

Adhering to principles of effective correctional treatment: Academic musings of a former clinician and administrator

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The now classic article by Andrews, Bonta and Hoge (1990) on risk, need and responsivity (RNR) as core principles of effective correctional intervention has been followed by a host of research papers in various publications including Forum on Corrections Research and the Compendium 2000 on Effective Correctional Programming.² These subsequent papers have examined, empirically validated, expanded upon and solidified RNR's position, not only in correctional theory and practice but also in the lexicon of corrections discourse. One paper in particular takes these principles beyond the commonly accepted characteristics of clinically relevant programming – i.e., risk, need and responsivity – by including setting, staff, implementation and integrity issues, to generate a total of 18 principles of effective correctional intervention (Andrews, 2001).

This paper is a reflection on some of Andrews' (2001) principles by an academic who, in random order and by coincidence more than anything else, has worn the shoes of a correctional administrator, clinician and researcher. Although administrative issues arise with each of these principles, let us begin with a sample of those that are relatively straightforward to implement at the organizational level and then move to some that can be difficult and problematic.

Adhering to the responsivity principle

General responsivity is one of the easier principles for a correctional agency to embrace. Soliciting a group of clinicians and researchers who know the offender treatment literature, including meta-analyses, can now, with considerable efficiency, produce a treatment program, with a standardized curriculum, that is cognitive-behavioural (CBT) in design and delivery and incorporates the elements commonly considered 'best practice' in current correctional practice. This is likely to include such components as relapse prevention, as well as numerous CBT techniques such as role playing, practice, cognitive rehearsal and homework. Accreditation panels of experts can then be established with some ease to evaluate the 'integrity'

of these services as a set of evaluation criteria may be derived quite directly from the principle of general responsivity.

The concern, however, indeed the 'knock' against what has become widespread practice, has been the so-called 'one size fits all' approach to offender treatment. The rebuttal of course is that such concerns can be accommodated by the 'specific responsivity' principle in that, of course, these programs are sensitive to the individual learning styles, demographic characteristics (e.g., race, gender) and strengths of the offender clientele. But are they? Although some programs are actually able to blend general with specific responsivity principles while maintaining the standard, and presumably more efficient, group format (the treatment of developmentally delayed sex offenders and aboriginal substance abusers are two common examples), the 'cookie cutter' criticism against other programs seems all too apt.

Indeed, the idiosyncrasies of individual clients are often too specific to be accommodated in a group format. In such instances, the only way to provide a clinical service that is really capable of adhering to specific responsivity is through individual treatment sessions. In the rush for efficiency and the quest to adhere to general responsivity, traditional one-on-one clinical services have receded from the minds of many correctional administrators, clinicians and researchers. Although still commonly practiced and indeed the norm among probation officers, researchers in particular should be devoting more time to investigating the crucial variables that have an impact on the outcome of individual client services and the factors that may interact with specific responsivity factors on such an outcome.

Adhering to the need principle

In this day and age, the need principle also lends itself to fairly easy implementation in correctional treatment settings. In large part, this is because of the proliferation of research (particularly meta-analyses) that espouses and demonstrates the superior effectiveness of programs and services that address the criminogenic needs of individual offenders

(Andrews, Zinger, Hoge, Bonta, Gendreau & Cullen, 1990; Aos, Miller & Drake, 2006; Dowden & Andrews, 2000; McGuire, 2005). The outcome of these programs in terms of reduced recidivism is considerably better than non-specific general counselling and psychotherapy.

Another kind of problem is to accept the proposition that a program will affect outcome even though it does not target a criminogenic need specifically, but sounds like it might.

An important caveat, of course, is that the designated treatment must address a criminogenic need of the offender who is participating in such a program. In other words, the offender referred to a substance abuse program must have a substance abuse problem if the program is to demonstrate a positive outcome for this specific client.

This principle may be violated by some clinicians and administrators who have a penchant for finding a problem where one does not really exist. This may occur particularly when a program is accessible (i.e., it is ready to begin and has vacancies). Believing that ‘something is better than nothing,’ one may be tempted to refer the offender to a treatment program because it is indeed designed to address a research-proven criminogenic need.

Another kind of problem is to accept the proposition that a program will affect outcome even though it does not target a criminogenic need specifically, but sounds like it might. Some of the kinds of programs that have been proposed to reduce recidivism are quite laughable. Gendreau and colleagues have gone to some length to expose them (Gendreau, Goggin, French & Smith, 2006; Latessa, Cullen & Gendreau, 2002). Others may be less clear and, indeed, may have a certain amount of intuitive appeal to the correctional administrator and clinician, although they remain untested.

