Correctional Programming and Treatment
TEST YOUR KNOWLEDGE

Test your present knowledge of correctional programming and treatment by answering the following questions, true or false. Check your answers on page 536 after reading the chapter.

1. Trying to rehabilitate criminals is mollycoddling them and costs society too much; therefore, we should stop trying.
2. Programs to treat offenders and prevent recidivism are the biggest budget items in corrections after salaries.
3. Even the best-run treatment programs reduce recidivism by only about 5%.
4. Personal experience will give you a better understanding of what will or will not work with criminals.
5. Because addiction is a brain disease, the major way of attacking it in corrections is through pharmaceutical means.
6. Sex offenders are less likely to reoffend than almost any other type of offender.
7. Most people arrested in major cities test positive for some kind of illegal drug.
8. There are more mentally ill individuals in U.S. jails and prisons than in mental hospitals.

LEARNING OBJECTIVES

- Explain what rehabilitation is and why it is imperative
- Describe the principles of evidence-based practices (EBP) and the risk, needs, and responsivity (RNR) model of treatment
- Discuss the use of cognitive behavioral therapy (CBT) in corrections
- Identify the various substance abuse programming used in correctional institutions
- Evaluate the special treatment modalities applied to sex offenders
- Describe the treatment options for mentally ill offenders

LIFE’S TURNING POINTS

Kathy Gardener was born to an “all-American” family in Dayton, Ohio. Her parents sent her to a Catholic girls’ school, where she did well in her studies. All seemed to be going well for Kathy until she was 16 years old, when she went to a local air force base with two older friends from the neighborhood to meet the boyfriend of one of the girls. The boyfriend brought along two of his friends, and the six of them partied with alcohol, drugs, and sex. It was Kathy’s first time experiencing any of these things, and she discovered that she liked them all. Thus, began a nine-year spiral into alcohol, drug, and sex addiction and into all of the crimes associated with these conditions, such as drug trafficking, robbery, and prostitution.

When she was 25 years old, she was involved in a serious automobile accident in which she broke her pelvis, both legs, and an arm and suffered a concussion. She was charged with a probation violation, drunken driving, and possession of methamphetamine for sale. Kathy spent 10 months recuperating from her injuries, during which she was drug, alcohol, and sex free. Because of her medical condition, she was placed on probation. Her probation officer (PO) was a real
“knuckle-dragger,” who demanded full and immediate compliance with all conditions of Kathy’s probation but who also became something of a father figure to her. While she was recuperating, she was often taken care of by a male nurse she described as “nerdy but nice.” Her parents, who had been estranged from her for some time, became reacquainted with her, and her PO and nurse taught her to trust men again. She also occupied her time taking online college courses on drug addiction and counseling. She eventually married her “nerdy nurse,” with her parents blessing, and one of the guests was the “knuckle dragger.”

Kathy’s story illustrates some core ideas in this chapter. No matter how low a person sinks into antisocial behavior, he or she is not destined to continue the downward spiral. There are a number of treatment programs available for all sorts of problems that get people into trouble with the law. Of course, not everyone is confronted with such a dramatic turning point in his or her life as a major automobile accident, leaving him or her plenty of time to ruminate about life and where he or she is going. Kathy’s addictive personality got her into all kinds of trouble, and she knew it. People must come to this realization, and when they do, there must be programs in place to help them turn their lives around, or else, they will probably fail, and the community will suffer.

THE RISE AND FALL (AND RISE AGAIN) OF REHABILITATION

As we have seen, there are five primary goals of the correctional system: deterrence, incapacitation, retribution, rehabilitation, and reentry. This chapter deals with the fourth of these goals: rehabilitation. The term rehabilitation means to restore or return to constructive or healthy activity (habilitation), but many offenders never experienced anything close to habilitation in the first place, so there is little to restore. Correctional treatment or programming has to begin at the beginning and try to provide some of the things previously missing from the lives of offenders. Such programming obviously cannot supply the warmth and nurturing so critical in the early years of life, nor the deep sense of attachment and commitment to social institutions that comes from such experiences. However, programming and treatment can provide some of the concrete rewards, such as an education and job training, that most of us have had largely thanks to the attachments to family and other social institutions we enjoyed as children, and it can do its best to change the destructive thinking patterns that infect criminal minds.

We try to rehabilitate criminals with the realization that whatever helps offenders helps the community. As former U.S. Supreme Court chief justice Warren Burger opined, “To put people behind walls and bars and do little or nothing to change them is to win a battle but lose a war. It is wrong. It is expensive. It is stupid” (as cited in Schmalleger, 2001, p. 439). In this chapter, we look at various ways in which treatment personnel have been fighting the war. When reading this chapter, keep in mind that the vast majority of money assigned to correctional agencies is spent on surveillance and control functions. According to the National Center on Addiction and Substance Abuse (2010), among the 1.5 million inmates in jails and prisons nationwide in 2006, only 11.2% had received professional treatment since admission.

The American Prison Association (now the American Correctional Association [ACA]) declared its commitment to rehabilitation in its Declaration of Principles, written almost a century and a half ago (see In Focus 11.1).
The American Correctional Association’s 1870 Declaration on Treatment

Corrections is responsible for providing programs and constructive activities that promote positive change for responsible citizenship.

Opportunity for positive change or “reformation” is basic to the concept of corrections because punishment without the opportunity for redemption is unjust and ineffective. Hope is a prerequisite for the offender’s restoration to responsible membership in society.

Sound corrections programs at all levels of government require a careful balance of community and institutional services that provide a range of effective, humane, and safe options for handling juvenile and adult offenders. Corrections must provide classification systems for determining placement, degree of supervision, and programming that afford differential controls and services for juvenile and adult offenders, thus maximizing opportunity for the largest number.

Corrections leaders should actively engage the community to assist in the restoration and reintegration of the offender.

Offenders, juvenile or adult, whether in the community or in institutions, should be afforded the opportunity to engage in productive work, participate in programs including education, vocational training, religion, counseling, constructive use of leisure time, and other activities that enhance self-worth, community integration, and economic status.

Source: American Correctional Association (2013).

Influenced by British pioneers Alexander Maconochie and Walter Crofton, rehabilitation was the goal of the early American prison reformers such as Zebulon Brockway. The ideal of rehabilitation reached the pinnacle of its popularity from about 1950 through the 1970s, when the medical model of criminal behavior prevailed. The medical model viewed crime as a moral sickness that required treatment, and prisoners were to remain in custody under indeterminate sentences until “cured.” Consistent with the switch from a punishment role to a more rehabilitative corrections role, classification systems, individual and group counseling, therapeutic milieus, and college classes were added to the usual rehabilitative fare of labor, basic education, and vocational training (Cullen & Gendreau, 2001).

The rehabilitative goal was questioned and then fell apart with the publication, in 1974, of Robert Martinson’s article, “What Works?—Questions and Answers About Prison Reform,” in which he concluded that “with few and isolated exceptions, the rehabilitative efforts that have been reported so far have had no appreciable effect on recidivism” (p. 25). Unfortunately, the rhetorical question, “What works?” got translated into a definitive, “Nothing works,” and became a taken-for-granted part of corrections lore. Before we can decide if something does or does not work, we have to define thresholds for what we mean. If we demand 100% success, then we can be sure that “nothing works.” A program designed to change people is not like a machine that either works or does not. Human nature being what it is, nothing works for everybody; some things work for some people some of the time, and nothing will work for everybody all of the time. High failure rates existed in many fields at their inception, but as practitioners in those fields learned from their mistakes and their successes, failure rates inevitably dropped.
THE SHIFT FROM “NOTHING WORKS” TO “WHAT WORKS?”

Many correctional programs Martinson surveyed sought to change behaviors unrelated to crime, used programs that were not intensive enough, and used inadequately skilled staff. Few programs were based on the proper assessment of offender risks and needs and were often faddish “let’s see what happens” programs, including everything from acupuncture to Zen meditation. While both of these practices are beneficial in their own right, they are hardly useful for changing criminal lifestyles. One probation department actually insisted that male offenders should “get in touch” with their feminine side by requiring them to dress in female clothes, and another required “poetry therapy” (Latessa, Cullen, & Gendreau, 2002). Correctional resources are scarce and should only be expended on programs that have proven themselves useful in reducing recidivism.

