who are incarcerated and released, rates of recidivism, and costs to society, there has been an increased interest in the concept of prisoner reentry. Reentry programs have been defined as those that (1) specifically focus on the transition from prison to community or (2) initiate treatment in a prison setting and link with a community program to provide continuity of care (Seiter and Kadela, 2003). Between 2001 and 2004, the federal government allocated more than $100 million to support the development of new reentry programs in all 50 states (Petersilia, 2004). The National Institute of Corrections, the American Probation and Parole Association, the National Governors Association, and various state departments of corrections have all created special task forces to work on the reentry issue.

With budget shortfalls at any level of government, the question soon becomes: Are prisoner reentry programs worth government investment? Sociologist Robert Martinson concluded in 1974 that most rehabilitation programs studied up to that point "had no appreciable effect on recidivism." However, in the 30-plus years since Martinson's scathing critique, the positive effects of offender treatment have been well documented (e.g., Cullen and Gendreau, 1989; Gendreau and Ross, 1987; Husband and Platt, 1993) and multiple studies have concluded that recidivism has significantly decreased (Andrews and Bonta, 1998; Ditton, 1999; Walker et al., 2004). Moreover,

several studies have indicated that the most effective interventions are those that use cognitive-behavioral techniques to improve mental functioning (Andrews and Bonta, 2003; Gendreau and Andrews, 1990). Cognitive-behavioral treatments have become a dominant therapy in clinical psychology, and analyses of cognitive-behavioral programs for offenders have come to positive conclusions.

CHAPTER 2

What is Cognitive-Behavioral Therapy?

Cognitive-behavioral therapy (CBT) for offenders is based on an assumption that the foundations for criminal activity are dysfunctional patterns of thinking. By altering routine misinterpretations of life events, offenders can modify antisocial aspects of their personality and consequent behaviors.

CBT in offender treatment targets the thoughts, choices, attitudes, and meaning systems that are associated with antisocial behavior and deviant lifestyles. It uses a training approach to teach new skills in areas where offenders show deficits, such as interpersonal problem awareness, generating alternative solutions rather than reacting on first impulse, evaluating consequences, resisting peer pressure, opening up and listening to other perspectives, soliciting feedback, taking other persons' well-being into account, and deciding on the most beneficial course of action.

The CBT therapist acts as a teacher or coach, and lessons are typically taught to groups in classroom settings. The lessons may include group exercises involving role-play, rehearsal, intensive feedback, and homework assignments and generally follow a structured curriculum with detailed lesson plans.

History and Background

Cognitive-behavioral therapy, as the name indicates, comes from two distinct fields. CBT is based in behavioral theory and cognitive theory.

Behavioral Theory

The development of behavioral theory in the late 1950s and 1960s provided the foundation of the behavior component of cognitive-behavioral therapy, but behaviorism itself has a longer history. It dates back to John B. Watson's groundbreaking 1913 journal article, "Psychology as the Behaviorist Views It" (often referred to as "The Behaviorist Manifesto"), and includes Ivan Pavlov's work in "classical conditioning" (involuntary behavior triggered by a stimulus; Pavlov, 1927) and the "operant conditioning" models of B.F. Skinner (voluntary behavior encouraged or discouraged by consequences; Skinner, 1938). Behaviorism focuses on observable, external behaviors and disregards internal mental processes.

As behaviorist theories developed, so did a number of efforts to apply them clinically (Glass and Arnkoff, 1992). Among noteworthy examples are Knight Dunlap's use of "negative practice" (involving the intentional repetition of undesirable behaviors such as tics; Dunlap, 1932) and Andrew Salter's "conditioned reflex therapy" (a method of directly practicing a behavior in a particular situation; Salter, 1949).

Emerging methods such as "systematic desensitization" to manage anxiety (gradual exposure to an anxiety-causing stimulus; Wolpe, 1958) and the application of Skinner's work to behavioral management (Skinner, 1958), spelled the beginning of modern behavioral therapy in the 1950s and 1960s. It soon gained a strong foothold in the field of psychology with the introduction of the concepts and applications of "modeling" (observing and copying the behaviors of others; Bandura, 1969); anxiety management through "flooding" (intensive exposure to an anxiety-causing stimulus); and social skills training (Lange and Jakubowski, 1976), which is an important component of contemporary cognitive-behavioral therapy.

Cognitive Theory

The historical roots of the cognitive component of CBT are found in philosophy as well as psychology. The basic concept of cognitive psychology—that one's view of the world shapes the reality that one experiences—is found in ancient Greek thinking such as Plato's concept of "ideal forms" (Leahy, 1996). Plato saw these forms as existing within the mind and representing what is real in the world. Philosophers of the 17th and 18th centuries also built their view of the world around the idea that the mind determines reality. This is particularly found in René Descartes' concept that "I think, therefore I am," and Immanuel Kant's idea that the mind makes nature (Collingwood, 1949).

In modern psychology, the cognitive approach was a reaction to the more narrow view of behavioral psychology, which did not attend to—and even rejected—the importance of internal thought processes. Albert Bandura's classic work *Principles of Behavioral Modification* (1969) challenged the traditional notions of behavioral psychology and stressed the importance of internal mental processes in the regulation and modification of behavior.

Albert Ellis's development of "rational-emotive therapy" (based on the idea that thoughts control feelings; Ellis and Harper, 1961) has been cited as the genesis of modern cognitive theory (Arnkoff and Glass, 1992). The work of Ellis is considered an important precursor to the work of Aaron Beck, who is commonly seen as the founder and developer of cognitive therapy (Arnkoff and Glass, 1992; J. Beck, 1995; Leahy, 1996). Beck's concepts emerged from his work on depression at the University of Pennsylvania (A. Beck, 1963, 1964). George Kelly, developer of the theory of "personal constructs" (mental templates, unique to the individual, that shape perceptions; Kelly, 1955), has also been called an early founder of cognitive therapy. Beck later made it clear that he borrowed from Kelly's work in devising his own theory on the "thinking disorder" of depression (A. Beck, 1996). The work of Jean Piaget

on the structure of thinking (Piaget, 1954) also provided a foundation for the development of cognitive therapies.

Blending the Two Theories

Following the work of Beck in applying the cognitive model to the treatment of depression (A. Beck, 1963, 1970, 1976), other cognitive therapies began to develop that blended the elements of behavioral therapy with cognitive therapy. The earliest of these cognitive-behavioral therapies (as noted in Dobson and Dozois, 2001) emerged in the early 1960s (e.g., Ellis, 1962), and the first major texts on cognitive-behavioral modification appeared in the mid- to late 1970s (e.g., Kendall and Hollon, 1979; Mahoney, 1974; Meichenbaum, 1977).

The "stress inoculation method" (Meichenbaum, 1975) involved teaching the individual mental coping skills and then practicing those skills when deliberately exposed to an external stressful situation. This cognitive approach had a strong behavioral therapy flavor, as does "systematic rational restructuring," which teaches the individual to modify internal sentences (thoughts) and then to practice the rational reanalysis of these thoughts through role playing and behavioral rehearsal (Goldfried, Decenteceo, and Weinberg, 1974). At the same time that behavioral theory was being added to cognitive practices, cognitive problem-solving therapies and training became prominent features of numerous behavioral treatment methods (D'Zurilla and Goldfried, 1971; Shure and Spivack, 1978; Spivack and Shure, 1974).

Thus, although behavioral therapies and cognitive approaches seemed to develop in parallel paths, over time the two approaches merged into what is now called cognitive-behavioral therapy. As Diane B. Arnkoff and Carol R. Glass of The Catholic University of America noted, "the line distinguishing behavior therapy from cognitive therapy has become blurred, to the point that cognitive-behavioral is a widely accepted term" (Arnkoff and Glass, 1992, p. 667). Similarly, G. Alan Marlatt of the University of Washington has remarked that the cognitive therapy of Ellis and Beck has over the years become progressively more behavioral while the behavioral therapy of Bandura and Meichenbaum has over the years become progressively more cognitive—together creating contemporary CBT (Marlatt, 1995, personal communication).

A review of the literature leads to the conclusion that the combining element of cognitive and behavioral approaches is found in the principle of "self-reinforcement." This concept simply states that cognitive and behavioral changes reinforce each other. When cognitive change leads to changes in action and behavior, there occurs a sense of well-being that strengthens the change in thought and in turn further strengthens the behavioral changes. This self-reinforcing feedback process is a key element of the cognitive-behavioral approach and is the basis for helping clients to understand the cognitive-behavioral process (see "The Cognitive-Behavioral Change Map," page 11).

Principles of CBT

CBT uses two basic approaches in bringing about change: (1) restructuring of cognitive events and (2) social and interpersonal skills training. The two approaches are built on two pathways of reinforcement: (1) strengthening the thoughts that lead to positive behaviors and (2) strengthening behavior due to the positive consequence of that behavior. The former has its roots in cognitive therapy, the latter in behavioral therapy. Together, they form the essential platform of CBT.

The Cognitive Focus of CBT: Cognitive Elements and Structures

Very early cognitive therapy theorists and practitioners focused on certain key cognitive structures and processes (e.g., A. Beck, 1976; A. Beck et al., 1979; Burns, 1989; Ellis and Harper, 1975). These processes are automatic thoughts and underlying assumptions and core beliefs.

Automatic thoughts. *Automatic thoughts* are short-term cognitive events. They seem to occur "without thought" or "automatically" as a response to external events (e.g., A. Beck, 1976, 1996; J. Beck, 1995; Freeman et al., 1990). These kinds of thoughts can also called "thought habits" in order to help clients understand that thinking habits are similar to behavioral habits, which can become the focus of change (Wanberg and Milkman, 1998, 2006).

Expectations, appraisals, and attributions are types of automatic thoughts. *Expectations* are thoughts that certain behaviors will bring certain outcomes (e.g., pleasure or pain). *Efficacy expectancy* (or *self-efficacy*) refers to an individual's assessment of his or her ability to successfully execute a particular behavior in an impending situation. If a person believes that he or she can perform a particular behavior, then most likely that individual will engage in that behavior. If the behavior is performed successfully, this reinforces the efficacy expectation.

This concept is of particular importance in the treatment of offenders. It is "perceived control." Efficacy expectations have a major effect on whether a person initiates a coping behavior and how much effort will be put toward implementing that coping behavior (Bandura, 1982). Self-efficacy is reinforced if the person copes successfully over time (Dimeff and Marlatt, 1995). Research has demonstrated that there is a strong association between an individual's level of perceived situational self-efficacy and that individual's actual level of performance accomplishments (Bandura, 1982).

Appraisals are the cognitive processes that continually evaluate the value and meaning of what an individual is experiencing as well as his or her responses to those experiences (Clark, 2004; Rosenhan and Seligman, 1995; Seligman, Walker, and Rosenhan, 2001). Often, cognitive appraisals become distorted and result in thinking errors. Identifying and changing thinking errors or distortions have become salient components of cognitive therapy. For example, an appraisal of the depressed person who experiences rejection might be

"I'm no good." This would also be classified as a thinking error or an error in logic. Appraisals, whether appropriate or distorted, usually precede and cause emotions (A. Beck, 1996). For example, the appraisal that "he's taking advantage of me" usually leads to the emotion of anger.

Attributions are the individual's explanation of why things happen or the explanation of outcomes of certain behaviors. An important part of attribution theory is where the individual sees the source of his or her life problems and successes (Rotter, 1966). This locus of control might be internalized ("I'm responsible for the accident") or externalized ("If they would have locked their doors, I wouldn't have ripped off their stereo"). Attributions can also be global or specific (Abramson, Seligman, and Teasdale, 1978). "I stole the car because life is not fair" is a global attribution whereas a specific attribution would be "I hit my wife because she yelled at me."

Underlying assumptions and core beliefs. The long-term cognitive processes—underlying assumptions and core beliefs—are less available to an individual's consciousness than automatic thoughts (Seligman, Walker, and Rosenhan, 2001). These mental processes are more durable and stable, and they help determine the short-term mental processes that are in the conscious state. Underlying assumptions and core beliefs can be seen as schemas, or organizational systems, that structure a person's automatic thinking (A. Beck, 1996).

One of the long-term cognitive processes is belief (Seligman, Walker, and Rosenhan, 2001). *Beliefs* are ideas that people use to judge or evaluate external situations or events. Changing irrational underlying core beliefs is a primary focus of cognitive therapy.