Here, a ‘catch-22’ may occur in that their potential impact remains a mystery until they are researched, and many self-respecting researchers dare not tread in these uncharted research waters. Moreover, what administrator is willing to risk his or her scarce treatment resources and even scarcer research expertise to undertake such an evaluation?

Indeed, only a few examples of this kind of treatment evaluation research exist (Richardson-Taylor & Blanchette, 2001). More organizations

should be prepared to consider evaluation research of less common kinds of intervention.

Adhering to the risk principle

Although simple enough on paper, adherence to the risk principle is perhaps the most difficult treatment-related task of the correctional administrator. Consider the high-risk, poorly motivated and disruptive offender in a specialized treatment setting, such as the Correctional Service of Canada’s regional treatment facilities or the provincial facility, the Ontario Correctional Institute. These are intensive, dedicated treatment institutions whose relatively few beds (typically about 200 beds to serve a catchment area that may accommodate up to 2,000 inmates) are considered a premium and therefore are the subject of considerable bureaucratic pressure to make the most of them. The treatment setting may be dedicated to particular types of offenders (e.g., sexual, violent, substance abusing, or mentally disordered offenders), or it may be a generic treatment environment devoted to addressing a range of antisocial attitudes and behaviours.

Clinicians and front-line workers in these settings often become frustrated by having to work with the high-risk, poorly motivated and disruptive offender who is taking up valuable treatment space. They may at times make a plea for transferring the offender back to a non-specialized institution based on the offender’s poor motivation, lack of progress, deterioration or what may appear to be ‘sabotage’ of treatment efforts, and disruptive behaviour that negates staff efforts with other offenders. On the other hand, the offender is described as very high risk on both static historical and dynamic criminogenic needs.

In this context, the administrator must consider the realities of the justice system. The offender is most likely serving a fixed sentence and his or her release date has been predetermined. Even the option of detaining an offender, if he or she is serving a federal sentence, to the expiration of the warrant is only a stop-gap measure that delays the inevitable release of a high-risk offender and runs the risk of exacerbating the situation by releasing said offender without any kind of community supervision. Moreover, the correctional administrator realizes that the only safeguard to the latter circumstance is the rarely used Section 810 Order which requires a return to court with an application from the Crown attorney to apply post-sentence conditions. In sum, it is out of the correctional administrator’s hands.

Moreover, the offender may have been assessed as being psychopathic. Such a diagnosis compounds

the deliberations as to whether one should pursue treatment with the offender any further. A well known 'Penetang treatment study' suggests to some clinical professionals and administrators that it is a waste of time to fill these scarce treatment facility beds with such offenders (Rice, Harris & Cormier, 1992). But treatment advocates remind us that the current treatment programs the offender is participating in are a far cry from the kind of treatment (a therapeutic community) that was evaluated by the Penetang group, thus rendering it irrelevant to the question at hand.

In fact, others have found that there is not an overall body of literature indicating that treatment of psychopathic offenders does not work (D'Silva, Duggan & McCarthy, 2004). Others have found that some psychopathic (sexual) offenders who do well in treatment have lower recidivism rates than those who do not do well in treatment (Langton, Barbaree, Harkins & Peacock, 2006). Finally, Steve Wong and Robert Hare (2005) have gone so far as to actually develop a treatment protocol for psychopathic offenders.

So, should one 'sacrifice' the offender in question by expelling the offender from treatment and return him or her to a traditional prison environment, for the benefit of the remaining offenders in treatment who would otherwise be denied the full impact of their intensive treatment program and for the benefit of the staff who would otherwise be at risk of becoming disillusioned about the treatment enterprise and burning out?

In the end, it is a difficult decision. Does one allow the high-risk, problematic offender to 'escape' from the often stressful environment of a treatment setting or does one persevere in the face of what appear to be great odds? If one chooses the latter, it is important that staff appreciate and accept the rationale for doing so. It is also vital that they be prepared for the most resistant of clients, trained in the use of motivational interviewing and related techniques as part of their treatment approach, and understand the changes most offenders have to go through to realize true change (Cox & Klinger, 2004; Miller & Rollnick, 2002; Prochaska & DiClemente, 1984).

Adhering to professional discretion

Allowing professional discretion, Andrews' 13th principle, is one that is embraced by some correctional clinicians and administrators and distained by others.