How have Martinson’s conclusions stood up over the last 30 years? Gendreau and Ross (1987) reviewed a number of studies of treatment programs and concluded, “It is downright ridiculous to say that ‘Nothing works’ . . . much is going on to indicate that offender rehabilitation has been, can be, and will be achieved” (p. 395). Others have stated that properly run community-based programs could result in a 30% to 50% reduction in recidivism (Van Voorhis, Braswell, & Lester, 2000), although on the basis of major literature reviews, reductions in the 10% to 20% range are more realistic expectations (Cullen & Gendreau, 2001). A success rate is the difference in recidivism between a treatment and a control group. A review of studies from prison, jail, probation, and parole settings conducted by Pearson, Lipton, Cleland, and Yee (2002) found that 55.7% of the subjects in treatment groups did not reoffend, versus 43.3% of control group subjects. On
average, this difference translates into about a 22.3% decrease in offending for treatment group members (.557 − .433 = .124 ÷ .557 = .223, or 23.3%). Although there are still plenty of failures, if treatment programs managed only half of this success rate, the financial and emotional savings to society would be truly enormous.

Mark Lipsey and Francis Cullen (2007) reviewed numerous studies of a variety of correctional intervention programs conducted from 1990 to 2006 and concluded that treatment works moderately well in reducing recidivism. Lipsey and Cullen believe the biggest problem in offender treatment is not that “nothing works” but that correctional systems do not use the available research to determine what works and then implement it. Rather, they tend to rely on convenience (“Who is available, and what methods do they use?”), custom (“We’ve always done it this way and see no reason to change”), and ideology (“Criminals are scumbags; why waste time and money on them?”).

**ETHICAL ISSUE 11.1**

**What Would You Do?**

You are the chairperson of your state’s financial appropriation committee. The director of state corrections is again asking for a substantial increase in the prison budget for new treatment counselors in the state’s five prisons. You know that there is a desperate need for rehabilitation, but given a realistic reduction in recidivism of about 10% achieved by most programs and given other pressing needs the state has, you have deep reservations about providing corrections with more money when the health, education, law enforcement, and infrastructure needs of the state are urgent. You know, however, that there are two “bleeding hearts” on the committee who might swing the vote in favor of hiring prison counselors. Would you recommend appropriating the money or simply deny the request without taking it to the committee?

**EVIDENCE-BASED PRACTICES**

Moving from the medical to the just-deserts or risk management model in corrections did not mean the death of the rehabilitation goal, but terms such as assessment and programming have replaced medical terms such as diagnosis and treatment. The main concern of corrections is to reduce the risk that offenders pose to society, not improving offenders’ lives. Of course, the two goals are not incompatible; if more offenders can be taught to walk the straight and narrow, the risk of community members being victimized by them is reduced proportionately. Even though programs are run on a financial shoestring, prison officials like programming because it keeps inmates busy and out of trouble. Inmates also like it because it gives them something to do outside of their cells and looks good on their parole board records.

The movement to a “what works” frame of mind has resulted in the most progressive agencies moving to evidence-based practice (EBP). EBP is the use of peer-reviewed research based on the best available data to guide policy and treatment decisions such that outcomes for offenders, victims, and survivors, and communities are improved. In other words, EBP simply means that in order to reduce offender recidivism, corrections must implement practices that have consistently been shown by rigorous empirical assessment to be effective in that endeavor. Extensive research has identified the following eight principles of evidence-based programming, as formulated by the National Institute of Corrections (n.d.) and illustrated in Figure 11.1.

1. **Assess Actuarial Risk/Needs**—Assessing offenders’ risk and needs (focusing on dynamic and static risk factors and criminogenic needs) at the individual and aggregate levels is essential for implementing the principles of best practice.

2. **Enhance Intrinsic Motivation**—Research strongly suggests that “motivational interviewing” techniques, rather than persuasion tactics, effectively enhance motivation for initiating and maintaining behavior changes. Motivational...
interviewing is a method of prompting behavior change by helping clients to explore and resolve discrepant thinking; that is, the ambivalent feelings of wanting, and not wanting, to change. The task of the counselor is to facilitate and engage intrinsic motivation on the assumption that if people can resolve the ambivalence themselves they will value it more than if it is resolved by others, and they will develop a “can-do” attitude.

3. **Target Interventions**
   a. **Risk Principle**—Prioritize supervision and treatment resources for higher risk offenders.
   b. **Needs Principle**—Target interventions to criminogenic needs.
   c. **Responsivity Principle**—Be responsive to temperament, learning style, motivation, gender, and culture when assigning to programs.
   d. **Dosage**—Structure 40% to 70% of high-risk offenders’ time for 3 to 9 months.
   e. **Treatment Principle**—Integrate treatment into full sentence/sanctions requirements. Taking a proactive approach to treatment using CBT.

4. **Skill Train With Directed Practice**—Provide evidence-based programming that emphasizes cognitive-behavior strategies and is delivered by well-trained staff.

5. **Increase Positive Reinforcement**—Apply four positive reinforcements for every one negative reinforcement for optimal behavior change results.

6. **Engage Ongoing Support in Natural Communities**—Realign and actively engage prosocial support for offenders in their communities for positive reinforcement of desired new behaviors.

7. **Measure Relevant Processes/Practices**—An accurate and detailed documentation of case information and staff performance, along with a formal and valid mechanism for measuring outcomes, is the foundation of EBP.

8. **Provide Measurement Feedback**—Providing feedback builds accountability and maintains integrity, ultimately improving outcomes. (n.p.)
Taking a closer look at some of these principles, the psychosocial assessment of offenders typically begins with the **risk, needs, and responsivity (RNR) model**. The RNR model is the premier treatment model in corrections today in the United States and in many other countries (Ward, Melser, & Yates, 2007). The **risk principle** refers to an offender’s probability of reoffending, and those with the highest risk are targeted for the most intense treatment (“Dosage” under Principle 3). Criminologists have documented numerous individual and environmental factors that put a person at risk for criminal behavior and recidivism. As we discussed in the previous chapter, criminogenic risk factors are divided into dynamic and static categories. Static factors are those that cannot be changed, such as age, sex, criminal history, and family background. Factors associated with recidivism that can be changed are called criminogenic needs. The **needs principle** refers to programming needs to provide offenders with something they lack that may be responsible for their offending. For instance, a major predictor of recidivism is unemployment, and if an offender’s educational deficiencies impair his or her ability to secure and retain employment, then education is a criminogenic need. However, if an offender’s educational level does not adversely affect his or her ability to secure and retain employment, education is not a criminogenic need. Other criminogenic factors that can be changed through treatment include substance abuse, alcohol dependency, anger or hostility issues, poor social skills, poor attitudes toward work or school, poor family dynamics, low self-control, and criminal values and thinking patterns. Some programming for offenders with serious mental problems is the domain of mental-health staff; other programming needs, addressing such things as criminal thinking patterns, problem-solving skills, coping with stress, anger management, impulse control, and relationship-building skills, are addressed in a way that matches their developmental stage.

**Risk principle:** A principle that refers to an offender’s probability of reoffending and maintains that those with the highest risk should be targeted for the most intense treatment.

**Needs principle:** A principle that refers to an offender’s prosocial needs, the lack of which puts him or her at risk for reoffending, and that suggests these needs should receive attention in program targeting.

---

**FIGURE 11.1**
Integrated EBP Model Illustrated

decision making, substance abuse, and risk-taking behavior, are dealt with by prison treatment specialists.

The **responsivity principle** maintains that if offenders are to respond to treatment in meaningful and lasting ways, counselors must be aware of their different development stages, motivation, and learning styles, as well as their need to be treated with respect and dignity (Andrews, Bonta, & Wormith, 2006). The crux of these three principles is that we can no longer rely on one-size-fits-all models and that treatment must be tailored to individual offenders’ risks and needs.