Most cognitive approaches see the process of treatment as starting with helping the client to identify automatic thoughts and cognitive distortions and then addressing the long-term underlying core beliefs that are associated with them (J. Beck, 1995; Dobson and Dozois, 2001; Freeman et al.,1990; Leahy, 1997). *Cognitive restructuring* (CR) is the main method and technique used to change cognitive processes and structures that have become maladaptive. "Self-talk" is a CR method that includes thought stopping, planting positive thoughts, countering, shifting the view, exaggerating the thought, etc. (see McMullin, 2000, for a resource in CR techniques). Other examples of cognitive restructuring approaches are training in problem-solving skills (D'Zurilla and Goldfried, 1971; D'Zurilla and Nezu, 2001); mood-management training (A. Beck, 1976; Monti et al., 1995); critical reasoning training (Ross, Fabiano, and Ross, 1986); and "rational responding," "scaling emotions," and "de-catastrophisizing" (Reinecke and Freeman, 2003).

The Behavioral Focus of CBT: Interpersonal and Social Skills

Coping and social skills training evolved over the last two decades of the 20th century to become an essential component of cognitive-behavioral therapy. It emerged out of social learning theory (Bandura, 1977) and has a solid empirical support from outcome research (Monti et al., 1995). Its premise is

that clients with maladaptive thinking and behavioral patterns lack adequate skills for facing daily issues and problems. There are a number of specific focal areas for interpersonal and social skill building (see Wanberg and Milkman, 1998, 2006, 2007 in press, for a comprehensive summary of these approaches). These include learning communication skills, assertiveness training, improving relationship skills, conflict resolution training, and aggression management.

The Community Responsibility Focus of CBT: Prosocial Skills Building

In the treatment of judicial clients, a third focus is added to the traditional CBT focus on cognitive restructuring and interpersonal skill building: developing skills for living in harmony with the community and engaging in behaviors that contribute to positive outcomes in society. This involves building attitudes and skills needed to be morally responsible and to develop empathy and concern for the welfare and safety of others (Little, 2000, 2001; Ross and Fabiano, 1985; Wanberg and Milkman, 1998). Traditional psychotherapy is egocentric; it helps individuals resolve their personal problems, feel better about themselves, and fulfill their inner goals and expectations. That certainly is an important component of the treatment of the judicial client. However, this egocentric psychotherapy, in and of itself, has failed to have significant impact on changing the thinking, attitudes, and behaviors of offenders (Wanberg and Milkman, 2006, 2007 in press). Therapy must also include a sociocentric approach to treatment that focuses on responsibility toward others and the community. This encompasses an emphasis on empathy building, victim awareness, and developing attitudes that show concern for the safety and welfare of others. It also includes helping offenders inculcate the belief that when a person engages in behavior that is harmful to others and society, they are violating their own sense of morality (Wanberg and Milkman, 2006).

Exhibit 1 (taken from the program Strategies for Self-Improvement and Change (SSC)) shows the composite of skills (relationship, cognitive self-control, and community responsibility) that form the basis for improved treatment outcomes in the areas of recidivism and relapse prevention and the attainment of more meaningful and responsible patterns of living (Wanberg and Milkman, 2006, 2007 in press).

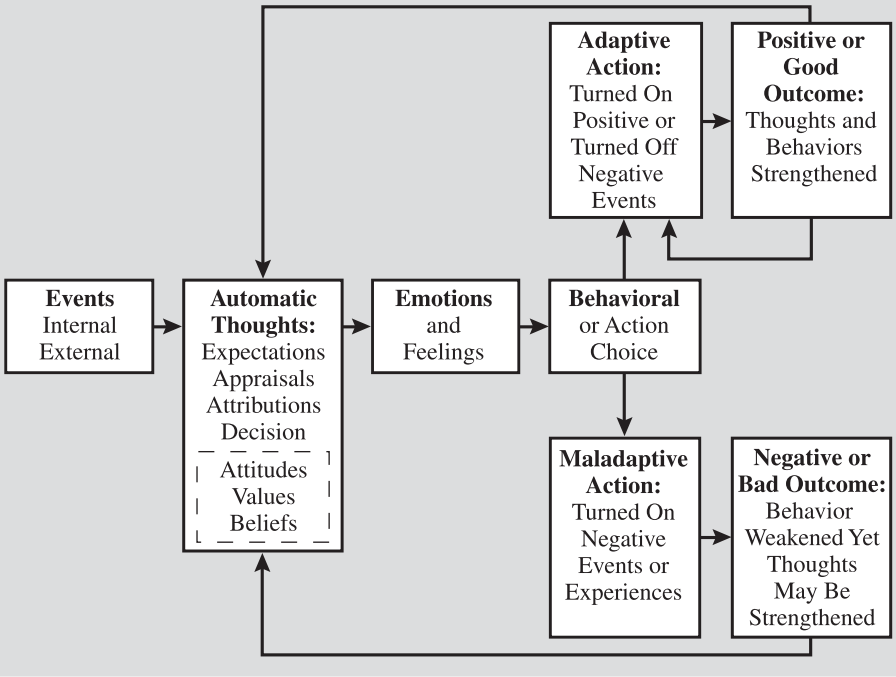
The Cognitive-Behavioral Change Map

Exhibit 2 illustrates how clients learn to restructure previous patterns of antisocial thought and behaviors (Wanberg and Milkman, 2006, 2007 in press). This cognitive-behavioral map is the centerpiece of the CBT rationale, providing a visual anchor for cognitive-behavioral restructuring. Clients use this model in individual or group settings to recognize high-risk situations, consider and rehearse lifestyle modifications, and learn a variety of strategies for identifying and changing distorted thinking processes through role plays and social skills rehearsal exercises.

EXHIBIT 1: SSC Goals and Objectives

SELF-CONTROL AND SELF-MANAGEMENT
Positive Outcomes and Responsible Living and Change

EXHIBIT 2: The Cognitive-Behavioral Map: The Process of Learning and Change



Note: Exhibits 1 and 2 are reprinted from *Criminal Conduct and Substance Abuse Treatment: Strategies for Self-Improvement and Change; The participant's workbook,* by K.W. Wanberg and H.B. Milkman (Thousand Oaks, CA: Sage Publications, 2006), with permission of the authors and the publisher.

The exhibit shows how events experienced by an individual trigger automatic thoughts (shaped by underlying beliefs), which are then translated into emotions that lead to behaviors. If an individual chooses a positive (adaptive) course of action (through rational thought and emotional control), or opts against a negative one (distorted thought and emotional dysregulation), the outcome will likely be good, which strengthens the recurrence of positive behavior and encourages positive thought processes. Conversely, if the individual chooses a negative (maladaptive) course of action, the outcome will likely be bad, strengthening more negative thought processes.

The Counselor's Role

The two most important components of intervention programs are the provider (counselor, therapeutic educator, or therapist) and the relationship between the provider and the client. Consequently, the two factors that seem to account for much of the success or failure of psychosocial therapies are the provider's personal characteristics and the strength of the therapeutic alliance (counselor-client relationship).

Personal Characteristics of the Counselor

After 50 years of studies, core provider characteristics have been identified for effective delivery of psychosocial therapies (Berenson and Carkhuff, 1967; Bohart, 2003; Carkhuff, 1969, 1971; Carkhuff and Berenson, 1977; Miller and Rollnick, 2002; Rogers et al., 1967; Truax and Mitchell, 1971; Wanberg and Milkman, 2006). Much of this research, and the description of the core characteristics, is based on the work of Carl Rogers and his associates (Rogers et al., 1967). They concluded that the communication of genuine warmth and empathy by the therapist alone is sufficient to produce constructive changes in clients. Other research determined that the most desirable characteristics that clients found in counselors were sensitivity, honesty, and gentleness (Lazarus, 1971).

Counselor-Client Relationship

A consistent finding in psychotherapy research over the past 20 years has been that, regardless of other factors, the strength of the therapeutic alliance has a strong impact on outcome. (Horvath and Symonds, 1991; Martin, Garske, and Davis, 2000). One study even concluded that a strong alliance is beneficial in and of itself and that a client may find a well-established alliance therapeutic regardless of other psychological interventions (Martin, Garske, and Davis, 2000). Similarly, there is evidence that a weakened or poor alliance is a good predictor of early, unilateral termination (Ford, 1978; Shick-Tyron and Kane, 1995).

The elements of the therapist-client relationship are central to verbal therapies, which are premised on acceptance, tolerance, and support (Bohart, 2003; Gurman and Messer, 2003; Lambert and Bergin, 1992; Wampold 2001). These are also seen as important elements in cognitive and behavioral therapies "as essential means for establishing the rapport necessary to motivate clients to complete treatment" (Lambert and Bergin, 1992). Clients who successfully

complete treatment have pointed to a number of relationship factors that are important to their change and improvement (Sloane et al., 1975). These involve being helped by the therapist to understand their problems, receiving encouragement from the therapist to practice facing the issues that bother them, being able to talk to an understanding person, and developing greater understanding from the therapeutic relationship.

Correctional Counseling Relationship

Clients within a correctional setting differ from noncorrectional clients in that they are required to attend education and treatment as part of their sentence. This means that counselors and therapeutic educators must integrate the therapeutic and correctional roles in delivering effective services to their clients. In fact, these professionals assume the role of "correctional practitioners."

There are some unique characteristics of the correctional counseling relationship that serve to enhance effectiveness in working with correctional clients. One research team has maintained that the provider should act as a model and demonstrate anticriminal expressions of behavior (Andrews and Bonta, 1994, 1998, 2003). Offenders look for antisocial characteristics and behaviors in others in order to justify their own antisocial and deviant behaviors. The effective correctional practitioner must be consistent and unerring in communicating prosocial and high moral values. Similarly, the provider must approve (reinforce) the client's anticriminal expressions and disapprove (punish) the client's procriminal expressions. Often, the latter requires going beyond disapproval to reporting violations of corrections policies and probation conditions.

CHAPTER 3

Prominent Cognitive-Behavioral Therapy Programs for Offenders

CBT programs, in general, are directed toward changing distorted or dysfunctional cognitions or teaching new cognitive skills and involve structured learning experiences designed to affect such cognitive processes. These processes include interpreting social cues, identifying and compensating for distortions and errors in thinking, generating alternative solutions, and making decisions about appropriate behavior.

Traditional cognitive-behavioral approaches used with correctional populations have been designed as either cognitive-restructuring, coping-skills, or problem-solving therapies. The cognitive-restructuring approach views problem behaviors as a consequence of maladaptive or dysfunctional thought processes, including cognitive distortions, social misperceptions, and faulty logic (e.g., Ross and Fabiano, 1985). The coping-skills approaches focus on improving deficits in an offender's ability to adapt to stressful situations. Problem-solving therapies focus on offenders' behaviors and skills (rather than their thought processes) as the element that is ineffective and maladaptive (Mahoney and Arnkoff, 1978). One study observed that most cognitive-behavioral programs developed for criminal offenders tend to be of the first type, focusing on cognitive deficits and distortions (Henning and Frueh, 1996).

Effective cognitive-behavioral programs of all types attempt to assist offenders in four primary tasks: (1) define the problems that led them into conflict with authorities, (2) select goals, (3) generate new alternative prosocial solutions, and (4) implement these solutions (Cullen and Gendreau, 2000).

Generally, cognitive-behavioral therapies in correctional settings consist of highly structured treatments that are detailed in manuals (Dobson and Khatri, 2000) and typically delivered to groups of 8 to 12 individuals in a classroom-like setting. Highly individualized, one-on-one cognitive-behavioral therapy provided by mental health professionals is not practical on a large scale within the prison system (Wilson, Bouffard, and Mackenzie, 2005).

There are six cognitive-behavioral programs that are widely used in the criminal justice system:

- Aggression Replacement Training® (ART®) (Goldstein and Glick, 1987).

- Criminal Conduct and Substance Abuse Treatment: Strategies for Self-Improvement and Change (SSC) (Wanberg and Milkman, 1998, 2007 in press).
- Moral Reconation Therapy® (MRT®) (Little and Robinson, 1986).
- Reasoning and Rehabilitation (R&R and R&R2) (Ross and Fabiano, 1985).
- Relapse Prevention Therapy (RPT) (Parks and Marlatt, 1999).
- Thinking for a Change (T4C) (Bush, Glick, and Taymans, 1997).

To date, MRT and R&R, have been more prevalently examined with respect to outcome evaluation (Wilson, Bouffard, and Mackenzie, 2005).

A description of each of the primary CBT programs for offenders is provided below along with summaries of published studies of program evaluation (when available).

Aggression Replacement Training®

Aggression Replacement Training® (ART®)* is a multimodal intervention originally designed to reduce anger and violence among adolescents involved with juvenile justice systems (Goldstein and Glick, 1987). More recently, the model has been adapted for use in adult correctional settings.

Based on previous work with at-risk youth, ART seeks to provide youngsters with prosocial skills to use in antisocial situations as well as skills to manage anger impulses that lead to aggressive and violent actions. It also seeks to increase their ability to view their world in a more fair and equitable manner by taking others' perspectives into account. Thus, ART is designed to train youngsters in what to do in anger-producing situations, using social skills training (Bandura, 1973; Goldstein et al., 1978); what not to do in anger-producing situations, using anger control training (Feindler, Marriott, and Iwata, 1984); and to consider others' perspectives using moral reasoning (Kohlberg, 1969; Gibbs and Potter, 1995). ART takes methods from each of these models and synthesizes them into a cognitive-behavioral intervention.