This divergence of opinion is seen most frequently in the area of offender risk assessment, particularly

when invoking a 'clinical' override to an actuarial or statistically derived 'objective' assessment of offender risk. Some correctional agencies encourage its use in the quest for improved prediction, as do some researchers search for 'incremental validity' to standardized risk assessment schemes (Wormith & Goldstone, 1984). Some approaches to risk assessment, commonly referred to as 'structured clinical judgment,' are actually built around the integration of statistical and clinical approaches to risk assessment (Lindsay & Beail, 2004; Webster, Douglas, Eaves & Hart, 1997).

Yet, fearful of losing the predictive accuracy of specific tools and the gains being made for the science of risk assessment, other researchers, clinicians and even some correctional agencies remain adamant about not interfering with a good thing (Quinsey, undated).

This can leave the administrative decision maker, such as a parole board member, in a quandary when the statistical tool suggests one kind of prognosis, while the sincere and well meaning clinician suggests another outcome believing that the current case represents the exception (something that can and does occur) to the actuarial prediction.

Similarly, professional discretion can play a role in treatment planning for an individual offender. There may indeed be occasions when an argument can be made for addressing what traditionally might be considered a 'non-criminogenic need' or, at worst, a minor concern. It may be hypothesized that the 'problem' (e.g., anxiety) represents an important criminogenic need for a specific offender and, if it is not addressed, the offender is very likely to reoffend.

Barring any new research that might shed light on such circumstances, there is no clear rule of thumb to follow when presented with such a scenario. On the one hand, the 'safe' position is to adhere to the actuarial prognostic and treatment of empirically demonstrated criminogenic needs. On the other hand, the principle of professional discretion acknowledges that idiosyncratic clients exist, and that clinicians can improve upon the standard 'cookie cutter' approaches to offender assessment and intervention.

Hopefully, these individual case 'experiments' will lead to the kind of systematic research that is required to establish more specific treatment guidelines for the clinician to practice and the administrator to endorse.

Adhering to implementation principles

Andrews' 17th principle places the responsibility for implementing the core correctional principles

squarely on correctional management. He believes that the correctional administrator is best positioned to create a milieu in which treatment will be most effective. By encouraging, perhaps demanding, a treatment friendly environment, correctional programming can grow and develop into a highly professional and effective service.

The obstacle to creating such an atmosphere in correctional settings has been the traditional disconnect between security and treatment, where different elements see their mandate as the *only* fundamental objective of the correctional setting. Too often, they fail to appreciate the goals of the other and end up working at cross purposes, competing with, rather than complementing, each other. Although it is easy to say that the two factions should work together to achieve a common goal – greater public safety for the community – there are often fundamentally different world views within these two factions as to how such a goal is best achieved.

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² For descriptions of these principles and empirical research validating their relevance to correctional treatment, the reader is referred to the following papers:
Andrews, D.A., Bonta, J., & Hoge, R.D. (1990). Classification for effective rehabilitation: Rediscovering psychology. *Criminal Justice and Behavior*, 17, 19-52;
Andrews, D.A. (in press). The risk-need-responsivity model of assessment and human service in prevention and corrections: Rehabilitative jurisprudence. *Canadian Journal of Criminology and Criminal Justice* (in press);
Andrews, D.A., Bonta, J., & Wormith, J.S. (2006). The recent past and near future of risk and/or need assessment. *Crime & Delinquency*, 52, 7-27;
Dowden, C., & Andrews, D.A. (1999, May). What works in young offender treatment: A meta-analysis. *Forum on Corrections Research*, 11(2), 21-24;
Gendreau, P., & Goggin, C. (1996, September). Principles of effective correctional programming. *Forum on Corrections Research*, 8(3), 38-41.

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- Aos, S., Miller, M., & Drake, E. (2006). *Evidence-based adult corrections programs: What works and what does not*. Olympia, WA: Washington State Institute for Public Policy.
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Theory and empirical research can only go so far to limit these differences. Ultimately, correctional management must forge a working team of clinicians and front-line correctional staff. There is no easy solution, only hard work and persistence.

Conclusion

It has become fashionable in research and bureaucratic circles to talk about 'technology transfer,' the translation of scientific findings to practice in the real world. To be fully implemented, technology transfer must exist at both the individual and organizational level.

In corrections, this requires both the front-line clinician and the corporate administrator to contribute to the process at their respective levels. Only if they are in sync with each other will the maximum benefit of the science, in this case the principles of effective correctional intervention, be realized in the field. ■

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