Offender risk (defined in Chapter 10) and **offender needs** are assessed by two separate scales: one for risk and one for needs. These scales are used to make predictions about offenders’ success or failure based on **actuarial data** (Principle 1)—that is, what has actually occurred and been recorded over many thousands of cases. As we saw in the previous chapter, it has been found time and time again across many professions that decisions made on the basis of actuarial statistical norms trump decisions based on the insight of individuals the great majority of the time (Andrews et al., 2006). Table 11.1 identifies and describes risks and dynamic needs that must be addressed; note that identifying needs mirrors the identification of risk. The other principles of EBP are either self-explanatory or addressed elsewhere in this book.

### MOTIVATIONAL INTERVIEWING

As noted earlier in Principle 2 of evidence-based practices, motivational interviewing is something that research has shown to be very effective in dealing with offenders’ treatment issues. The objective of motivational interviewing is to increase offenders’ motivation for positive behavioral change by the exploration and resolution of the ambivalence about changing assumed to exist in offenders. It can be used as a formal plan for several sessions of assessment and feedback or as a one-time response to something an offender has done. For example, if an offender fails a UA (urinalysis), the probation and parole officer may ask the offender to explore the positive and negative aspects of drug abuse as the offender sees it to assess his or her ambivalence about quitting (Thigpen, Beauclair, Brown, & Guevara, 2012).

Motivational interviewing is the blending of two strands of counseling thought. According to Burke, Arkowitz, and Menchola (2003), “Motivational interviewing is a relatively new and promising therapeutic approach that integrates the relationship-building principles of humanistic therapy with more active cognitive-behavioral strategies targeted to the client’s stage of change” (p. 843). Motivational interviewing is humanistic in its assumption that the solution to people’s problems lie within themselves and in its emphasis on building rapport between treatment provider and offender. It is also confrontational—but with a difference. Rather than the treatment specialist or probation and parole officer confronting an offender, he or she is trained to guide the offender to confront himself or herself.

There are two stages in motivational interviewing: the contemplative and the action stages. The first stage involves strategies employed by the treatment specialist or probation and parole officer designed to get offenders actually thinking about the desirability of change, and the second stage implements plans of action to put that desire into practice. The contemplative stage involves empathy and developing discrepancy, and the action stage involves rolling with resistance and supporting self-efficacy. The concepts are briefly described below.

#### Empathy

The prerequisite for all counseling is the development of a positive and trusting relationship between the treatment provider and the offender. If the offender does not have
TABLE 11.1 Major Risk and/or Need Factors and Promising Intermediate Targets for Reduced Recidivism

<table>
<thead>
<tr>
<th>FACTOR</th>
<th>DYNAMIC NEED</th>
<th>RISK</th>
</tr>
</thead>
<tbody>
<tr>
<td>History of antisocial behavior</td>
<td>Early and continuing involvement in a number and variety of antisocial acts in a variety of settings.</td>
<td>Build noncriminal alternative behavior in risky situations.</td>
</tr>
<tr>
<td>Antisocial personality pattern</td>
<td>Adventurous, pleasure seeking, weak self-control, restlessly aggressive.</td>
<td>Build problem solving skills, self-management skills, anger management, and coping skills.</td>
</tr>
<tr>
<td>Antisocial cognition</td>
<td>Attitudes, values, beliefs, and rationalizations supportive of crime; cognitive emotional states of anger, resentment, and defiance; criminal versus reformed identity.</td>
<td>Reduce antisocial cognition, recognize risky thinking and feeling, build up alternative less risky thinking and feeling, adopt a reform and/or anticriminal identity.</td>
</tr>
<tr>
<td>Antisocial associates</td>
<td>Close association with criminal others and relative isolation from anticriminal others; immediate social support for crime.</td>
<td>Reduce association with criminal others; enhance association with anticriminal others.</td>
</tr>
<tr>
<td>Family and/or marital</td>
<td>Two key elements are nurturing and/or caring and monitoring and/or supervision.</td>
<td>Reduce conflict, build positive relationships, enhance monitoring and supervision.</td>
</tr>
<tr>
<td>School and/or work</td>
<td>Low levels of performance and satisfaction in school and/or work.</td>
<td>Enhance involvement, rewards, and satisfactions.</td>
</tr>
<tr>
<td>Leisure and/or recreation</td>
<td>Low levels of involvement and satisfaction in anticriminal leisure pursuits.</td>
<td>Enhance involvement, rewards, and satisfactions.</td>
</tr>
<tr>
<td>Substance abuse</td>
<td>Abuse of alcohol and/or other drugs.</td>
<td>Reduce substance abuse; reduce the personal and interpersonal supports for substance-oriented behavior; enhance alternative to drug abuse.</td>
</tr>
</tbody>
</table>


the necessary trust, the rest of the process will be unworkable. To develop that trust, the treatment provider must display empathy by active, reflective, and accepting listening to what offenders are saying. According to Thigpen et al. (2012), this is the most challenging part of motivational interviewing because it requires “expressing accurate empathy to clients by using reflections that convey an understanding of clients’ words and meaning” (p. 15). Motivational interviewing stresses that the counselor must accept that an offender’s ambivalence about change is normal (a reflection of the self-consistency motive) and not pathological defensiveness.

**Developing Discrepancy**

If the offender appears comfortable and trusting, the activity can move on to the process of developing discrepancy. As previously noted, an assumption of motivational interviewing is that offenders are ambivalent about changing their lives; they want to, and they do not want to, at the same time. Discrepancy development is about helping offenders identify their ambivalent feelings between how they are presently and how they would like to be. The counselor or officer strives to increase psychological discomfort (cognitive
dissonance) in offenders so that they will become motivated to reduce it. As Miller and Rollnick (in M. Clark, 2005) put it, “MI [motivational interviewing] considers ‘confrontation to be the goal, not the counselor’s style.’ That is, the goal of helping is to create a ‘self-confrontation’ that prompts offenders to ‘see and accept an uncomfortable reality’” (p. 25). If offenders can be guided to confront a reality that is disquieting to them by themselves, rather than having the counselor or officer point it out, they are more likely to accept it and become motivated to do something about it: “People are more persuaded by what they hear themselves say than by what other people tell them” (Miller & Rollnick, 2002, p. 39). And as Thigpen et al. (2012) opine, “The key to developing discrepancy is trusting and supporting the client in doing his/her own discovery, rather than pointing out and advising him/her on how to discover something that could be meaningful” (p. 64).

**Roll With Resistance**

The counselor or officer is most likely to meet with resistance during the process of developing discrepancy. The motivational-interviewing system says that you must “roll with resistance”; that is, you must avoid arguments by reflecting feelings back on offenders and by turning problems back on them to work out for themselves.

Rolling with resistance describes the ability to avoid getting ‘hooked’ or caught up in a client’s demonstration of resistance, regardless of the form it takes (e.g., rebellious, rationalizing, reluctant, resigned). Rolling with resistance implies taking the client’s manifestation of resistance seriously as a signal for changing tactics, but not taking it personally. (Thigpen et al., 2012, p. 70)

Too much resistance probably means that the process has moved into the action phase (see Figure 11.2) prematurely, and you should return to the contemplative stage and try another strategy.
Support Self-Efficacy

Self-efficacy is the extent to which a person believes in his or her ability to complete tasks and achieve goals. To support self-efficacy means “to be willing to pay close attention and either create or use available opportunities for reinforcing the client’s sense of capacity or confidence for achieving (prosocial) goals” (Thigpen et al., 2012, p. 71). Self-efficacy is essentially the confidence persons have in themselves to successfully accomplish what they set out to do. Counselors or officers must reinforce any positive statements made by offenders that indicate a can-do attitude. The basics of the process of motivational interviewing are presented in schematic form in Figure 11.2.