Social Skills Training

Social skills training (the behavioral component) teaches interpersonal skills to deal with anger-provoking events. It is based on the assumption that aggressive and violent youth have skill deficits and that this is related to their offending behaviors. The 10 social skills (5 cognitive and 5 affective) are:

- Making a compliment.
- Understanding the feelings of others.

* Aggression Replacement Training® (ART®) was awarded trademarks in 2004 by the U.S. Patent and Trademark Office protecting printed matter and training seminars, training programs, and their variants.

- Getting ready for difficult conversations.
- Dealing with someone else's anger.
- Keeping out of fights.
- Helping others.
- Dealing with accusations.
- Dealing with group pressure.
- Expressing affections.
- Responding to failure.

Anger Control Training

Anger control training (the affective component) seeks to teach at-risk youth skills to reduce their affective impulses to behave with anger by increasing their self-control competencies (Feindler, 1981; Novaco, 1975; Meichenbaum, 1977). Youth learn to identify those factors that create their anger and role-play ways to competently use self-control techniques. Topics include:

- Triggers (external events that cause emotions and the internal statements that increase angry responses).
- Cues (physical reactions that indicate anger arousal).
- Anger reducers (counting backwards, deep breathing, pleasant imagery).
- Reminders (self-statements that instruct youth in ways to reduce, reinterpret, or diffuse angry emotions and/or aggression).
- Self-evaluation (self-rewarding and self-coaching techniques to improve performance).
- Thinking ahead ("if-then" statements to identify consequences for one's actions).

Once youth have reduced their anger arousal by using these techniques, they decide upon an appropriate social skill (that they have already learned in social skills training) to use in an anger-provoking situation.

Moral Reasoning

Moral reasoning (the cognitive component) is a set of procedures designed to raise the young person's level of fairness, justice, and concern with the needs and rights of others.

Youth attend an hour-long class in each of these components (on separate days) each week for 10 weeks. ART is usually part of a differential program, prescriptively chosen to meet the needs of aggressive/violent youth (Glick, 2006, Goldstein and Stein, 1976).

Facilitator Training

The authors of the ART intervention place a strong emphasis on maintaining the integrity of its original design and have developed an accreditation process for those delivering the program. A detailed list of standards and practices, the criteria used to deliver ART, and specific training information is available from G & G Consultants, LLC at *www.g-gconsultants.org.*

Three levels of training are offered including:

- Group Facilitator (Trainer), a 36- to 40-hour didactic seminar.
- Trainer of Group Facilitator (Trainer), a minimum 4- or 5-day, 32- to 40-hour seminar that may include up to 280 hours of additional study once the group facilitators have implemented the program three times with their clients under supervision.
- Master Trainer, an individualized program for those with at least 5 years' experience delivering the program and at least 3 years as a trainer of group trainers.

Training materials used include *Aggression Replacement Training* (Goldstein, Glick, and Gibbs, 1998) and *Aggression Replacement Training: A Comprehensive Intervention for Aggressive Youth* (Goldstein and Glick, 1987).

Criminal Conduct and Substance Abuse Treatment: Strategies for Self-Improvement and Change

Strategies for Self-Improvement and Change (SSC) was developed by Kenneth Wanberg and Harvey Milkman (authors of this publication). It provides a standardized, structured, and well-defined approach to the treatment of clients who manifest substance abuse and criminal justice problems. It is a long-term (9 months to 1 year), intensive, cognitive-behavioral-oriented treatment program for adult substance-abusing offenders. The recommended client age is 18 years or older. However, some older adolescents may benefit from portions of the curriculum.

SSC can be presented in either a community or an incarceration setting. Phase I, which culminates in a comprehensive relapse and recidivism prevention plan, can serve as a stand-alone program that may be followed by Phases II and III either in aftercare settings or while monitored by correctional supervisory personnel.

SSC is behavioral oriented, skill based, and multimodal. It attends to both extrapersonal circumstances (events) and intrapersonal processes (thoughts, emotions, beliefs, attitudes) that lead to criminal conduct and substance abuse. The treatment curriculum for SSC consists of 12 treatment modules that are structured around the 3 phases of treatment. Each module is taught in a logical sequence with basic topics covered first, serving as the foundation for more difficult concepts covered later. Sessions are divided into three parts:

- Session introduction and rationale, which includes session objectives and key words.
- Session content and focus, which includes all of the exercises and worksheets.
- Summary of session activities and process group, which includes a scale that clients use to rate their level of knowledge and skills learned in the session and suggested topics for the group.

Overview of the Treatment Program

Phase I: Challenge to Change. This phase involves the client in a reflective-contemplative process. A series of lesson experiences is used to build a working relationship with the client and to help the client develop motivation to change. Sessions are also directed at providing basic information on how people change, the role of thought and behavior in change, and basic information about substance abuse and criminal conduct. A major focus of Phase I is to help the client develop self-awareness through self-disclosure and receiving feedback. The assumption underlying this approach is that self-disclosure leads to self-awareness, which in turn leads to self-improvement and change. The client is confronted with his or her own past and then challenged to bring that past into a present change focus. The goal is to get the client to define the specific areas of change and to commit to that change. This phase includes a review of the client's current alcohol/other drug use and criminal conduct, with the results of this review becoming a focus of the reflective-contemplative process. Each client undergoes an indepth assessment of his or her life situation and problems and looks carefully at the critical areas that need change and improvement. The individual identifies targets of change and, through ongoing process group feedback and counselor/client collaboration, develops a comprehensive relapse and recidivism prevention plan.

Phase II: Commitment to Change. This phase involves an active demonstration of implementing and practicing change. The focus is on strengthening basic skills for change and learning key CBT methods for changing thought and behavior that contribute to substance abuse and criminal conduct. Themes of these sessions include coping and social skills training with an emphasis on communication skills; managing and changing negative thoughts and thinking errors; recognizing and managing high-risk situations; managing cravings and urges that lead to alcohol and other drug use and criminal conduct; developing self-control through problem solving and assertiveness training; managing thoughts and feelings related to anger, aggression, guilt and depression; understanding and developing close relationships; and understanding and practicing empathy and prosocial values and moral development. Social responsibility therapy (SRT) is a strong part of Phase II.

Phase III: Ownership of Change. This phase, the stabilization and maintenance phase, involves the client's demonstration of ownership of change over time. This involves treatment experiences designed to reinforce and strengthen the commitment to established changes. This phase includes a review of

the concepts of relapse and recidivism prevention and sessions on critical reasoning, conflict resolution, and establishing and maintaining a healthy lifestyle. Change is strengthened though helping the client become involved in a variety of auxiliary methods, including mentoring, role modeling, self-help groups, and other community-based recovery maintenance resources. This phase also provides skills training in managing work and leisure time activities.

Screening and Assessment

An important component of SSC is the screening and assessment process. The client is engaged in the assessment process as a partner with the provider, with the understanding that assessment information is just as valuable to the client as to the provider and that change is based on self-awareness. One module is devoted to engaging the client in an indepth, differential assessment process, having the client investigate areas of change that are needed, and then constructing a master profile and a master assessment plan that the client can use as a guide for change. A variety of instruments and procedures are recommended to enhance this partnership assessment approach.

An effective assessment approach recognizes that there is a general influence of certain problems on a person's life and within that problem area there occurs a wide variety of differences among people (Wanberg and Horn, 1987). For example, alcohol has a general influence on the life of the alcohol-dependent individual. Yet, individuals who have alcohol problems differ greatly. Some are solo drinkers and others drink at bars; some have physical problems from drinking and others do not; some drink continuously, some periodically.

Assessment, then, should consider these two levels of evaluation. Assessment of the general influence is the basis of screening. Looking at the more specific influences and problem areas involves the application of a differential or multidimensional assessment.

SSC structures the differential assessment around five broad areas:

- **Assessment of alcohol and other drug (AOD) use and abuse.** Inclusion guidelines for AOD services are provided with both minimum symptom criteria and descriptions of psychometric tests. The framework includes identifying the types of drugs used and the perceived benefits and real consequences and concerns of use. The assessment process employs a variety of tools, including self-report questionnaires and participation in reflection groups.
- **Assessment of criminal conduct.** A key focus in this assessment area is the extent of antisocial patterns, including criminal associations and criminal attitudes. Risk factor assessment focuses on the modifiable, crime-inducing needs of the offender. Another area of assessment is the identification of patterns of criminal thinking and thinking errors. The "thought report" is a foundational assessment tool used throughout this process.

- **Assessment of cognitive and affective (emotional) processing.** Through assessment, understanding, conceptualizing, and intervening, treatment helps the client to understand and control emotions and actions, which in turn will influence his or her thought processes.
- **Assessment of life-situation problems.** There are several areas of assessment other than AOD and criminal conduct that SSC addresses at both the screening and more indepth levels of evaluation. These areas are social-interpersonal adjustment; psychological-emotional adjustment; work and finances; marriage, family, and relationships; and health.
- **Assessment of motivation and readiness for treatment.** Work on stages of change (Prochaska and DiClemente, 1992; Prochaska, DiClemente, and Norcross, 1992) has made it clear that an essential component of assessment is that of determining the client's readiness and motivation for treatment. The area of treatment motivation and readiness should be assessed during the clinical intake interview. A number of questions and issues can be addressed to evaluate this area: willingness to be involved in treatment; whether the person feels a need for help at the present time; whether the client has thought about making changes in particular areas; whether the client has actually made deliberate changes; the degree of problem awareness; and whether others feel that the client should make changes or needs help.

Facilitator Training

Facilitator training sessions in SSC methods run for a total of 26 hours and are held frequently across the United States. They are presented twice annually through the Center for Interdisciplinary Services in Denver, Colorado.

Moral Reconation Therapy®

Developed by Greg Little and Ken Robinson between 1979 and 1983 for use in prison-based drug treatment therapeutic communities, Moral Reconation Therapy® (MRT®)* is a trademarked and copyrighted cognitive-behavioral treatment program for offenders, juveniles, substance abusers, and others with "resistant personalities." Although initially designed specifically for criminal justice-based drug treatment, MRT has since been expanded for use with offenders convicted of driving while intoxicated (DWI), domestic violence, and sex offenses; parenting skill and job attitude improvement; and to address general antisocial thinking.

The term "moral reconation" was coined in 1972. "Conation" is an archaic term that was used in psychology until the 1930s, when the term "ego" replaced it. It refers to the conscious, decisionmaking portion of one's personality. "Reconation" implies a reevaluation of decisions. "Moral" indicates the process of making correct, prosocial decisions about behaviors.

* Moral Reconation Therapy® (MRT®) was awarded its first federal trademark in 1995.

MRT is based on the experiences of its authors, who noted that offenders were often highly functional during stays in therapeutic communities but returned to criminal behaviors after release. They felt that the offenders' character and personality traits that led to failure were not being addressed.

The underlying theory of MRT is that offenders and drug abusers have low moral reasoning. It is based on Lawrence Kohlberg's (1976) theory that moral development progresses through six stages and only a few members of the adult population attain the highest level (see Wilson, Bouffard, and MacKenzie, 2005). MRT's authors state that "clients enter treatment with low levels of moral development, strong narcissism, low ego/identity strength, poor self-concept, low self-esteem, inability to delay gratification, relatively high defensiveness, and relatively strong resistance to change and treatment" (Little and Robinson, 1986, p. 135). These traits lead to criminal activity, whereas those who have attained high levels of moral development are not likely to behave in a way that is harmful to others or violates laws. MRT is designed to improve clients' reasoning levels from self-centered ones to those that involve concern for the welfare of others and for societal rules. It draws a clear connection between thought processes and behavior (Wilson, Bouffard, and MacKenzie, 2005).

The program was initially used at the Federal Correctional Institute in Memphis and continued to be refined until Little and Robinson's workbook for adult offenders entitled *How to Escape Your Prison* was published in 1986. It has been revised numerous times since. In 1987, MRT was implemented at Memphis's Shelby County Jail for use with female offenders. The program continued to expand, and today MRT is used in more than 40 states as well as Canada and Puerto Rico.

Nine personality stages of anticipated growth and recovery are identified in the program:

- **Disloyalty:** Typified by self-centered behavior and a willingness to be dishonest and blame and victimize others.
- **Opposition:** Includes the same behaviors as "disloyalty," only occurring less often.
- **Uncertainty:** Person is unsure of how he or she stands with or feels about others; these individuals still make decisions based on their own pain or pleasure.
- **Injury:** Destructive behavior still occurs, but recognition of the source of the problem also occurs; some responsibility for behavior is taken and some decisions may be based on consequences for others.
- **Nonexistence:** Person feels alienated from things but has a few satisfying relationships; these individuals sway between making decisions based on formal rules and decisions based on pleasure and pain.

