Cognitive Behavioural Therapy
Thinking for Change Against Crime
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Abstract
The 1970s and ‘80s pessimistic view of the effectiveness of rehabilitation for criminal offenders has since evolved into an optimistic, research-driven perspective. Findings indicate that re-offending rates are up to 33% lower in offenders who undergo Cognitive Behavioural Therapy (CBT) based programs thus supporting the current national and international view that such programs are the most successful, therapeutic and cost-effective means of rehabilitation. However, CBT is under-utilised, and its scope limited to correctional settings where participation in CBT-based programs are compulsory and time-restricted. With an emphasis on practical self-help strategies and the recent availability of online self-training for non-professionals who wish to implement CBT-based programs in communities, such as the U.S. ‘Thinking for a Change’ (T4C) program, the current paper argues that CBT has broader applications. This paper contends that CBT principles have applicability beyond institutional contexts, with positive long-term implications for released offenders that require greater awareness in the Australian Criminal Justice System.

1. Introduction

Cognitive Behavioural Therapy (CBT) is a type of psychotherapy that helps people change unhelpful or unhealthy thinking habits, feelings, and behaviours. Psychotherapy is a form of treatment for emotional and psychological problems that involves talking with a mental health professional such as a psychiatrist, psychologist, or counsellor. This paper will analyse the success of CBT in reducing re-offending rates (i.e. recidivism) among the offender population and assert that the scope of CBT in promoting positive change in individuals’ lives in fact extends beyond solely professionally-delivered institutional settings to self or peer-delivered community (i.e. non-professional) settings.

The paper will first define the aims and components of CBT. Subsequently, the paper will describe the results of a variety of empirical studies evaluating the effectiveness of CBT-based programs in reducing recidivism in the overseas prison population, paying particular attention to programs involving sex offenders. The paper will then describe the prominent
overseas models that CBT-based rehabilitation programs are structured around, and in addition, summarise the effectiveness of CBT programs used within the Australian prisoner population. Finally, the paper will argue that non-professionals are able to deliver CBT based programs by describing the effectiveness of the Thinking for a Change (T4C) program used in the U.S. which is readily accessible online. This has radical implications for the potential of community-based CBT programs to be delivered outside an institutional context so that released offenders can voluntarily continue to develop valuable social skills and pro-social attitudes in order to bring about meaningful change in their lives.

2. Cognitive Behavioural Therapy (CBT)

CBT is a combination of two therapies: the ‘cognitive therapy’ and the ‘behavioural therapy’. It may be used to treat an array of problems including anxiety, social phobia, posttraumatic-stress disorder, schizophrenia, anger and sexual offending just to name a few. CBT involves the use of practical self-help strategies, which are designed to bring about positive and immediate changes in the quality of a person’s life. The aim is to teach people that it is possible to have control over their thoughts, feelings and behaviours. It helps the person challenge and overcome customary beliefs, and use practical strategies to change or modify their behaviour with the result being more positive feelings, which in turn lead to increased positive thoughts and behaviours.

2.1. Cognitive Therapy

The aim of Cognitive Therapy is to change the way a person thinks about the issue that is causing concern. Problematic or distorted thoughts cause self-destructive feelings and behaviours. For example, someone who believes they are unworthy of love or respect may feel withdrawn in social situations and behave in a shy manner. Cognitive therapy challenges these problematic thoughts. One technique employed during cognitive therapy involves asking the person to come up with evidence to ‘prove’ that they are unlovable. This may include prompting the person to acknowledge family and friends who love and respect them. This evidence helps the person realise that their underlying belief is false; this

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process is called ‘cognitive restructuring’. Through this process, a person learns to identify and challenge negative thoughts and replace them with positive thought patterns.

**2.2. Behavioural Therapy**

The aim of behavioural therapy is to teach the person techniques or skills to alter their behaviour. For example, a person who behaves shyly at a party may be socially inept and possess negative thoughts and feelings about themselves. Behavioural therapy teaches the person more helpful behaviours in order to combat negativity. For example, the person may be taught conversational skills which they practise in therapy and in social situations. Negative thoughts and feelings gradually reduce as the person increasingly employs practised behaviour and gains confidence.³

A defining feature of CBT is the proposition that symptoms and dysfunctional habits, beliefs, and behaviours are often cognitively mediated and hence, improvement can be produced by their modification.⁴ CBT can be contrasted with purely behavioural treatments in which cognition is not considered an important explanatory variable and is not identified as a specific target for intervention.⁵ In summary, CBT is based on scientific principles and collaboration (i.e. client and therapist work together), it focuses on the ‘here and now’, is structured, time-limited, goal-oriented, progress-monitored, regularly reviewed, administered individually or in a group, skills-based, and places an emphasis on between-session skills practice. The client’s self-motivation is also a vital component to the success of CBT.