Cognitive Behavioral Therapy

The therapeutic concepts and methods that proponents of the RNR model find most useful in addressing offender risks and needs are cognitive behavioral (Ward et al., 2007). Most of today’s programming consists of cognitive behavioral therapy (CBT). CBT is an approach that tries to solve dysfunctional cognitions, emotions, and behaviors in a relatively short time through goal-oriented, systematic procedures, and it has been called “the most overtly ‘scientific’ of all major therapy orientations” (McLeod, 2003, p. 123). There are a number of different treatment models that fall under the CBT model; they include moral reconation, reasoning and rehabilitation, rational emotive behavior therapy, and, of course, motivational interviewing. We cannot go into the fine nuances that differentiate these models but must be content with outlining the commonalities of all CBT approaches. What these models have in common is that they attempt to change dysfunctional thinking patterns by improving empathy, moral reasoning, planning, and problem-solving skills, and CBT combines the principles of operant psychology, cognitive theory, and social-learning theory. Operant psychology asserts that behavior is determined by its consequences (rewards and punishments). Cognitive theory asserts that at a more proximal level, self-defeating behaviors are the result of unproductive thought patterns relating to our history of rewards and punishments (D. Wilson, Bouffard, & Mackenzie, 2005). We can do nothing about past experiences (they are static risk factors), but we can do something to put the way we think about those things into proper perspective. (Thinking is dynamic—open to change.) Finally, social-learning theory is a sociological view of socialization that asserts that behavior is learned by modeling and imitation, as well as our history of rewards and punishments.

Albert Ellis (1989) claims that the great religious leaders of the past were cognitive behavioral therapists because they were trying to get people to change their behavior from self-indulgence to temperance, from hatred to love, and from cruelty to kindness by appealing to their rational long-term self-interest. The common message imparted by religion is the need for personal change and the rewards that such change brings with it: “Do these things, and you will feel good about yourself now, and you will be eternally rewarded.” This is what CBT tries to do: change offender’s antisocial and self-destructive behavior into prosocial and constructive behavior by changing the way they think and by showing them that it is in their best interests to do so.

CBT and Criminal Thought

The first lesson of CBT is that criminals think differently from the rest of us. Yochelson and Samenow (1976) and Samenow (1999) pioneered treatment theories based on challenging criminal thinking errors when they realized that modalities based on “outside circumstances” theories did not work. The task is to understand how criminals perceive and evaluate themselves and their world so that we can change them. Criminal thinking
is destructive; it lands them in trouble with family, friends, employers, and the criminal justice system. Habitual offenders tend to perceive the world in fatalistic fashion, believing that there is little that they can do to change the circumstances of their lives. To illustrate this fatalism and other criminal thinking patterns, Boyd Sharp (2006) cites a cartoon in which one of the characters named Calvin says,

I have concluded that nothing bad I do is my fault. . . . I’m a helpless victim of countless bad influences. An unwholesome culture panders to my undeveloped values and it pushes me into misbehavior. I take no responsibility for my behavior. I’m an innocent pawn of society. (p. 3)

Criminals think like Calvin, in the context of a society where many people prefer to claim victimhood rather than personal responsibility. (McDonald’s made me fat, cigarette companies made me smoke, and so on.) Many mainstream criminological theories locate the blame for crime on external factors, such as poverty and peer pressure, rather than allowing criminals the dignity of owning responsibility for their behavior. Criminals are eager to jump on authoritative pronouncements that excuse their behavior, and defense lawyers are equally quick to argue them in court. All of this reinforces the patterns of criminal denial that treatment providers find so frustrating (B. Sharp, 2006; Walsh & Stohr, 2010). Challenging and changing maladaptive thought patterns takes on a central role in treatment, as corrections workers strive to impress on offenders that whatever influences external factors may have on behavior, before they can affect behavior, they have to be evaluated by individuals. The frustrations we experience in everyday life certainly do influence our behavior, but they just as certainly do not determine it. The important thing is not the presence of stresses, strains, and frustrations but whether we deal with them constructively or destructively. The task of correctional workers is to teach criminals to stop blaming outside circumstances for their problems, how to take responsibility for their lives, and how to deal constructively with adversity.

CBT methods are used to address issues relating to self-control, victim awareness, relapse prevention, critical reasoning, and anger control (Vanstone, 2000). CBT therapy literally “exercises the thinking areas of the brain and thereby strengthens the [neuronal] pathways by which the thinking brain influences the emotional brain” (Restak, 2001, p. 144). If you receive a high enough “dosage” of CBT, it can literally reorganize the brain’s wiring patterns (Vaske, Galyean, & Cullen, 2011). A number of brain-imaging studies show that CBT changes brain processes exactly the way that drugs such as Prozac do (Linden, 2006). A systematic review of brain-imaging studies revealed neurobiological changes in people undergoing cognitive behavioral therapy. These studies show that cognitive behavioral therapy modifies the brain circuits involved in the regulation of negative emotions and fear extinction in treatment subjects. In short, CBT is able to change dysfunctions of the brain (Porto et al., 2009). However, these studies have only been conducted with individuals with problems such as depression, anxiety, and obsessive–compulsive disorder, in which patients, unlike most criminals, are intensely motivated to overcome their problems.

**SUBSTANCE ABUSE PROGRAMMING**

Alcohol is, at the same time, our most popular and most deadly way of drugging ourselves. Police officers spend more than half their law enforcement time on alcohol-related offenses. One third of all arrests (excluding drunk driving) in the United States are for alcohol-related offenses, about 75% of robberies and 80% of homicides involve
Many of you have seen the movie The Silence of the Lambs, featuring the manipulative and charming Dr. Hannibal Lecter—a psychopath. While psychopaths are only about 1% of the general population, they compose 15% to 25% of prison inmates (Kiehl & Hoffman, 2011). Psychopaths have been found to have brains that do not make proper connections between areas governing the rational and emotional components of behavior in hundreds of brain-imaging studies (reviewed in Raine, 2014). The tend to make decisions based almost entirely on rationality (“How do I maximize benefits for myself?”), without those decisions being moderated by the social emotions of empathy, guilt, shame, and embarrassment. (“How will my decisions impact others, and how will that make me feel?”)

The conventional wisdom has been that treatment makes psychopaths worse. A study of psychopaths treated in a therapeutic community had a higher violent recidivism rate than untreated psychopaths (Hare, 1993). Treatment provides psychopaths with new information that they use to become better at manipulating others. As one psychopath remarked, “The programs are like finishing school. They teach you how to put the squeeze on people” (Hare, 1993, p. 199). This, as well as the strongly genetic nature of psychopathy, led to the conventional wisdom in corrections that psychopaths are impossible to treat (Polaschek, 2014).

Attitudes about treating psychopaths are beginning to change with the emergence of new techniques. The new thinking is that instead of treating psychopathy in general, we should target specific subtraits of the syndrome: cognitive, emotional, and behavioral (Felthous, 2015). Felthous recommends medication with an anti–impulsive aggression agent (a selective serotonin reuptake inhibitor such as Prozac), which he says has been shown to be highly effective in a number of studies.

There are new approaches specifically designed for psychopaths that are much more intensive than traditional methods. One such method is decompression therapy (DT). DT is based on positive reinforcement alone because punishment tends to make psychopathy worse and more resistant. (Nearly all of the boys in the program were deemed uncontrollable at the other institutions.) Group members are monitored continuously by staff for any sign of positive behavior, and when it occurs, it is reinforced with some sort of reward. Rewards are scaled; that is, the longer their good behavior persists, the greater the rewards become. Rewards can be a kind word or pat on the back, which can graduate to a candy bar and then to the right to play video games. The treatment program is intense, requiring several hours per day and lasting at least six months. The basic idea behind psychological decompression treatment is similar to the physical decompression a deep-sea diver undergoes during the ascent from a dive. The psychological analog of the physical process is to methodically build (or rebuild) the kind of social connections that are absent in psychopaths and to reduce toxic thoughts and behaviors.

One study of DT followed 248 incarcerated “unmanageable” boys for an average of 54 months after release and showed that 56% of the 101 youths who received the DT recidivated, versus 78% of those who received traditional group therapy who were rearrested. The recidivism rate for violence was 18% for the decompression group, versus 36% for the traditional therapy group (Caldwell & Rybroek, 2005). According to Kiehl and Hoffman (2011), although decompression treatment costs $7,000 more per inmate than traditional treatment, when compared with the costs associated with recidivism and incarceration, the initially high cost of decompression treatment provides an overall positive cost–benefit ratio for taxpayers of about $43,000 more per inmate.

**DISCUSSION QUESTIONS**

1. How would the poor connections between the rational and emotion areas of the brain be useful to psychopaths in pursuit of their goals?