- **Danger:** Person commits to goals and makes decisions primarily on law and societal values; when regression occurs, these individuals experience anguish and loss of self-esteem.
- **Emergency:** Social considerations are made, but "idealized ethical principles" influence decisionmaking.
- **Normal:** These individuals are relatively happy, contented people, who have chosen the right goals for themselves and are fulfilling them properly; decisionmaking based on pleasure and pain has been virtually eliminated.
- **Grace:** The majority of decisions are based on ethical principles; supposedly, only a small percentage of adults reach this stage.

Curriculum

MRT is conducted in open-ended groups that may meet once a month or up to five times per week. Group size can vary from 5 to more than 20. Groups are structured and address issues such as:

- Confronting personal beliefs.
- Assessing relationships.
- Facilitating identity development.
- Enhancing self-esteem.
- Decreasing hedonism.
- Developing tolerance for the delay of gratification.

Homework tasks and exercises are completed outside of the group and then presented to group members during meetings. MRT does not require high reading skills or high mental functioning levels, as participants' homework includes making drawings or writing short answers. The most important aspect of the treatment is when the participant shares work with the group. The facilitator is trained to ask appropriate questions concerning the exercises and to maintain focus on the participants' completion of MRT's 16 steps, which are:

- **Steps 1 and 2:** Client must demonstrate honesty and trust.
- **Step 3:** Client must accept rules, procedures, treatment requirements, and other people.
- **Step 4:** Client builds genuine self-awareness.
- **Step 5:** Client creates a written summary to deal with relationships that have been damaged because of substance abuse or other antisocial behavior.

- **Step 6:** Client begins to uncover the right things to do to address the causes of unhappiness.
- **Step 7:** Client sets goals.
- **Step 8:** Client refines goals into a plan of action.
- **Step 9:** Client must continue to meet timetables he or she set up.
- **Step 10:** Client conducts a moral assessment of all elements of his or her life.
- **Step 11:** Client reassesses relationships and forms a plan to heal damage to them.
- **Step 12:** Client sets new goals, for 1 year, 5 years, and 10 years, with a focus on how accomplishment of the goals will relate to happiness.
- **Steps 13–16 (optional):** Involves client's confrontation of the self with a focus on an awareness of self. Goals continue to be defined and expanded to include the welfare of others.

Activities

These activities are mandatory for clients in Moral Reconation Therapy:

- Client must become honest at the beginning of the treatment.
- Client must display trust in the treatment program, other clients, and staff.
- Client must become honest in relationships with others and actively work on improving relationships.
- Client must begin actively to help others in need of help and accept nothing in return; he or she must perform a major amount of public service work for those in need (again, accepting nothing in return).
- Client must perform an ongoing self-assessment in conjunction with receiving assessments from other clients and staff; these assessments require that clients be morally accountable on all levels of functioning: their beliefs, their attitudes, and virtually all their behavior.

Facilitator Training

Facilitator training sessions in MRT methods run for 32 hours and are held frequently across the United States. Sessions are offered monthly in Memphis, Tennessee, and frequently in other locations throughout the United States. For further information on training schedules, contact the *Cognitive-Behavioral Treatment Review & Moral Reconation Therapy News* at 3155 Hickory Hill Suite 104, Memphis, TN 38115, 901–360–1564; e-mail: CCIMRT@aol.com; Web sites: *www.ccimrt.com* and *www.moral-reconation-therapy.com.* Louisiana State University at Shreveport issues continuing education units for accredited trainers.

Reasoning and Rehabilitation

Developed by Robert Ross and Elizabeth Fabiano in 1985 at the University of Ottawa, Reasoning and Rehabilitation (R&R) is a cognitive-behavioral program that, like MRT, is based on the theory that offenders suffer from cognitive and social deficits (see Ross, Fabiano, and Ross, 1986). Ross and Fabiano's research that stands as the basis for the principles of R&R was published in the text *Time to Think: A Cognitive Model of Delinquency Prevention and Offender Rehabilitation* (1985). The techniques used in this program were modified from techniques used in previous correctional programs as well as methods that the authors found to be of value when used with offenders. They were field tested in an experimental study with high-risk probationers in Ontario, Canada.

The authors attempted to provide a program that could be used in a broad range of institutional or community corrections settings as well as one that could be used concurrently with other programs in which offenders may participate. They encourage significant individuals in the offender's life to be familiar with the program principles so that they can reinforce and encourage the offender in skill acquisition.

Approach

This program focuses on enhancing self-control, interpersonal problem solving, social perspectives, and prosocial attitudes (see Wilson, Bouffard, and MacKenzie, 2005). Participants are taught to think before acting, to consider consequences of actions, and to conceptualize alternate patterns of behavior. The program consists of 35 sessions, running from 8 to 12 weeks, with 6 to 8 participants. The sessions include audiovisual presentations, games, puzzles, reasoning exercises, role playing, modeling, and group discussions. The program developers sought to ensure value and appeal of the materials to offenders, thereby providing a program that is both enjoyable yet demanding. Session topics include problem-solving techniques (e.g., information gathering, conceptualizing, alternative thinking, assertive communication), creative thinking, social skills, managing emotions, negotiation, critical reasoning, and values. Also important are learning to respond to complaints, being openminded, and responding to the feelings of others.

R&R's authors believe that highly trained professionals (e.g., psychiatrists, psychologists, social workers) may not always be the ones implementing rehabilitation programs, and therefore took steps to ensure that line staff would also be adept at implementing the program, as long as they possess the following characteristics:

- Above-average verbal skills.
- Ability to relate empathetically to offenders while maintaining rules, regulations, and the mission of the correctional agency.
- Sensitivity to group dynamics.
- Ability to confront offenders but not demean them.

- Above-average interpersonal skills.
- Successful experience managing unmotivated, hostile, or critical individuals.
- Humility and the consideration of others' views.
- Enthusiasm.
- Understanding of the cognitive model.

Trainers are encouraged to add to or modify the program to best serve specific types of offenders. The authors make note of the importance of trainers presenting the material just above the functioning level of the offenders so as to be challenging, yet not overwhelming or discouraging.

R&R2

A shorter version of R&R, known as R&R2, is a program specifically for adults that was developed by Robert Ross and Jim Hilborn in 1996. This is a specialized, 15-session edition that seeks to target those over age 18 whose antisocial behavior led them to social services or criminal justice agencies.

The authors of R&R2 believe that long-term intervention can both "tax the motivation of many offenders and [be] associated with high attrition rates"; it can also tax the motivation of trainers and overburden agency budgets (Ross and Hilborn, 2007 in press, p. 16). The authors also note that evaluation reviews have concluded that the largest effects, proportionally, occur when cognitive programs are small and that shorter cognitive skills programs can be as effective as longer ones.

R&R2 is also designed to correct a shortcoming of previous versions that did not allow the program to be tailored to the needs and circumstances of the group recipients (Ross and Hilborn, 2007 in press). The new program offers specialized versions specific to age, sex, nature of the antisocial behavior, risk of recidivism, and culture.

R&R2 principles include:

- Motivational interviewing.
- Prosocial modeling.
- Relapse prevention.
- Desistance (encouragement to acquire a long-term prosocial lifestyle).

R&R2 program objectives, as with the original, are designed to increase prosocial competence among the participants. Additional objectives include:

- **Provider assessment.** This program can be used as an assessment device, with the participant's performance providing a more complete measure of cognitive functioning than testing alone. It can also direct the

provider toward needs for other programs, including the more specialized versions of R&R2.

- **Participant assessment.** R&R2 allows participants to experience CBT and assess whether they may be open to further program treatments.
- **Motivation.** Participants may become engaged in the process and more motivated to get involved in longer treatment programs.
- **Preparation.** Often, programs require a higher level of cognitive skills than many participants possess. R&R2 allows them to learn the skills required to continue with cognitive behavioral programs.

An IQ of approximately 70 or higher, as shown by prescreening, is necessary for participants to benefit from this training. Any severe psychopathology should be predetermined as well, so that one participant's disruptiveness will not interfere with the other participants' progress.

The authors emphasize their consideration of the "Risk Principle"; that is, they concede that high-risk offenders' engagement with low-risk offenders within the program may provide modeling of delinquent behaviors. Separate groups for low-risk offenders are therefore important. (On the other hand, individuals who have learned more prosocial behaviors could be included with high-risk offenders to serve as role models.)

The ideal implementation of R&R2 is to teach low-risk offenders the skills to function prosocially and avoid being involved in longer programs with high-risk offenders. According to the authors, the trainer's observations of the participants' performance in the shorter program may also help them identify those who are most likely to be harmed by their enrollment in programs alongside high-risk offenders.

The R&R2 program does not require participants to discuss their illegal behavior. Trainers are encouraged to redirect antisocial talk or behavior when it occurs within the group toward more acceptable and positive discussions.

The program provides just over 1,000 minutes of actual training. Lessons require the transfer of cognitive skills to real-life events, and every one of the 16 sessions has homework assignments. Each session includes time for feedback from participants on their observations and experiences that occurred between sessions. R&R2 manuals include the "Handbook," which is a detailed instruction manual for trainers that has all materials required for each session, and the "Participant's Workbook," which contains handouts, exercises, and worksheets that should be available for each participant. The ideal group size is 8 participants or, depending on the characteristics of the group, no less than 4 and no more than 10. R&R2 requires no special facilities, although an overhead projector and flip chart are needed. The manual suggests a preferred room setup. Sessions are flexible, but two to three 90-minute sessions per week are suggested. Staggering entry into the program is possible and trainers can provide new entrants with "catchup" sessions.

The authors caution that R&R2 should not be considered only an "offending behavior" or "therapeutic" program. They assert that it is an "approach to the treatment not only of criminal behavior but of a variety of antisocial behaviors" (Ross and Hilborn, 2007 in press, p. 21). It is a way of equipping antisocial individuals with the skills and attitudes necessary to help them avoid future problems or to cope with problems more effectively.

Facilitator Training

Those interested in learning to facilitate Ross and Fabiano's Reasoning and Rehabilitation program are directed to their *Reasoning and Rehabilitation: A Handbook for Teaching Cognitive Skills,* T3 Associates, Ottawa, Ontario.

Relapse Prevention Therapy

As described by authors George A. Parks and G. Alan Marlatt (2000), Relapse Prevention Therapy (RPT) was originally developed to be a maintenance program to prevent and manage relapse following addiction treatment. Designed to teach individuals how to anticipate and cope with relapse, RPT rejects the use of labels such as "alcoholic" or "drug addict," and encourages clients to think of their addictive behavior as something they *do* rather than something they *are*.

RPT uses techniques from cognitive-behavioral coping-skills training to teach clients self-management and self-control of their thoughts and behavior. This approach views addictive behaviors as acquired habits with "biological, psychological, and social determinants and consequences" (Marlatt, Parks, and Witkiewitz, 2002, p. 2). Since impaired judgment and loss of impulse control are often associated with alcohol and drug abuse, the program has also been used as a component in treating aggression and violent behavior (Cullen and Freeman-Longo, 2001) as well as sex offending (Laws, Hudson, and Ward, 2000). Most recently, RPT has been extended as a case management tool applicable to any type of criminal conduct (Parks et al., 2004).

Approach

Parks and Marlatt (2000) indicate that 75 percent of relapses, as reported by Marlatt and Donovan (2005), were due to three categories of high-risk situations: negative emotional states, interpersonal conflict, and social pressure. More recently, relapse determinants have been categorized into a total of eight types (Marlatt, Parks, and Witkiewitz, 2002). One is "Intrapersonal-Environmental Determinants," which are associated with factors within the individual and reactions to nonpersonal events. This includes coping with negative emotions, dysphoric states, and reactions to stress (exams, public speaking, financial difficulties, etc.). Another category is "Interpersonal Determinants," which includes factors surrounding the presence or influence of others, such as interpersonal conflict, frustration and anger, and social pressure (either direct or indirect).

RPT proposes that relapse is less likely to occur when an individual possesses effective coping mechanisms to deal with such high-risk situations. With this, the individual experiences increased self-efficacy and, as the length of abstinence from inappropriate behavior increases and effective coping with risk situations multiplies, the likelihood of relapse diminishes.

RPT involves five therapeutic strategies:

- Coping-skills training, which teaches ways to handle urges and cravings that occur in early stages of the habit change journey.
- "Relapse Road Maps," which are used to identify tempting and dangerous situations, with "detours" presented for avoiding these situations and successfully coping without having a lapse or relapse.
- Strategies to identify and cope with cognitive distortions, such as denial and rationalization, that can increase the possibility of relapse with little conscious awareness.
- Lifestyle modification techniques, so that alcohol or drug use is replaced with constructive and health-promoting activities and habits.
- Learning to anticipate possible relapses, with unrealistic expectations of perfection replaced with encouragement to be prepared for mistakes or breakdowns and skills taught on how to learn from those mistakes and continue on.

RPT begins with the identification of an individual's high risk for situations where relapse could occur and with an evaluation of his or her ability to cope with those situations. Indepth programs of change are necessary because it is impossible to identify all the possibilities for high-risk situations for any one client. Marlatt, Parks, and Witkiewitz (2002) identified two additional required aspects: helping clients create a balanced lifestyle to increase their capacity to deal with stress and, therefore, increase self-efficacy; and teaching an identification process toward early warning signs of high-risk situations and ways to evoke self-control strategies to prevent relapse.

In summary, RPT clients are taught to:

- Understand relapse as a process, not an event.
- Identify and cope with high-risk situations.
- Cope effectively with urges and cravings.
- Implement damage control procedures during lapses to minimize their negative consequences and get back on the road to recovery.
- Stay engaged in treatment, particularly after relapses occur.
- Create a more balanced lifestyle.

Facilitator Training

Workshops of 1 to 5 days are offered by the Addictive Behaviors Research Center at the University of Washington in Seattle. Programs focus on several key themes and are flexible to meet the needs of different organizations and trainees. Topics include Cognitive-Behavioral Therapy for Offenders 101, Cognitive-Behavioral Offender Substance Abuse Treatment, Relapse Prevention with Offenders, Integrated Treatment of Co-Occurring Disorders, Offender Re-Entry Planning, and Relapse Prevention as an Offender Case Management Tool.

Consultation and technical assistance on implementing Cognitive-Behavioral Programs is also available. Contact George A. Parks, Ph.D., Department of Psychology, Box 351629, University of Washington, Seattle, WA 98195–1629, 206–685–7504.

Thinking for a Change

In December 1997, the National Institute of Corrections (NIC) introduced a new integrated cognitive-behavioral change program for offenders and sought a limited number of local, state, or federal correctional agencies to serve as field test sites for the program, Thinking for a Change (T4C). An overwhelming response from the corrections community requesting participation in the project necessitated immediate program expansion and the inclusion of a much broader scope of participation for the field test. Since its introduction, correctional agencies in more than 40 states have implemented T4C with offender populations. These agencies include state correctional systems, local jails, community-based corrections programs, and probation and parole departments. The offender populations included in the project represent both adults and juveniles and males and females. More than 5,000 correctional staff have been trained to facilitate offender groups. Nearly 500 individuals have participated in Thinking for a Change: Advanced Practicum (Training of Trainers), which enables participants to train additional facilitators at their agencies to deliver the program. As research of the effectiveness of the program continues to mount, so does the interest from the correctional community to adopt a quality, evidenced-based cognitive-behavioral change program.

Approach

T4C (Bush, Glick, and Taymans, 1997) uses a combination of approaches to increase offenders' awareness of self and others. It integrates cognitive restructuring, social skills, and problem solving. The program begins by teaching offenders an introspective process for examining their ways of thinking and their feelings, beliefs, and attitudes. This process is reinforced throughout the program. Social-skills training is provided as an alternative to antisocial behaviors. The program culminates by integrating the skills offenders have learned into steps for problem solving. Problem solving becomes the central approach offenders learn that enables them to work through difficult situations without engaging in criminal behavior.

Offenders learn how to report on situations that could lead to criminal behavior and to identify the cognitive processes that might lead them to offending. They learn how to write and use a "thinking report" as a means of determining their awareness of the risky thinking that leads them into trouble. Within the social skills component of the program, offenders try using their newly developed social skills in role-playing situations. After each role-play, the group discusses and assesses how well the participant did in following the steps of the social skill being learned. Offenders also apply problem-solving steps to problems in their own lives. Written homework assignments, a social skills checklist, and input from a person who knows the participant well are all used by the class to create a profile of necessary social skills, which becomes the basis for additional lessons. Through a variety of approaches, including cognitive restructuring, social-skills training, and problem solving, T4C seeks to provide offenders with the skills as well as the internal motivation necessary to avoid criminal behavior.

The broad spectrum of the program's sessions makes T4C meaningful for a variety of offenders, including adults and juveniles, probationers, prison and jail inmates, and those in aftercare or on parole. A brief 15-minute prescreening session to reinforce the participant's need for the program and the necessity of positive participation is the first step in T4C. Small groups of 8 to 12 individuals are encouraged in order to facilitate interactive and productive feedback. The program can be used concurrently or consecutively with other treatment programs.

The curriculum is divided into 22 lessons, each lasting 1 to 2 hours. No more than one lesson should be offered per day; two per week is optimal. It is recommended that at least 10 additional sessions be held using the social skills profile developed by the class (as noted above). Lessons are sequential, and program flow and integrity are important; however, in situations of high turnover or movement to other facilities, some sessions can be used as points to reorganize or combine existing groups, freeing up one facilitator to work with a new set of offenders.

The program is available online, on CD–ROM, or via a "distance learning" program of tapes. A Spanish translation is also available online or on CD–ROM. Exhibit 3 (page32) presents an overview of the T4C program.

Facilitator Training

Training for facilitators of T4C is readily available on the NIC Web site, *www.nicic.org*. Included are:

- A 2-day curriculum entitled "What Are They Thinking?" (created by the Dallas County Community Supervision and Corrections Department, Dallas, Texas, 2004) is available at *www.nicic.org/Library/020100*. This program covers the Thinking Reports and Problem Solving processes that are used in T4C. Theoretical foundations and evidence justifying the use

EXHIBIT 3: Overview of Thinking for a Change

- Twenty-two lessons with capacity to extend program indefinitely.
- Additional 10 lessons recommended for participants to explore self-evaluations done in the 22nd lesson.
- One to two hours weekly.
- Facilitators need not have any specific credential or level of education, but must:
  - Be caring.
  - Like to teach.
  - Understand group processes and interpersonal interactions.
  - Be able to control an offender group.
  - Be trained in a 3- to 5-day T4C implementation plan with two master trainers.
- Lesson format: Understand, learn, perform.
  - Homework review.
  - Summary and rationale for the specific lesson.
  - Definition of words and concepts.
  - Activities:
    - Skits.
    - Modeling.
    - Feedback.
    - Overheads.
    - Handouts.
    - Pocket cards.

of CBT are highlighted as well as ways to use T4C in offender supervision and demonstration and observation of the techniques involved. A PowerPoint presentation for use with the curriculum can be found at *www.nicic.org/downloads/ppt/020100-ppt.ppt*.

- *A Manual for Delivery of Cognitive Self Change* (written by Jack Bush of the Vermont Department of Corrections, 2002) is available in PDF format at *www.nicic.org/Library/021558*. The manual is an indepth guide to utilization of the T4C program and includes an overview of Cognitive Self Change, the Thinking Report, Cognitive Check-ins; delivery of the program, case management, program standards, and administrative procedures; admission, discharge, and transfer procedures; group delivery,

program management, and supervision; and helpful forms and program memoranda.

- Thinking for a Change: Facilitator Training: Lesson Plans (developed by T4C creators Jack Bush, Barry Glick, and Juliana Taymans, 2001) is a 32-hour training program designed to teach the theoretical foundations of CBT and specifically the basic components of T4C, including cognitive self-change, social skills, problem solving, and implementation of the program. This file is available in ZIP format at *www.nicic.org/Library/017124*.

CHAPTER 4

Measuring the Effectiveness of Rehabilitation Programs

There are several potent obstacles in measuring the effectiveness of rehabilitation programs. First, tracking the offender over time is difficult because of offenders' geographic instability and the difficulty in accessing accurate judicial records. Second, it is possible a reduction in the number of reoffenses might be attributed to treatment; however, conclusive evidence from meta-analysis simply does not exist. One study identified just 19 reentry program evaluations that contained a comparison group (Seiter and Kadela, 2003). Only two of these evaluations were randomized experiments. Further, determining if an offender has been slowed in reoffending cannot be tracked and there is no consideration of types of offenses; a more violent offense is often included or categorized with less violent infractions. In addition, there are no objective criteria for determining the relative seriousness of the reoffense. Finally, omission of unpublished studies can upwardly bias the findings of a review (Hedges, 1990; Lipsey and Wilson, 2001).

Because most outcome evaluations are based on recidivism, there are many positive treatment outcomes that are rarely measured. For example, one of the positive results of a female offender's engagement in treatment is that her children are much less likely to be born drug-addicted (Travis, 2003). When recidivism is used as the sole criterion for judging a program's viability, the longer term impact of program participation may be missed.

However, from a research standpoint, the broader definitions are too conceptual and all-encompassing to be of much use in evaluating program success. A narrower definition of program success (i.e., reduced recidivism) makes the evaluation task manageable, even if it fails to capture the range and diversity of assistance to the offender and benefit to the community. Therefore, from a research perspective, most studies focus on recidivism as the unit of measure in determining a program's effectiveness.

Recidivism and CBT

As previously noted, Robert Martinson concluded that rehabilitation programs in the prison system "have had no appreciable effect on recidivism" (Martinson, 1974). Since that time, however, an abundance of research has shown positive effects of cognitive-behavioral approaches with offenders. At the same time that cognitive-behavioral treatments have become dominant in

clinical psychology (Dobson and Khatri, 2000), many studies report that recidivism has been decreased by cognitive-behavioral interventions (e.g., Allen, MacKenzie, and Hickman, 2001; Andrews et al., 1990; Cullen and Gendreau, 1989; Ditton, 1999; Gendreau and Ross, 1987; Husband and Platt, 1993; MacKenzie and Hickman, 1998; Walker et al., 2004).

A meta-analysis of 69 studies covering both behavioral and cognitive-behavioral programs determined that the cognitive-behavioral programs were more effective in reducing recidivism than the behavioral programs (Pearson et al., 2002). The mean reduction in recidivism was about 30 percent for treated offenders. Other meta-analyses of correctional treatment concluded that cognitive-behavioral methods are critical aspects of effective correctional treatment (Andrews et al., 1990; Losel, 1995). Yet another study similarly determined that the most effective interventions are those that use cognitive-behavioral techniques to improve cognitive functioning (Gendreau and Andrews, 1990).

Factors That Determine Effect Size

Multiple factors can determine effect size. For example, the definition of recidivism can significantly determine statistical outcomes. If one defines recidivism as rearrest after intervention, the effect size will be significantly lower (i.e., treatment appears less beneficial) than it would be if recidivism were defined as reconviction or reincarceration.

Other factors relate to variation in recidivism effects. When offenders who were defined as being at high risk to reoffend were treated through CBT, they actually reoffended less after treatment than low-risk offenders. The number of sessions and fewer dropouts due to quality control monitoring created more effect size. Further, for treatment of high-risk offenders, treatment providers received greater levels of CBT training, which were associated with larger effects.

CBT programs designed for research or demonstration purposes (in contrast to "real world," routine-practice programs) were also associated with larger effects. Research and demonstration programs included smaller sample sizes, providers with mental health backgrounds, greater monitoring of quality control, and greater monitoring of offender attendance and adherence to treatment. The quality of the CBT was thus a major factor in determining the treatment effectiveness.

Another critical factor in the evaluation of program efficacy is whether the program includes anger control and interpersonal problem solving. Additionally, successful CBT programs include multiple sessions per week and/or added individual meetings to increase the frequency of offender contact; a low number of treatment dropouts; quality control review of treatment application; and attendance monitoring. According to one meta-analysis, none of the major CBT "brand name" programs (i.e., the ones

discussed in this publication) produced effects on recidivism that were significantly larger than the average effects of the other programs (Lipsey and Landenberger, 2006).

CHAPTER 5

Evaluating Specific CBT Curricula

While there are too many moderating variables (e.g., staff training and supervision, length of contact in treatment, aftercare provisions, quality control) to identify a specific CBT program as superior in achieving measurable treatment outcomes, there have been significant efforts to demonstrate the effectiveness of standardized CBT curricula.

Studying the Effectiveness of Aggression Replacement Training®

Ramsey County Juvenile Probation and Uniting Networks for Youth collaborated to improve outcomes for those in the juvenile justice system, specifically, those with a medium-to-high risk of reoffending. The Wilder Research Center conducted an evaluation summary of Aggression Replacement Training (ART) between the fall of 2002 and the fall of 2004 with 295 youth who received ART (Hosley, 2005). Four agencies provided the services, including a residential program, a school-based program, and two community-based programs. The youth were racially and culturally diverse (39 percent black, 28 percent white, 24 percent Asian, 6 percent Latino, and 3 percent of another or mixed race). Ninety-two percent were male, mostly between the ages of 14 and 17. Two-thirds had received previous interventions.