2. Are the time and costs of DT worth it?

3. Why do you think this rewards-only, no-punishment program apparently has some positive effects with psychopaths?

**References**


a drunken offender and/or victim, and about 40% of other violent offenders in the United States were drinking at the time of the offense (Mustaine & Tewkesbury, 2004).

Alcohol is a very powerful and addictive drug and is the biggest curse of the criminal justice system, despite the system’s current obsession with illegal drugs. Illegal-drug usage presents almost as big a problem, with about 67% of state and 56% of federal prisoners being regular drug users prior to their imprisonment (Seiter, 2005). Clearly, mind-altering substances, both legal and illegal, are strongly associated with criminal behavior, and as such, the tendency of many criminals to overindulge in them must be addressed by correctional agencies.

Substance abuse problems are extremely difficult to treat because individuals most at risk for becoming addicted share many of the same traits associated with chronic criminal behavior, with many of these traits being strongly genetic (Vaughn, 2009). For instance, alcoholism researchers divide alcoholics into two types: Type I and Type II. Type II alcoholics start drinking and using other drugs earlier, become more rapidly addicted, and exhibit many more character disorders, behavior problems, and criminal involvement, both prior and subsequent to their alcoholism, than Type I alcoholics (Crabbe, 2002). Genetic researchers maintain that genes are much more heavily involved in Type II than in Type I alcoholism (Crabbe, 2002).

It has been shown that drug addiction and criminality are part of a broader propensity to engage in many forms of deviant and antisocial behavior (Fishbein, 2003; Vaughn, 2009). For instance, the U.S. government’s Arrestee Drug Abuse Monitoring (ADAM) Program collects urine samples from arrestees across the country to test for the presence of drugs. Figure 11.3 shows the percentage of adult arrestees in five large U.S. cities who tested positive for illicit drugs over a 3-year period. The numbers show that illicit-drug abuse is clearly strongly associated with criminal behavior, but the association is not necessarily a causal one. A large body of research indicates that drug abuse does not appear to initiate a criminal career, although it does increase the extent and seriousness of one (Menard, Mihalic, & Huizinga, 2001). In other words, research seems to point to the fact that chronic drug abuse and criminality are part of a broader tendency of some individuals to engage in a variety of deviant and antisocial behaviors. Numerous studies have shown that traits characterizing antisocial individuals, such as conduct disorder, impulsiveness, and psychopathy, also characterize drug addicts (Fishbein, 2003; McDermott et al., 2000). The large body of research indicating a strong genetic vulnerability to alcoholism and drug addiction helps to explain why the many millions who drink and/or experiment with drugs do not descend into the hell of addiction and why others are “sitting ducks” for it (Walsh, Johnson, & Bolen, 2012).

DRUG TREATMENT WITH SWIFT CONSEQUENCES FOR FAILURE: HAWAII’S HOPE PROGRAM

The state of Hawaii has a drug treatment program highly touted by the National Institute of Justice (NIJ, 2012) called Hawaii’s Opportunity Probation with Enforcement
(HOPE). The results of this program are based on 493 drug-using probationers with an elevated risk of violating probation, two thirds of whom were randomly assigned to the HOPE program and the rest to regular supervision. The program emphasizes a “no nonsense” delivery of both treatment and “swift and certain” punishment for violations. HOPE probationers are more closely monitored for drug usage and other violations than control probationers. Figure 11.4 shows that this program had very positive results after 12 months. For instance, HOPE participants were 55% (47 − 21 = 26 ÷ 47 = .553, or 55.3%) less likely to be arrested and 72% less likely to have used drugs. This experiment needs to be repeated in other locations with larger samples, and if results of any further studies come close to Hawaii’s, there is real cause for optimism.

**Perspective from a Practitioner**

**Margaret Jackson, Drug Treatment Specialist**

**Position:** Drug treatment specialist

**Location:** Phoenix, Arizona

**Education:** BS in criminal justice, Northern Arizona University; MA in criminal justice administration, Boise State University; drug and alcohol counseling courses at Rio Salado University

**What are the primary duties and responsibilities of a drug treatment specialist?**

My primary duties are to provide drug abuse treatment to inmates in the federal prison system. I provide individual and group counseling and therapy to drug- and alcohol-addicted inmates incarcerated in the federal prison system. The Federal Bureau of Prisons provides a voluntary but criteria-based program called the Residential Drug Abuse Program (RDAP), a 9-month (a minimum of 500 hours of direct treatment) modified therapeutic community (TC). I provide clinical services using CBT techniques and introduce community as method to the inmates and develop a working system of a therapeutic community. The first step in working with inmates in this process is to determine their eligibility to receive counseling and therapy; one of the tools I use for this is a psychosocial assessment. If an inmate is eligible for treatment, I will use the psychosocial assessment to create an individual treatment plan for the inmate. Once eligibility has been determined and an assessment for treatment has been conducted, a team of three other therapists and I are responsible for providing residential treatment to the offenders. The inmates are assigned a series of workbooks and attend daily meetings. I construct the inmate’s individual therapeutic treatment plans, reviews, and recommendations for further treatment upon release from federal prison.

**What are the qualities or characteristics that are most helpful for one in a probation or parole career?**

- Be fair and consistent
- Have good judgment
- Be aware of population at hand
- Know your craft well
- Be reliable
- Be a team worker
- Be able to communicate with multiple agencies
- Be attentive to detail when writing reports and preparing inmate charts

**Describe, in general, a typical day for a drug treatment specialist in corrections.**

Monday through Friday, the TC starts with a morning meeting called community meeting. This meeting is an inmate-run, self-help meeting, with drug treatment staff supervising. During the treatment meetings and groups, inmates are learning and demonstrating therapeutic language and actions in a public “community” setting. After community meeting, inmates are (Continued)
separated into their appropriate phase group based on the date they entered treatment. RDAP, similar to other TCS, uses a hierarchical form for the 9 to 12 months they are in treatment. Program participants typically have 3.5 hours of treatment daily; during this time, I am working directly with the inmates, providing therapy. Therapy consists of using their RDAP workbooks and a facilitator guide to treat the inmate's addictions and behaviors. In RDAP, there are three phases of treatment, with new inmates entering treatment every 3 months (approximately 25 inmates per phase). With inmates phasing in and out of treatment, creating individual treatment plans, reviews of progress, and treatment summaries for each inmate are my responsibility to maintain and develop.

What is your advice to someone either wishing to study or now studying criminal justice to become a practitioner in this career field?

It would be important to understand the population for which you are providing therapy. In this regard, being an intern in a correctional setting would be beneficial to someone becoming a practitioner, due to the nature of working inside a prison. Finally, practice development and presentation of lectures and seminars to groups, as this will be a skill used often when providing group therapy.

Disclaimer: Opinions expressed in this article are those of the author and do not necessarily represent the opinions of the Federal Bureau of Prisons or the Department of Justice.

**THERAPEUTIC COMMUNITIES**

Therapeutic communities (TCs) are residential settings for drug and alcohol treatment that use the community spirit generated by the influence of peers and various group processes to help individuals overcome their addiction and develop effective social skills. Most such communities offer long-term (typically 6 to 12 months) residence, in which opportunities for attitude and behavioral change operate on a hierarchical model, whereby treatment stages reflect increased levels of personal insight and social responsibility. The interactions of the residents are both structured and unstructured but always designed to influence attitudes and behaviors associated with substance abuse (Litt & Mallon, 2003).

TCs provide dynamic mutual self-help environments, in which residents transmit and reinforce one another's acceptance of and conformity with the highly structured and stringent expectations of the TC and of the wider community. Life in a TC is extremely hard on people who have never experienced any sort of disciplined expectations from others, and as a consequence, there are many dropouts; some residents withdraw voluntarily, and others are removed by TC staff for noncompliance.