Hosley (2005) points out that while 77 percent of the youth had an offense in the year prior to entering ART, only 31 percent had an offense in the year after participating. Although this reoffense rate is described as similar to the overall rate of reoffending among all Ramsey County youth, those who participated in ART were described prior to participation as being generally at a higher risk for reoffending. Even though many participants were reported to have continued problems at school, between 80 and 90 percent were still in school 3 months after the ART program. Eighty percent of the youth also reported at 3 months post-ART that it had made a positive difference in their lives (Hosley, 2005, p. 2).

Hosley (2005) reported positive feedback from youth and their families concerning their satisfaction with the services and staff who provided ART. Twenty-five items showed statistically significant increases, with the largest improvements in the following areas:

- Understanding someone's anger.
- Handling it well when accused.
- Figuring out methods other than fighting.
- Thinking of one's abilities before beginning a new task.
- Apologizing to others.
- Staying out of situations portending trouble.
- Asking permission when appropriate.
- Handling complaints fairly.
- Figuring out what caused a problem.

Hosley (2005) points out that research with comparisons to control groups will be necessary to more strongly correlate the use of ART in reduction of aggressive behavior; improved emotional, behavioral, and cognitive health; and, ultimately, a decrease in recidivism with juvenile or adult offenders.

Studying the Effectiveness of Criminal Conduct and Substance Abuse Treatment: Strategies for Self-Improvement and Change

There has been a highly successful initiative to establish a statewide provider base for Strategies for Self-Improvement and Change (SSC) in Colorado. As of December 2001, a total of 483 providers representing 153 sites and 137 agencies have been trained in the delivery of SSC. An SSC program delivery effectiveness study was completed using client and provider self-reported data (Wanberg and Milkman, 2001). Important findings include the following:

- As of December 2001, 72 different agencies in Colorado were documented as presenting SSC, with a cumulative client enrollment in excess of 3,000.
- Clients in the SSC sample were clearly more involved with alcohol and other drug abuse and criminal conduct than a sample taken from the statewide offender population; more than 75 percent of the SSC clients fit the moderate-to-severe range of substance abuse patterns.
- SSC treatment has been successfully presented in a variety of settings, including jail, prison, residential treatment, therapeutic community, and outpatient settings with positive provider ratings of program effectiveness across all settings; 70 percent rated SSC as being of great benefit to clients who achieved a high completion rate for the programs to which they were assigned.
- Providers reported that from 50 to 56 percent of outpatient clients maintained substance abstinence during SSC, and 60 percent of outpatients were rated as abstaining from any criminal conduct during SSC.

- Providers rated 80 percent of the SSC clients as having "fair" to "very good" prognosis in the areas of alcohol and other drug use and criminal conduct.
- SSC clients assigned positive ratings of program effects; an average of 75 to 80 percent reported that their cognitive and behavioral control over alcohol and other drug use as well as criminal thinking and conduct improved during SSC.

Studying the Effectiveness of Moral Reconation Therapy®

Greg Little, a founder of Moral Reconation Therapy (MRT) who has been involved in much of the MRT outcome research, has reported that outcome data on MRT include almost 88,000 individuals (14,623 MRT-treated individuals and 72,898 individuals in control and comparison groups) (Little, 2000). He notes that few treatment approaches have been researched as extensively as MRT.

According to Little (2001), studies show that adult offenders who attend MRT treatment during incarceration have significantly reduced recidivism rates for 1 year after release. MRT leads to a 23-percent decline in expected recidivism which, Little explains, is substantial, because the expected rate of recidivism is 48 percent 1 year after release (Little, 2005). MRT, therefore, cuts the expected 1-year recidivism rate in half. Little's 1999 research at the Shelby County Correction Center showed an 8.4-percent reincarceration rate for MRT-treated individuals as opposed to 21 percent for nontreated controls.

Little conducted a 2005 meta-analysis of nine MRT outcome studies (only one of which was associated with the developers of MRT). He concluded that treatment of probationers and parolees with MRT cut recidivism by nearly two-thirds for 6 months to more than 2 years (Little, 2005). This conclusion, he states, is consistent with a prior analysis on MRT treatment and recidivism with incarcerated felons. The previous report of 65 outcome studies on MRT use with felony offenders (Little, 2001) included 13,498 MRT-treated individuals and 72,384 nontreated individuals in a control group. Seven of these studies reported 1-year rearrest and reincarceration rates for those who had been treated during incarceration. These 7 studies included 21,225 subjects. With an expected recidivism rate of 48 percent, the results of the meta-analysis showed that MRT treatment cut recidivism by nearly one-half (Little, 2005).

The 2005 analysis reflects studies of 2,460 MRT-treated individuals and 7,679 individuals in control groups. Little describes the nine studies as coming from master's theses, government program reports, and university evaluations, in addition to the one associated with the developers of MRT, which was performed by staff of the University of Maryland under the auspices of the National Institute of Justice. The studied programs included an implementation

of MRT at the Anchorage (Alaska) Wellness Court; a community-based program in Portland, Oregon; the High-Risk Parolee Re-Entry Program in Illinois; the Las Cruces (New Mexico) Juvenile Drug Court; an independent study of rearrest rates of 30 offenders; the Albuquerque (New Mexico) Juvenile Court; the Payne County (Oklahoma) Drug Court; the 16th Judicial District of Tennessee's drug court implementation; and the Oklahoma Department of Corrections Parole and Probation Division.

The conclusion of this meta-analysis was that MRT outcome research has shown to be consistent in findings. As the use of MRT extends beyond incarcerated populations to probation and parole, outcome research continues to show "a host of beneficial effects" (Little, 2005, p. 16). In summary, "short-term recidivism is cut by at least 50 percent in MRT-treated offenders" (Little, 2005, p. 16).

Additional investigations reported by Little determined that 37.1 percent of treated subjects and 54.9 percent of controls were reincarcerated within 5 years. At 7 years, 44 percent of treated subjects and 60 percent of controls were reincarcerated. (Although rearrest rates were 19.9 percent lower for MRT participants than for nonparticipants, this was not statistically significant.)

Other studies by Little and MRT codeveloper Ken Robinson indicate that there is a positive correlation between the MRT step progression and moral reasoning among drug offenders. Pre- and posttests also showed a statistically significant difference in moral reasoning among impaired driving offenders. Additional research found that recidivism and moral reasoning were negatively correlated among impaired driving offenders (Brame et al., 1996).

Little's review of published reports on MRT outcome research showed that virtually all of the studies that evaluated changes in moral reasoning, self-esteem, and various other personality variables resulted in expected outcomes, with the majority indicating significant changes (Little, 2001). MRT was also shown to significantly lower recidivism for periods of up to 10 years after treatment. Little reports that inmate enthusiasm for and completion rates of MRT are high. He notes that of the 65 studies he reviewed, 34 were conducted independently from the developers of MRT.

Little pointed out in his 2001 research review that several cost-savings studies of MRT have been done. The Washington State Institute for Public Policy conducted a large, independent evaluation of 18 programs, typically for adult offenders. Reported findings concluded that for each $1 spent on MRT treatment, $11.48 was saved in eventual criminal justice-related costs. Little concluded that MRT is cited as the most cost-effective program when compared with other cognitive programs, including Reasoning and Rehabilitation (R&R). He asserted that other programs, employing the teaching of life skills and cognitive skills actually lost money (Little, 2000).

Another study not conducted by MRT's developers compared recidivism rates for MRT, R&R, and other CBT programs (Wilson, Bouffard, and MacKenzie, 2005). It found that R&R showed somewhat smaller effectiveness than MRT.

A study of the Portland Better People program, which utilizes MRT, examined 68 former offenders who participated in MRT and 68 who did not (Boston, Meier, and Jolin, 2001). Results showed that 9 percent of those in the treatment group were rearrested while 21 percent of nonparticipants were rearrested. This study points out the importance of not only reducing recidivism but also increasing public safety and improving the community, which can be done by assisting clients in becoming responsible caring people with strong character who are able to take care of their families and themselves. Toward that end, the study authors planned future research to focus on the use of MRT and its effects on employment.

A well-constructed study of MRT and problem behavior was conducted at the Oklahoma Department of Corrections (Brame et al., 1996). This longitudinal study followed 65,390 individuals from 1993, when MRT was implemented throughout Oklahoma's correctional system, through early 1995. The study asked whether or not participation in MRT was associated with reduced levels of problem behavior, specifically, official misconduct within prison facilities and/or recidivism incidents within the community.

Study results indicated that MRT participation appeared to be associated with a lower risk of misconduct and recidivism. The study notes, however, the importance of how program participation was determined. Since participation was not randomized, the study authors believe it "premature to reach closure on…whether individuals…were apt to have done better or worse than individuals who did not participate in MRT." The authors refrain from concluding a cause-and-effect relationship between MRT and lower rates of misconduct and recidivism and state they were "unable to report an unconditional beneficial effect of MRT programming."

The study ultimately concluded only that among prison inmates who had participated in MRT, there was a reduction in problem behavior when they were participating as compared with when they were not participating. This was clearly an important correlation, which would be expected if the MRT program did indeed have beneficial effects. Nevertheless, it was not sufficient to demonstrate that the program actually had a beneficial effect. There was no way of knowing whether the program itself caused improved behavior or whether it merely signaled individuals' willingness and desire to have changed for the better.

A 2005 evaluation of a number of cognitive-behavioral programs for offenders noted three high-quality, quasi-experimental studies showing positive effects of MRT (Wilson, Bouffard, and MacKenzie, 2005). However, none of the findings of these studies were statistically significant because small sample sizes resulted in large confidence intervals (that is, a high degree of uncertainty). One study of 60 offenders that was not conducted by the developers of MRT (and which Wilson and colleagues considered to be of high quality) showed what these authors termed "a clinical significance," with a reduction in the reoffense rate from 20 percent to 10 percent and a reduction in the reincarceration rate from 10 percent to 0 percent.

Yet another evaluation, which Wilson and colleagues considered methodologically weak, found a positive overall effect among 98 male offenders who were volunteers in an MRT program. The study compared these offenders with all other offenders released from a short-term detention center in Florida. There were no controls for offender differences between those who chose the MRT program and those who did not. Another study (also unrelated to the MRT program developers) found substantially reduced rates of rearrest (45 percent versus 67 percent at 48 months and 62 percent versus 95 percent at 60 months), but again, there were no controls for selection bias, hence providing little basis for MRT's effectiveness.

The mean recidivism rate across the six evaluations reviewed by Wilson and colleagues shows a statistically significant positive result. Thus, they state that "there is reasonably strong evidence for the effectiveness of MRT at reducing long-term recidivism rates among offenders" (Wilson, Bouffard, and MacKenzie, 2005, p. 189). They caution readers to remember that three of the four strong studies were conducted by the developers of MRT. They do conclude, however, that the structured nature of the program and the "manualization" (precise curriculum manual) of the program increases program integrity and therefore increases the program's usefulness when implemented by criminal justice personnel.

Another group of researchers have reiterated the weakness of studies performed by researchers other than MRT's developers and asserted that "solid conclusions are difficult to draw" (Allen, MacKenzie, and Hickmann, 2001, p. 506). In addition, the summary of a study of 256 youth offenders in a Maryland county jail noted that "this trial casts doubt on the wisdom of this program's [MRT's] wide-spread implementation" (Armstrong, 2003). The randomized experiment found that the risk of recidivism for the MRT treatment group was not statistically significantly different from that of the control group.

Studying the Effectiveness of Reasoning and Rehabilitation

In their 2005 review, Wilson and colleagues. examined seven evaluations of R&R programs, three of which were true experimental studies. They reported that results were mixed, with the scientifically higher quality studies finding that R&R resulted in lower rates of reoffense. Although the three true experimental studies found positive results in recidivism rates, one was not statistically significant, with R&R participants' recidivism rate at 26 percent compared with a rate of 29 percent for non-R&R participants.

A second group of researchers reported that while R&R evaluation studies tend to support the effectiveness of the program in reducing recidivism, a definitive conclusion is still difficult to confirm due to methodological weaknesses as well as the inconsistency of findings (Allen, MacKenzie, and Hickman, 2001).

John Wilkinson, at the University of Surrey, England, conducted a quasi-experimental design that targeted repeat offenders who were at high risk of reoffending and had the thinking styles and attitudes that R&R was intended to change (Wilkinson, 2005). With a sample size of 185, statistical significance would be an important indicator; however, findings for reduction in reconviction were not statistically significant enough for the author to generalize the effectiveness of R&R. His findings showed that 67 percent of the R&R group were reconvicted within 2 years as compared with 56 percent of untreated offenders (sentenced to custody from time of sentence). "It would seem . . . R&R did not reduce offending" (Wilkinson, 2005, p. 81). The author offers the alternative fact that 5 percent fewer R&R participants were reconvicted after release than was predicted on the basis of age and previous convictions as compared with the custody group, which had 14 percent more reconvictions than predicted. This, he states, could be taken as indicating success. Wilkinson also reported that the R&R group showed lower rates of reconviction; however, offenders who completed the program and were not reconvicted had either no change or a negative change in attitudes toward crime, impulsiveness, and self-control (which is contrary to the hypotheses on which R&R is based).