TCs also operate within prison walls and are most often known as residential substance abuse treatment (RSAT) communities. These RSATs typically last 6 to 12 months and are composed of inmates in need of substance abuse treatment and whose parole dates are set to coincide with the end of the program. RSAT inmates are separated from the negativity and violence of the rest of the prison, are provided with extensive cognitive behavioral counseling, and attend Alcoholics Anonymous (AA) and Narcotics Anonymous (NA) meetings, as well as many other kinds of rehabilitative classes (Dietz, O’Connell, & Scarpetti, 2003). Most participants in these RSATs are positive about most aspects of their experience, with most inmates listing cognitive self-change programs as the most positive aspect of their treatment (Stohr, Hemmens, Shapiro, Chambers, & Kelly, 2002). Dietz et al. (2003) also found that most inmates in prison-based TCs were positive about the program and that they had significantly fewer rule violations and rates of grievance filing than inmates in the general population.
**FIGURE 11.3** Percentage of Arrestees Testing Positive for Drugs in Five U.S. Cities, 2007–2013

*Differences between each year and 2013 are significant at the 0.05 level or less.*

Note: Most recent data available.


**FIGURE 11.4** Comparison of Outcomes Between HOPE and Control Probationers

An interesting program implemented in a prison setting and transitioning into the community is the Delaware Multistage Program (Mathias, 1995). In Phase 1, offenders spend 12 months in a prison-based TC called Key; in Phase 2, they spend 6 months in a prerelease TC called Crest; and finally, in Phase 3, they receive an additional 6 months of counseling while on parole or in work release. The National Institute of Justice (2015a) lists several phases of treatment that offenders go through during their time in the Crest program after release from prison:

- **Entry, evaluation, and orientation:** Offenders get used to life outside of prison.
- **Primary:** Counselors and offenders explore the challenges and issues faced by individual offenders and prepare appropriate responses to minimize the likelihood of relapse.
- **Job seeking:** Offenders develop job-seeking and interviewing skills.
- **Work release:** Offenders maintain residence at Crest while working in the community.

The final component of the program, after offenders have completed Crest, is aftercare while on parole and living full-time in the community. They are required to return weekly to an assigned center for group counseling and are subject to random mandatory drug testing.

Figure 11.5 compares drug use and arrest outcomes for offenders completing all phases (Key, Crest, and Key-Crest) 18 months after release from prison and a group of offenders who did not participate in any of the phases. We see that 76% of Key-Crest members remained drug free, and 71% remained arrest free, compared with only 19% and 30%, respectively, of the control group. Put another way, 3 times as many Key-Crest participants were drug-free after 18 months than the comparison group, and 2.37 times more Key-Crest participants were arrest free than the comparison group.

Inciardi, Martin, and Butzin (2004) followed this same group 5 years after release from prison. As expected, the greater the time lapse between treatment and evaluation, the greater the relapse rate. Over the 5-year period, it was found that 71% of drug abusers who went through a residential treatment program and who received additional treatment upon release (the Key-Crest group) had relapsed, and 52% had been rearrested. However, the contrast with the comparison group still makes the Key-Crest program impressive. Among the comparison subjects, 95% had relapsed, and 77% had been rearrested. This study shows how extremely difficult it is to battle addiction, even after a long period of forced abstinence and extensive psychosocial treatment.

**PHARMACOLOGICAL TREATMENT**

Allan Leshner (1998) informs us that addiction is a brain disease and a “prototypical psychobiological illness, with critical biological, behavioral, and social context elements” (p. 5). As addiction is basically a brain chemistry problem, pharmacological treatment with drug antagonists (drugs that work by blocking the effects of other drugs) stabilizes brain chemistry and renders addicts more receptive to psychosocial counseling. Proponents of pharmacological treatment emphasize that it is not a magic bullet and that it augments, not replaces, traditional treatment methods.
There are many drug antagonists, but only one has claimed success in curbing both alcohol and drug addiction: naltrexone. Naltrexone reduces craving among alcohol- and drug-abstinent addicts and reduces the pleasurable effects of those who continue to use (Schmitz, Stotts, Sayre, DeLaune, & Grabowski, 2004). A study of drug addicts on federal probation found that about one third of probationers who received naltrexone plus counseling relapsed, as opposed to two thirds of those who only received counseling (Kleber, 2003). A new drug called Vivitrol is a slow-release (it releases the drug into the bloodstream slowly over a period of days) version of naltrexone that controlled clinical trials have shown to be effective in preventing not only drug abuse relapse but also to diminish the cravings that drive it. “Vivitrol is the first non-narcotic, non-addictive, extended release medication approved for the treatment of opioid dependence—marking an important turning point in our approach to treatment” (Volkow, 2010, n.p.).

Proponents of pharmacological treatment claim that the effects of such treatment are more effective and immediate and wonder why the correctional system is relatively uninterested in pharmacological treatment (Kleber, 2003). It could be that corrections professionals received their training primarily in the social sciences, and there are some who have genuine ethical problems regarding chemical treatments for behavioral problems. However, according to the National Institute on Drug Abuse (2006), while medication is important for treating many addicts because medication helps them to stabilize their lives, it must be combined with counseling.

### ANGER MANAGEMENT

A central component of many treatment programs in corrections is anger management, particularly in violent, drug, and sex offender treatment programs. Anger management programs: Programs that consist of a number of techniques by which someone with problems controlling anger can learn the causes and consequences of anger, to reduce the degree of anger, and to avoid anger-inducing triggers.
programs consist of a number of CBT techniques by which someone with problems controlling anger can learn the causes and consequences of anger, to reduce the degree of anger, and to avoid anger-inducing triggers. Anger is often central to violent criminal behavior, and given the frustrations resulting from being in custody or under correctional supervision in the community, it often leads to violence. Anger is a normal and often adaptive human feeling that is aroused when we feel that we have been offended or wronged in some way. The tendency to undo that wrongdoing by retaliating is motivated by anger and is adaptive in the sense that it warns those who have offended or wronged you that you are not to be treated that way. The problem, however, is not anger per se but rather the inability of some to manage it. These individuals often become excessively angry over minor real or imagined slights, to the point of rage.

Anger management classes are taught in groups and designed to increase offenders’ responsibility for ownership of their emotions (anger) and their reactions to them. Offenders often become frustrated and angry because they think life is not fair to them (“I’m a victim of circumstances”) and the world owes them a living. This kind of destructive thinking must be challenged and replaced by individual responsibility. Anger management classes also teach such skills as rational thinking (“Did this person really mean to dis me?”) to increase offenders’ ability to react to frustration and conflict in assertive rather than aggressive ways and to develop effective communication skills (Jolliffe & Farrington, 2009). There appears to be a growing consensus that properly conducted anger management programs reduce inmate violence and reduce violent recidivism for program completers versus control subjects by about 8% to 10% (Jolliffe & Farrington, 2009; Serin, Gobeil, & Preston, 2009). Although this seems like a small return on a corrections investment, even an 8% reduction in violent offenses prevents much needless suffering and saves millions of dollars in expenses.

**SEX OFFENDERS AND THEIR TREATMENT**

The American public harbors all sorts of very negative images of sex offenders. We lock them up under civil commitment orders after they have completed their prison terms, and all 50 states have sex offender registration laws (Talbot, Gilligan, Carter, & Matson, 2002). However, the term sex offender defines a very broad category of offenders, ranging from “flashers” to true sexual predators, just as property offenders include everyone from petty shoplifters to career burglars. At least 98% of all sex offenders are either in the community on probation or parole or will be some day (Carter & Morris, 2002), making the issue of sex offender treatment of the utmost importance.

Although it is part of popular lore that sex offenders are untreatable and will never stop their offending, as a category of offenders, they are actually less likely to reoffend than any other category. A review of 61 studies of sex offender recidivism found an average rate of reconviction for sexual crimes of 13.4% over a 4- to 5-year follow-up (Hanson &
Perhaps the most instructive study of recidivism conducted to date was a study by the Bureau of Justice Statistics, whose researchers tracked 9,691 sex offenders released from prisons in 15 states in 1994 (Langan, Schmitt, & Durose, 2003). Over the 3-year period of the follow-up, sex offenders had a lower rearrest rate (43%) than 272,111 non–sex offenders released at the same time in the same states (68%). Rearrest rates included all types of crimes and technical violations, such as failing to register as a sex offender or missing appointments with their parole officers. Only 3.5% of the sex offenders were reconvicted of a new sex crime during the follow-up period. Because recidivism rates include only those offenders who have been caught, in common with other types of offenders, the above figures should be considered bare minimums.

State-of-the-art treatment of sex offenders must include a thorough assessment of psychosocial problem areas, deviant arousal patterns, and polygraph assessment (Marsh & Walsh, 1995). A number of states have made polygraph testing mandatory for sex offenders on probation or parole to determine if offenders are engaging in noncompliant behavior. The polygraph is also used for the purpose of obtaining a complete sexual history of the offender for treatment purposes and for offenders in denial of the offense or who minimizing its seriousness or their responsibility for it. (“She wanted it.” “I was drunk.”) Monitoring examinations are administered typically every 6 months. Counselors are in agreement that effective treatment is impossible until the full extent of the offender’s sex-offending history is acknowledged by him or her and known to treatment personnel (Walsh & Stohr, 2010). But sex offenders are notorious for hiding their sexual histories, so polygraph assessment is needed to access their sexual histories. Comparing self-reports before and after polygraph testing across two decades of research, it has been found that child molesters underreport the number of sex crimes they have committed by about 500% and overreport their own childhood sexual victimization (the “I’m a victim too” excuse) by about 250% (Hindman & Peters, 2001). The polygraph may therefore be seen as a very useful tool if the first goal of treatment is to honestly acknowledge one’s sexual history.

Another useful tool in the assessment of sex offenders is the penile plethysmograph (PPG). The PPG measures blood flow in the penis by a placing a small, expandable,
pressure-sensitive rubber gauge filled with mercury at the base of the penis. This gauge sends information to a machine that relays information about the level of expansion of the penis as the offender is exposed to sexually suggestive pictures and videos. Machine readings then enable treatment professionals to determine the offender’s level of sexual attraction to various subjects (boys, girls, rape, sadism, and so on) by measuring changes in his erectile responses. This enables an evaluation of offenders’ attraction to deviant sex relative to consensual adult sex by creating a measure dividing the level of penile arousal to deviant stimuli to arousal to consenting sex. Hanson and Bussière’s (1998) meta-analysis showed PPG response to sexual depictions of children to be the most accurate method of identifying sexual-recidivism risk.

PHARMACOLOGICAL TREATMENT

Unlike treatment for other problems in corrections, there has been a great deal of interest in the pharmacological treatment of sex offenders. Numerous researchers have concluded that optimal treatment (following a thorough psychosocial and physiological assessment) combines the biomedical with cognitive behavioral approaches (Walsh & Stohr, 2010). The biomedical approach involves so-called chemical castration. There are a number of medications that are used for chemical castration, but the most widely used is a synthetic hormone called Depo-Provera, which is also sold as a method of female birth control. Depo-Provera works in males to reduce sexual thoughts, fantasies, and erections by drastically reducing the production of testosterone, the major male sex hormone. (Other medications used to treat sex offenders affect testosterone receptor sites rather than reducing its production.) Depo-Provera prevents testosterone production, and it is testosterone activating a part of the brain called the hypothalamus that controls the male sex drive. Depriving the brain of testosterone allows offenders to concentrate on their psychosocial problems without distracting sexual fantasies and urges (Marsh & Walsh, 1995). A review of 11 meta-analyses covering 353 separate studies, from 1943 to 2009, found that surgical castration had the strongest effect on recidivism, followed by chemical castration (Kim, Benekos, & Merlo, 2016). Insight-oriented therapies such as psychoanalysis had essentially no effect, but cognitive behavioral therapy had a significant effect, though much less if not combined with some form of antitestosterone medication.

Following the state of California in 1997, several states now mandate chemical castration (“castration” is reversible upon withdrawal from the drug) for repeat offenders. Not all sex offenders should be treated with this drug because there are sometimes negative side effects, and treatment can only be provided by a medical doctor. However, a number of reviews of the literature from Europe and America show that antiandrogen drugs such as Depo-Provera result in recidivism rates for repeat rapists and child molesters that are remarkably low (in the 2% to 3% range) when compared with offenders treated with only psychosocial methods (Maletzky & Field, 2003).

MENTALLY ILL OFFENDERS

As graphically indicated in Figure 11.7, from the Council of State Governments Justice Center (2013), mental illness lurks behind many factors that are linked to criminal behavior. Mentally ill offenders under correctional supervision present a particularly difficult treatment problem. Alcoholics and drug addicts ingest substances that alter the functioning of their brains in ways that interfere with their ability to cope with everyday life, although their brains may be normal when not artificially befuddled. Mentally ill persons also have brains that limit their capacity to cope, but that limitation is intrinsic
to their brains, not attributable to intoxicating substances. Studies around the world have found that mentally ill persons (mostly schizophrenics and manic depressives) are at least 3 to 4 times more likely to have a conviction for violent offenses than persons in general (Fisher et al., 2006). Most mentally ill persons, however, are more likely to be victims than victimizers, and many of them make their problems worse by abusing alcohol and/or drugs (Walsh & Yun, 2013). It because of their substance abuse and greater propensity for violence, in addition to mental-hospital deinstitutionalization, that the mentally ill are overrepresented in the correctional system.

Torrey and his colleagues (2014) tell us that there were an estimated 356,268 inmates with severe mental illness in prisons and jails in the United States in 2012 and approximately 35,000 severely mentally ill patients in psychiatric hospitals. In addition, the David L. Bazelon Center for Mental Health Law (2008) estimates that about 16% of individuals on probation or parole have some form of mental illness. This state of affairs results from the deinstitutionalization of all but the most seriously ill patients from mental hospitals that occurred in the 1960s. For instance, there were 559,000 persons in U.S. mental hospitals in 1955; in 2000 (with a U.S. population about 80% greater), there were only 70,000 (Gainsborough, 2002), and as we have seen, it was down to 35,000 in 2012. Deinstitutionalization of the mentally ill from mental hospitals has shifted to their institutionalization in jails and prisons, which, in essence, has resulted in the criminalization of mental illness (Lurigio, 2000). Table 11.2 presents the highlights of a Bureau of Justice Statistics report on the mental-health problems of prison and jail inmates (James & Glaze, 2006).

Mentally ill offenders in jails and prisons are often victimized by other inmates, who call them “bugs” and exploit them sexually and materially (stealing from them), although most inmates seek to avoid them. Mentally ill offenders are also punished by corrections
officers for behavior that, though not pleasant, is symptomatic of their illness. These behaviors include such things as excessive noise, refusing orders or medication, self-mutilation, and poor hygiene. Obviously, correctional facilities are not the ideal place for providing mental-health treatment, even assuming that the staff is aware who the mentally ill are among their charges. Few correctional or probation and parole officers have any training about mental-health issues, and one nationwide survey of probation departments found that only 15% of them operated special treatment programs for the mentally ill (Lurigio, 2000). It is not that anyone expects correctional workers to become treatment providers because that’s a job for psychologists and psychiatrists. However, they should be expected to recognize signs and symptoms of mental illness, should know how to effectively deal with situations involving mentally ill persons, and should have a basic understanding of the causes of and treatment for the major mental illnesses.