Wilkinson concluded that the effectiveness of the R&R program has yet to be demonstrated and that his findings are "broadly in line" with other studies that show R&R did not bring about significant reduction in recidivism (Wilkinson, 2005, p. 81).

Studying the Effectiveness of Relapse Prevention Therapy

A meta-analytic review of Relapse Prevention Therapy (RPT) confirms the "overall efficacy of RP[T] in reducing substance use and improving psychosocial adjustment" (Irvin et al., 1999, p. 569). Although treatment outcomes varied among the moderator variables (i.e., treatment modality, theoretical orientation of prior therapy, treatment setting, type of outcome measures used to determining effectiveness, medication used, and type of substance use disorder treated by RPT), the overall results showed that RPT was effective across the board and did not appear to vary with treatment modality or setting. The authors' review of 26 published and unpublished studies concluded that RPT is highly effective for alcohol and polysubstance use disorders when administered along with the use of medication and when evaluated immediately following treatment with the use of uncontrolled pre- and posttests.

A review of 24 randomized controlled trials of the effectiveness of relapse prevention (Carroll, 1996) suggests "that relapse prevention is better than no treatment, equal to or better than 'placebo' control groups, and at least equal to the best available active substance abuse treatments that the field has to offer" (George A. Parks, 2006, personal communication). Carroll's choice of studies included those randomized control trials that were defined as "relapse prevention" and that "explicitly invoked the work of Marlatt" (Carroll, 1996, p. 51).

Carroll (1996) also points out that relapse prevention therapy might not prevent relapse better than other therapies, but suggests that relapse prevention is more effective than alternatives, in that it reduces the intensity of lapses when they occur. As described by Parks (2006, personal communication), the basis of RPT is teaching cognitive and behavioral coping skills. Slip-ups by clients occur more often in the early stages of treatment. With continued RPT, clients learn to anticipate high-risk situations and become better equipped to deal with them as they occur. In summary, relapse prevention is a promising intervention in substance abuse treatment.

Studying the Effectiveness of Thinking for a Change

Two evaluations of Thinking for a Change (T4C) were found. The first is a doctoral dissertation from the University of Texas Southwestern Medical Center at Dallas (Golden, 2002). This study centers on 42 adult male and female medium- and high-risk offenders on probation. Completers and dropouts from the T4C program were compared with those not assigned to the program, with procriminal attitudes, social skills, and interpersonal problem-solving skills as the studied factors. Ratings were based on self-report measures, applied-skill tests, and facilitator ratings as well as recidivism during the 3-month and 1-year postprogram completion time periods.

The study found that new criminal offense rates for those who completed the T4C program were 33 percent lower than for the comparison group. No differences were found between groups for technical violations of probation. On attitudinal measures of procriminal sentiments, again no differences were shown between the groups. Social skills did improve for completers and dropouts, but remained the same for the comparison group. Completers of the program improved significantly in interpersonal problem-solving skills, while dropouts and comparisons showed no change.

As this study reports, positive changes in thought processes that correlate with criminal and delinquent behavior do not necessarily reduce the behavior. Nonetheless, the author supports the use of T4C based on the realization that even a 33-percent reduction in new criminal offenses has a practical implication in terms of keeping thousands out of jail and thereby saving millions of dollars. The author also believes that the improvement of interpersonal and problem-solving skills of offenders is a worthwhile goal itself.

The author points toward the shortcomings of her study, including the small sample size, noting that the trend observed toward reduced offenses would have been statistically significant with a larger sample size. Also, generalization of the results is difficult because the sample consisted mostly of young, unmarried, black males of lower socioeconomic status in a large urban setting. The author also cites the limitation of the self-report measurements, in that they rely on respondents' insight and honesty. In an attempt to overcome this shortcoming, she also used facilitator evaluations, applied-skills measures,

several different self-report measures, an official information database to verify the self-reports, and a short version of the Marlowe-Crowne Social Desirability Scale (which measures defensiveness).

The author further notes that the study showed that new criminal charges, as well as technical violations, typically had occurred at least 3 months after completion of T4C for program participants, while those for the comparison group and dropouts occurred within the first 3 months of the probationary period. Thus, she recommends "booster sessions" or an aftercare group to assist in relapse prevention.

The second study, of 233 probationers, was conducted in Tippecanoe County, Indiana (Lowenkamp and Latessa, 2006). It showed a significant reduction in recidivism (defined as arrest for new criminal behavior) over an average of 26 months (ranging from 6 to 64 months) for those who participated in the T4C program. Of the 136 treatment cases, the 90 who were "successful T4C participants" had a recidivism rate of 18 percent; the recidivism rate of the 121 probationers who participated in T4C was 23 percent. The recidivism rate of the 96 probationers in the control group was 35 percent.

CHAPTER 6

"Real World" Program Applications

Treatment Dimensions

Five dimensions of effective correctional supervision and counseling have been delineated, as follows (Andrews and Bonta, 2003):

- **Relationship:** Relating in open, enthusiastic ways.
- **Authority:** Being firm but fair; distinguishing between rules and requests; monitoring; reinforcing compliance; refraining from interpersonal domination or abuse.
- **Anticriminal modeling and reinforcement:** Demonstrating and reinforcing vivid alternatives to procriminal styles of thinking, feeling, and acting.
- **Concrete problem solving:** Using skill-building and removal of obstacles toward increased reward levels for anticriminal behavior in settings such as home, school, and work.
- **Advocacy:** Obtaining the most appropriate correctional services for the client.

The following principles of treatment have also been suggested (Cullen and Gendreau, 2000):

- Services should be behavioral in nature.
- Interventions should employ cognitive-behavioral and social learning techniques such as modeling, role playing, and cognitive restructuring.
- Reinforcement in the program should be largely positive, not negative.
- Services should be intensive, lasting 3 to 12 months (depending on need) and occupying 40 to 70 percent of the offender's time during the course of the program.
- Treatment interventions should be used primarily with higher risk offenders, targeting their criminogenic (crime-inducing) needs.
- Less-hardened or lower risk offenders do not require intervention and may be moved toward more criminality by intrusive interventions.

- Conducting interventions in the community as opposed to an institutional setting will increase treatment effectiveness.

Another researcher similarly argues that effective rehabilitation programs should take place mostly in the community and not in institutional settings (Petersilia, 2004). This same researcher suggests that programs should include at least 6 months of intensive therapy, focus on high-risk individuals, use cognitive-behavioral treatment techniques, and match the therapist and program to the specific learning styles and characteristics of the individual offender. As the individual progresses, vocational training and other job-enhancing opportunities should be provided. Programs that begin in a jail or prison need to have an intensive and mandatory aftercare component.

Others have found that the treatment setting had no effect on recidivism (Lipsey and Landenberger, 2006). These researchers noted that offenders treated in prison close to the end of their sentences showed recidivism decreases comparable to offenders treated in the community. This discrepancy with research findings requires further study to determine if indeed there is a difference in recidivism based on the treatment setting.

The effectiveness of treatment programs can vary substantially to the extent that an offender's individual differences (e.g., age, prior record, and intellectual development) are measured and taken into account in the delivery of services (Gendreau and Ross, 1979). In terms of staffing, again, there is a need to match styles and modes of treatment service to the learning style of the offender. Depending on the offender's characteristics (e.g., intelligence, levels of anxiety) he or she may respond more readily to some techniques than others.

Motivation Effects

Offenders vary greatly in terms of their motivation to participate in treatment programs. Policymakers and practitioners often feel that providing services to those who want them is money well spent, while forcing services on a resistant group of individuals is a waste of resources (Re-Entry Policy Council, 2002). Evidence shows that behavioral change is more likely to occur when an individual has the self-motivation to improve (Bogue, Clawson, and Joplin, 2005). Feelings of ambivalence that usually accompany change can be explored through "motivational interviewing," a style and method of communication used to help people overcome their ambivalence regarding behavior changes. Research shows that motivational interviewing techniques, rather than persuasion tactics, effectively improve motivation for initiating and maintaining behavior changes (Miller and Rollnick, 2002).

Risk Factors

"Static" and "dynamic" risk factors can be differentiated as intervention targets (Andrews and Bonta, 1994, 1998). *Static risk factors,* rooted in the past and therefore unalterable and inappropriate targets for change, include:

- Early involvement in deviance and acting-out behavior.

- Emotional, psychological, and family disruption in childhood and adolescence.
- Involvement with an antisocial peer group as a youth and school problems or failure.
- Alcohol and other drug use in childhood and adolescence.

Dynamic risk factors are parts of the offender's daily experience and are more amenable to change. They have also been referred to as "criminogenic needs." These factors do more than "simply forecast criminal events. They actually influence the chances of criminal acts occurring through deliberate intervention" (Andrews and Bonta, 1994).

Some dynamic risk factors are more appropriate and promising targets for change than others. Andrews and Bonta (2003, p. 432) list the following ways providers can work with dynamic risk factors:

- Changing antisocial attitudes.
- Changing antisocial feelings.
- Reducing current antisocial peer associations.
- Promoting familial affection and communication.
- Promoting familial monitoring and supervision.
- Promoting child protection (preventing neglect and abuse).
- Promoting identification and association with anticriminal role models.
- Increasing self-control, self-management, and problem-solving skills.
- Replacing the skills of lying, stealing, and aggression with more pro-social alternatives.
- Reducing chemical dependencies.
- Shifting the balance of personal, interpersonal, and other rewards and costs for criminal and noncriminal activities so that the noncriminal alternatives are favored.
- Providing the chronically psychiatrically troubled with low-pressure, sheltered living arrangements.
- Ensuring that the client is able to recognize risky situations and has a concrete and well-rehearsed plan for dealing with those situations.
- Confronting the personal and circumstantial barriers to service (e.g., client motivation, background stressors with which clients may be preoccupied).
- Changing other attributes of clients and their circumstances that, through individualized assessments of risk and need, have been linked reasonably with criminal conduct.

Efforts to work with dynamic risk factors in the following ways may be less successful (Andrews and Bonta, 2003, p. 432):

- Increasing self-esteem (without simultaneous reductions in antisocial thinking, feeling, and peer associations).
- Focusing on vague emotional or personal complaints that have not been linked with criminal conduct.
- Increasing the cohesiveness of antisocial peer groups.
- Improving neighborhoodwide living conditions without touching the criminogenic needs of high-risk individuals and families.
- Showing respect for antisocial thinking on the grounds that the values of one culture are equally as valid as the values of another culture.
- Increasing conventional ambition in the areas of school and work without concrete assistance in realizing these ambitions.
- Attempting to turn the client into a "better person," when the standards for being a better person do not link with recidivism.

Role Models and Reinforcers

The lists below characterize effective role models and reinforcers for judicial clients as well as effective means of disapproval (Andrews and Bonta, 1994, pp. 204–205). Effective CBT providers and support staff regularly model these skills as they interact with correctional clients.

What makes an effective role model for judicial clients?

- Demonstrates behavior in concrete and vivid ways.
- Takes care to illustrate the behavior in some concrete detail when only a verbal description is being offered.
- Is rewarded himself/herself for exhibiting the behavior and makes specific reference to the rewards.
- Rewards the person for exhibiting the modeled behavior or some approximation of it.
- Is generally a source of reinforcement rather than only of punishing or neutral events.
- Makes evident the general similarities between himself/herself and the other person (e.g., "I had a similar problem at your age").
- Recognizes that the other person may have good reason to fear or distrust the modeled behavior and hence will model a "coping" as opposed to a "master" style (e.g., "I too was afraid to approach the teacher about my grades, but, scared as anything, I went up and asked her about it," vs. "I just walked up to her and…").

What are effective reinforcers for judicial clients?

- Strong and immediate statements of approval, support, and agreement with regard to what the client has said or done (includes nonverbal expression, eye contact, smiles, shared experiences, etc.).
- Elaboration of the reason why agreement and approval are being offered (e.g., exactly what it is the provider agrees with or approves of).
- Expression of support that is sufficiently intense to distinguish it from the background levels of support, concern, and interest that one normally offers.
- While less important than the items above, the provider's feedback should at least match the client's statement in emotional intensity (i.e., be empathic), and his or her elaboration of the reason for support should involve some self-disclosure (i.e., openness).

What is effective disapproval of procriminal expressions?