Treatment for the mentally ill in prisons and jails consists primarily of antipsychotic and antidepressive medication, typically administered by a nurse. Many mentally ill individuals, especially paranoid schizophrenics, often refuse to take their medication. It is permissible in a number of states to forcibly treat mentally ill inmates if they meet state-specific criteria, which is typically if inmates pose a risk to others or themselves. This is determined on a case-by-case basis by a review committee composed of correctional and medical professionals (Torrey et al., 2014). Of course, just because such procedures are authorized by the state does not mean that they are utilized or that the inmate will be treated. According to Torrey and his colleagues (2014),

### TABLE 11.2
Prevalence of Mental-Health Problems Among Prison and Jail Inmates

<table>
<thead>
<tr>
<th>SELECTED CHARACTERISTICS</th>
<th>PERCENTAGE OF INMATES IN . . .</th>
<th>STATE PRISON</th>
<th>LOCAL JAIL</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>WITH MENTAL PROBLEM</td>
<td>WITHOUT</td>
<td>WITH MENTAL PROBLEM</td>
</tr>
<tr>
<td>Criminal record</td>
<td>61%</td>
<td>56%</td>
<td>44%</td>
</tr>
<tr>
<td>Current or past violent offense</td>
<td>25%</td>
<td>19%</td>
<td>26%</td>
</tr>
<tr>
<td>Three or more prior incarcerations</td>
<td>74%</td>
<td>56%</td>
<td>76%</td>
</tr>
<tr>
<td>Substance dependence or abuse</td>
<td>63%</td>
<td>49%</td>
<td>62%</td>
</tr>
<tr>
<td>Drug use in month before arrest</td>
<td>13%</td>
<td>6%</td>
<td>17%</td>
</tr>
<tr>
<td>Family background</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Homelessness in year before arrest</td>
<td>27%</td>
<td>10%</td>
<td>24%</td>
</tr>
<tr>
<td>Parents abused alcohol or drugs</td>
<td>39%</td>
<td>25%</td>
<td>37%</td>
</tr>
<tr>
<td>Charged with violating facility rules*</td>
<td>58%</td>
<td>43%</td>
<td>19%</td>
</tr>
<tr>
<td>Physical or verbal assault</td>
<td>24%</td>
<td>14%</td>
<td>8%</td>
</tr>
<tr>
<td>Injured in a fight since admission</td>
<td>20%</td>
<td>10%</td>
<td>9%</td>
</tr>
</tbody>
</table>

*Includes items not shown.

Note: Most recent data available.

Given the many legal difficulties in providing treatment for individuals with serious mental illness in prisons and jails, it is not surprising that many of them, including those who are most severely ill, receive no treatment whatsoever. This leaves corrections officers with few options for controlling mentally ill inmates’ psychotic, often violent behavior. One option is seclusion, which often makes the inmate’s mental illness worse. (pp. 104–105)

What is both morally and fiscally required of the criminal justice system is to provide offenders with mental illness the support and structure they need to avoid further criminal behavior. One of the ways this is attempted is through mental-health courts, which are modeled on drug courts in use across the nation (and discussed earlier). As with drug courts, mental-health courts seek to divert offenders from jails and prisons by facilitating their access to services, providing intensive judicial monitoring, and promoting collaboration between the court, probation, and mental-health service and social-service providers.

EDUCATIONAL AND VOCATIONAL PROGRAMS

In addition to psychological treatment issues addressed here, prisons also provide academic education leading to the GED and/or provide English literacy classes. Inmates who were too bored with formal education as teenagers or were more attracted to other things may be more open to such programs now that there are far fewer other things to occupy their minds. These programs are sorely needed because, when compared with the general population, inmates are severely undereducated. The lack of education limits their job prospects and their ability to handle common tasks that confront them in everyday life. Inmates who earn a GED may also have the opportunity to further their education, possibly provided by volunteers from local colleges or by taking advantage of free MOOCs (massive open online courses), if they have computer privileges.

Studies have demonstrated that inmates who go beyond the GED and participate in post-secondary education (PSE) have lower recidivism rates. One meta-analysis of 15 studies found that 14 showed that overall, recidivism rates for ex-inmates who had participated in PSE were about 46% lower than for ex-inmates who did not (Chappell, 2004). Of course, we cannot discount the motivation and intelligence of those who self-select into PSE and thus were probably less likely to recidivate anyway. This is a problem encountered with all kinds of prison programs; they are voluntary, and volunteers may be more likely to be motivated to change. On the other hand, an inmate’s voluntary participation in a program may be motivated by a desire to impress the parole board or to just get out of the cell for a while. Once in the program, however, an inmate may come to value it for its own value.

When individuals are not randomly assigned to a treatment (correctional education), it is necessary to use a comparison group and use statistical controls to try to eliminate the self-selection factor. A Rand Corporation meta-analysis of 58 studies using comparison groups concluded, “After examining the higher-quality studies, we found that, on average, inmates who participated in correctional education programs had 43 percent lower odds of recidivating than...
inmates who did not” (Davis, Bozick, Steele, Saunders, & Miles, 2013, p. 57). The study also suggests that prison education programs are cost-effective. It was estimated that for each $1 invested in prison education, incarceration costs were reduced by $4 to $5 during the first three years after release. Unfortunately, the 2008 recession cut deeply into prison treatment budgets, and many educational programs were cut. However, Davis et al. (2013) indicate that there has been an uptick in prison education budgets since about 2011, as states have come to understand the long-term budgetary advantages of providing prisoners with minimal educational tools.

Prison education programs have their strongest effect indirectly via the increased probability of employment. The Rand study found that prisoners who participated in vocational programs were 28% more likely to gain employment upon release than individuals who had not participated in vocational training. Those who participated in academic programs (GED and postsecondary education) had only 8% higher odds of obtaining employment after release than individuals who did not participate in academic programs. However, even the successful completion of the GED should favorably affect inmates’ sense of agency and self-esteem and offer them a glimmer of hope that they can make it in the legitimate world. Further discussion of vocational programs is deferred until the next chapter on parole and reentry.

**SUMMARY**

- Although the vast majority of the correctional budget is spent on security, rehabilitation efforts have not completely ceased. The success rates of many rehabilitation programs are low, but outcomes are significantly better for treated offenders than for similarly situated offenders who did not receive treatment.

- Successful treatment programs implement EBPs that proceed by conducting a thorough assessment of offenders’ risks and needs and then address these issues using the principles of responsivity. This model is best begun using the techniques and guidance of motivational interviewing.

- The major programming and counseling model used in corrections is cognitive behavioral therapy (CBT). CBT is used to address and change criminal thinking patterns and to get them to take responsibility for their own lives.

- Treatment is best accomplished for severe substance abusers in therapeutic communities, although even then, there is a significant percentage of failure. Much of this failure has to do with the intense psychological craving for the substance of abuse, which is something that may be significantly alleviated by certain alcohol and drug antagonists, such as naltrexone.

- Similar observations were made about sex offenders, who have difficulty refraining from acting out their sexual fantasies with inappropriate targets. Repeat sex offenders treated with Depo-Provera combined with cognitive behavioral counseling have much lower recidivism rates compared with offenders treated only psychologically.

- Mentally ill individuals are represented in the correctional system by a factor of at least 3 or 4 times their prevalence in the general population. The correctional system is not equipped to deal with mentally ill people, who are often victimized by other jail or prison inmates or disciplined by corrections officers for exhibiting behavior that is basically part of their mental disease.

**KEY TERMS**

- Actuarial data 268
- Addiction 278
- Anger management programs 279
- Chemical castration 282
- Cognitive behavioral therapy (CBT) 271
- Evidence-based practice (EBP) 265
- Motivational interviewing 268
- Needs principle 267
DISCUSSION QUESTIONS

1. In your estimation, are the time, effort, and finances spent on rehabilitative efforts worth it, given the low success rates? Would longer periods of incarceration better protect the public?

2. Cognitive behavioral approaches stress thinking and rationality. How about emotions? Do you think that human behavior is motivated more by emotions than by rationality?

3. Given the greater involvement of genes in Type II alcoholism, in what ways would you treat Type II alcoholics differently from Type I alcoholics if you were a treatment provider? How about if you were a probation and parole officer?

4. Should all sex offenders undergo Depo-Provera treatment? What are the ethical problems of such invasive treatment?

5. Discuss the various component parts of the responsivity principle.

USEFUL INTERNET SITES

Please note that the sites listed can be accessed at edge.sagepub.com/stohrcorrections.

Center for Evidence-Based Practices: www.ohiosamicoe.cwru.edu

The center’s website provides consulting, training, evaluation for service innovations that improve quality of life and other outcomes for people with mental illness and substance use disorders.

Information on Risk and Needs: www.riskandneeds.com

This site offers everything you ever wanted to know about assessing risk and needs. It also provides a chat room.

Treatment of Sexual Offenders: www.atsa.com

A site with much information about policy, prevention, research, and evaluation of sexual offenders.

The Prison Studies Project: prisonstudiesproject.org/why-prison-education-programs/#_ftn17

This is a directory of nationwide postsecondary programs in U.S. prisons, by state, that is searchable and continually updated.