- Strong and immediate statements of disapproval, nonsupport, and disagreement with what the client has said or done (includes nonverbal expressions, frowns, or even an increase in the physical distance between the provider and the client).
- Elaboration of the reason for disagreement and disapproval.
- Expression of disapproval stands in stark contrast to the levels of interest, concern, and warmth previously offered.
- Levels of disapproval should be immediately reduced and approval reintroduced when the client begins to express or approximate anticriminal behavior.

Clients With Serious Mental Disorders

As noted in Chapter 1, the change in social policy regarding the institutionalization of the severely mentally ill has influenced the populations within the criminal justice system. Ideally, psychiatric patients would be at no higher risk for arrest and incarceration than the rest of the population. This unfortunately is not the case, as individuals with severe mental disorders have a substantially greater risk of being incarcerated (Munetz, Grande, and Chambers, 2001). As previously described, estimates of mentally ill prisoners in state facilities are in the range of 15–20 percent. Offenders with a serious mental disorder are poorly compliant with treatment regimens and have a high level of substance abuse.

These offender subpopulations commonly require strategic, extensive, and extended services. However, too often, individuals within this group are neither explicitly identified nor provided a coordinated package of supervision and services (Bogue, Clawson, and Joplin, 2005). The evidence indicates that incomplete or uncoordinated approaches can have negative effects, often wasting resources (Gendreau and Goggin, 1995).

The increased number of people with mental illness has alerted many to the need for alternative policy responses (Council of State Governments, 2002). To varying degrees, these alternative programs move individuals with mental illness out of the criminal justice system and into the mental health system for treatment (Draine and Solomon, 1999). Promotions of these interventions usually contain some variant of the argument that treatment in the mental health system is more appropriate for a person with mental illness than accountability in the criminal justice system. Treatment within a jail diversion program is considered an alternative to criminal justice processing.

Jail diversion programs are broadly categorized as "prebooking" and "postbooking" programs (Lattimore et al., 2003). Postbooking programs screen individuals with mental illness in jails and provide processes for them to be directed into psychiatric treatment as an alternative to prosecution or continued incarceration within the criminal system. Prebooking programs provide mechanisms for police to refer individuals directly into treatment as an immediate alternative to arrest. Prebooking programs include training police how to respond to mental and emotional disturbance. In police encounters, officers are more likely to see psychotic behaviors as indicative of a need for psychiatric treatment rather than arrest (Watson, Corrigan, and Ottati, 2004). In the specific instance of domestic violence, victims will be more likely to report offenses if the response of the criminal justice system is centered on a rehabilitative approach (Walsh, 2001).

Some researchers have argued that cognitive-behavioral approaches are not universally applicable to all groups of offenders, including the mentally ill (Cameron and Telfer, 2004). They stress that the effectiveness of rehabilitation depends on the application of treatment matched to the needs of the person. They determined that the efficacy of cognitive-behavioral approaches when applied outside the mainstream of adult offenders was questionable.

Other researchers identified a group of "exceptional offenders" who are psychopaths with mentally disordered thought patterns (Andrews and Bonta, 2003). Group-based cognitive-behavioral treatment shows promise for these types of offenders, but only if matched to offender need and the responsiveness of the offender to the treatment. This is especially the case when impulsivity is assessed in an antisocial personality disorder with psychopathic features.

Diversity Considerations

"Clinically relevant treatment" holds the best promise for reduced recidivism (Andrews, Bonta, and Hogue, 1990). It can be defined as those interventions that "maintain respect for, and attention to[,] diversity in both people and programming" (Andrews, Bonta, and Hogue, 1990, p. 20).

Gender, age, and ethnic origin intersect to produce consistent statistical patterns of offending. According to the U.S. Department of Justice, in 2004, in both jails and prisons, there were 123 female inmates per 100,000 women in the United States, compared with 1,348 male inmates per 100,000 men (Bureau of Justice Statistics, n.d.; Harrison and Beck, 2005a). An estimated

12.6 percent of black males, 3.6 percent of Hispanic males, and 1.7 percent of white males in their late twenties were in prison or jail. Female populations in state and federal prisons are growing at a rate approximately 45 percent greater than that for male populations (2.9 percent for females versus 2.0 percent for males). At midyear 2004, 34,422 federal inmates were noncitizens, representing more than 20 percent of all prisoners in federal custody. Nearly 6 in 10 persons in local jails were racial or ethnic minorities. Whites made up 44.4 percent of the jail population; blacks, 38.6 percent; Hispanics, 15.2 percent; and other races (Asians, American Indians, Alaska Natives, Native Hawaiians, and other Pacific Islanders), 1.8 percent.

On a per capita basis, men were more than seven times more likely than women to have been held in a local jail. African Americans were nearly five times more likely than whites, nearly three times more likely than Hispanics, and more than eight times more likely than persons of other races to have been in jail. When total incarceration rates are estimated separately by age group, black males in their twenties and thirties are found to have high rates relative to other groups. Among the more than 2.1 million offenders incarcerated on June 30, 2004, an estimated 576,600 were black males between ages 20 and 39. Female incarceration rates, though significantly lower than male rates at every age, reveal similar racial and ethnic differences. Among black females, the rate was highest among those ages 35 to 39.

Similar ethnic and racial statistics also apply to offenders who have severe mental disorders (Munetz, Grande, and Chambers, 2001). It does not appear that the interaction of race with a severe mental disorder substantially raises the already high risk of incarceration incurred by both individual African-Americans and persons with a severe mental disorder.

The United States is now one of the leading countries in incarceration (Simon, 2000). Half of the prison population (more than 1 million) consists of nonviolent prisoners (Irwin and Schiraldi, 2000).

Given these fairly consistent statistics, it is surprising that programs and treatment generally have not taken into consideration ethnicity, race, sex, age, and degree of violence as they relate to the therapist and the treatment program (Nagayama Hall, 2001). Most research in these areas is published in specialty journals, and there is a paucity of research in prestigious journals, which makes access to this information more difficult.

At a minimum, counselors should be aware of their own cultural identifications and biases, always showing respect and understanding for client diversity and differences in social learning experiences.

Strategies To Improve Treatment Outcomes

The two principal ingredients of successful treatment are (1) selecting an appropriate population of criminal justice clients who will benefit from the service and (2) using a manualized treatment curriculum (Taxman, 1999).

Appropriate Offender Selection

Appropriate offender selection for treatment is predicated on making the distinction between offense criteria versus offender criteria for program eligibility (Taxman, 2004). The offense is often used as the selection criterion because it is readily available through official criminal justice documents. The offender perspective, on the other hand, focuses on dynamic factors (traits that are current and subject to change) such as frequency of drug use during the past 30 days, amount of consumption per episode, or adequacy of housing and living conditions. An assessment of dynamic factors allows the system to match offenders to treatment programs that can target crucial psychological and social needs that influence criminal conduct.

One study used dynamic assessment tools to distinguish between two broad categories of alcohol and other drug-involved criminal justice clients: criminal (those with an entrepreneurial involvement in the drug trade) and addict (those who compulsively used drugs and used crime as a means to obtain drugs) (Taxman, Reedy, and Ormond, 2003). CBT outcomes for the two populations were markedly different. The addict population showed a reduction in rearrest rates from 41 percent without treatment to 26 percent with treatment. Most striking, however, is the finding that the rearrest rates for the treated criminal group were similar to those of matched samples of criminal offenders who did not attend treatment (approximately 44 percent). Drug treatment programs typically do not address the criminogenic values of an offender and thus did not target those in the criminal category. Thus, it was shown that assigning appropriate offenders to treatment programs by using dynamic assessment tools (and avoiding offense-specific treatment assignments) can lead to improved treatment outcomes and better utilization of limited treatment resources.

Manualized Treatment Curricula

The emphasis of cognitive-behavioral treatment for substance abuse and criminal conduct is on acquiring new skills to improve resiliency in three focal areas: intrapersonal (safe regulation of thoughts, feelings, and impulses); interpersonal (adaptive communication, negotiation, and boundary setting); and community responsibility (empathy and adherence to community norms, morals, and ethical standards). Principle issues of misunderstanding and other elements that undermine the delivery of effective CBT treatment for judicial clients have been outlined as follows (Taxman and Bouffard, 2003):

- Purpose of the treatment unclear.
- Goals of the services unclear.
- Whether services can be provided in a correctional setting.
- Appropriateness of the content of the therapy to change offender behaviors.
- Ability of the treatment staff to work with offenders.

Significant progress toward the remediation of the above-listed concerns has been made through the evolution of specialized curriculums that serve as a guide for content and style of treatment delivery. This "manualized" approach to treatment provides an operational design that has been shown to improve offender outcomes (Taxman, 2004). From a management perspective, programs that adopt empirically validated, manualized curriculums have greater confidence in the quality of treatment services. Idiosyncratic treatment methods deployed by counselors with a broad range of personal and professional treatment experiences are controlled through an administrative mandate for standardized treatment services. Manualized curriculums allow program managers to be aware of the nature of treatment sessions so that programs can achieve continuity of services in the wake of staff absences and staff turnover. Additionally, program managers can develop objective means to assess treatment progress by developing indices to measure increments in cognitive restructuring and coping skills development.

Effective use of manualized curriculums requires adherence to several quality assurance practices. These include thorough training of staff in the delivery of treatment sessions and clinical oversight and feedback to treatment staff.

The advantages of adopting manualized treatment curricula are that it (Taxman, 2004; Wanberg and Milkman, 2006):

- Defines the treatment philosophy, providing conceptual information on the nature of the treatment experience.
- Provides goals and objectives for each session that can be measured to ascertain client progress throughout the continuum of treatment services.
- Provides skill development exercises that clients can practice within treatment sessions or as homework to augment the treatment experience.
- Provides the basis for defining productive and meaningful "learning experiences" that can be assigned as sanctions for rule violations.
- Capitalizes on interactive learning styles, facilitating skills for self-assessment and self-regulation.
- Provides the basis for incremental skill development in intrapersonal, interpersonal, and community domains.

Conclusions

During the past decade, the number of people in the United States who are incarcerated has swelled to well over 2 million, approximately 7 percent of whom are women. The expanded correctional population has encountered a decline in mental health services. With annual releases exceeding half a million, parole services appear to be stretched beyond their normal limits. Compared with the 1990s, released prisoners have a higher prevalence of untreated substance abuse and mental illness with fewer opportunities for employment and housing and less eligibility for welfare. Along with the deinstitutionalization of people with mental illness, there has been a corresponding need for mental health services within the prison population. In consideration of the fact that more than 50 percent of those who are released from custody are rearrested with the first year, from a cost-benefit perspective, additional dollars should be spent on correctional treatment.

In fact, multiple studies using meta-analytic techniques have concluded that recidivism is significantly decreased among correctional clients who receive cognitive-behavioral treatment (CBT) under the auspices of judicial supervision. In essence, CBT uses two basic approaches to bring about change: (1) restructuring of thoughts that trigger negative emotions and problem behaviors; and (2) interpersonal skills training. Effective CBT for the offender population also includes a sociocentric perspective, whereby a critical treatment focus is on responsibility toward others and the community. Positive outcomes associated with increased cognitive-behavioral proficiency strengthen prosocial thoughts and actions.

CBT lessons are typically taught in group settings with the therapist acting as teacher and coach, guiding participants through structured lesson plans that feature skills modeling, role play, rehearsal, intensive feedback, written exercises, and homework assignments. Some unique characteristics of effective "correctional practitioners" include relating in open, enthusiastic ways; acting as role models who demonstrate anticriminal expressions of attitude and behavior; manifesting authority in a firm but fair manner; communicating prosocial and high moral values; explicitly approving (reinforcing) the client's anticriminal expressions and disapproving (punishing) procriminal expressions (which involves reporting violations of corrections policies); and advocating for the most appropriate services for criminal justice clients.

Six widely used CBT programs have been reviewed in this publication. Although all the programs reviewed are "evidence-based" from the perspective of providing highly structured manuals for the delivery of cogent CBT role plays and exercises designed to facilitate prosocial adjustment, to date it is not possible to conclude that any one "brand name" program is superior to others. Although meta-analytic studies have conclusively shown that CBT significantly reduces recidivism, effect size (i.e., the amount of reduction in recidivism) is affected by multiple variables, such as whether recidivism is defined as rearrest or reconviction, the number of sessions taken, and the level of training for CBT providers. Research programs that included smaller sample sizes and treatment providers with mental health backgrounds also showed larger treatment effects (i.e., less recidivism).

Adoption of a high-quality, manualized CBT curriculum has many advantages over unproven treatment models and less standardized approaches. It provides conceptual information on the nature of the treatment experience; measurable goals and objectives for each session; skill development exercises that clients can practice during each session; productive and meaningful learning experiences that can be assigned as sanctions for rule violations; means to address different learning styles within the criminal justice population; tools for self-assessment and self-regulation; and incremental skill development in the areas of interpersonal, intrapersonal, and community functioning.

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