**3. The Use of CBT to Reduce Recidivism in the Offender Population**

The debate surrounding the effectiveness of rehabilitation for criminal offenders has changed from the rather pessimistic perspective of the 1970s and 1980s to an optimistic

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³ Ibid.
research-driven perspective. A consistent theme in numerous reviews of the rehabilitation literature is the positive effects of CBT approaches to offender populations in reducing recidivism.

3.1. Sex Offenders

A vast array of research has been conducted on the implementation of CBT in the sex offender population. Hall conducted a meta-analysis of 92 published studies on sex offender treatment outcomes since 1988. Hall concluded that CBT had significant effects in both community and institutional settings, the former being more effective. Higher recidivism rates were found in the majority of untreated (27%) individuals when compared to treated (19%) individuals. Furthermore, although CBT and hormonal treatments were not significantly different in their effectiveness in preventing recidivism, the results of the meta-analysis revealed that up to two thirds of participants refused hormonal treatment and 50% who began with hormonal treatment discontinued it. On the other hand, refusal and dropout rates for CBT are approximately one third. This superior compliance rate suggests that the use of CBT has a distinct practical advantage. Hall and colleagues suggest that the differences in compliance rates may be due to the invasiveness of hormonal treatments (i.e. intramuscular injections).

Similarly, Maletzky and Steinhauser conducted 5-year follow-ups over 25 years of 7,275 sexual offenders in the United States who entered a CBT program. The authors concluded that CBT for most offenders appeared effective when provided in individual and group therapy, as measured by self-reports, criminal records reviews, and, when available, by polygraph assessments. Furthermore, the authors stated that the outcomes appeared most positive among situational offenders, such as child molesters and exhibitionists (< 10% overall recidivism rate), than in predatory and preferential offenders, such as homosexual offenders.

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pedophiles and rapists (16-22% overall recidivism rate). Recidivism rates increased with the duration of time after treatment. Participants terminating treatment prematurely had higher failure rates than those who did not but, even among those dropping out, recidivism was uncommon except among rapists. Thus, from the data the authors concluded that it appeared therapy was becoming increasingly successful over the 25-year span of the study. The authors suggested that this result could perhaps be a reflection of improved treatment techniques and increased sophistication in their use.

Thus, there appears to be robust and converging empirical evidence that CBT is the most effective treatment to reduce recidivism in sex offenders (see also: Marshall & Serran\textsuperscript{13}; Yates\textsuperscript{14}; Brooks-Gordon, Bilby & Wells\textsuperscript{15}; Looman, Dickie & Abracen\textsuperscript{16}; Duwe & Goldman\textsuperscript{17}).

### 3.2. General Offender Population

Broadly speaking, CBT has also been found to be one of the most effective treatments in reducing recidivism among criminal offenders in general. The therapy is successful as it explicitly targets ‘criminal thinking’ as a factor contributing to deviant behaviour among criminal offenders. Criminal thinking occurs when offenders view themselves as the ‘victim’ of society and fail to see how their own behaviour has contributed to their problems.

CBT for offenders emphasises individual accountability and attempts to teach offenders skills to understand their thought process and the choices which influenced their criminal behaviour. Following this stage, offenders are taught techniques to identify risky thinking patterns and restructure their biased or distorted cognitive thinking. These techniques involve cognitive skills training, anger management and other supplementary components. Cognitive skills training aims to teach abstract thinking, critical reasoning, long-term planning and perspective taking. The Campbell Collaboration (an international research network that produces systematic reviews of the effects of social interventions) conducted a

meta-analysis of 58 studies examining the effects of CBT on recidivism among criminal offenders. The results of the study found that 12 months after receiving CBT, the probability of not re-offending was 1.53 times greater for those treated when compared to those untreated. These findings provide further support demonstrating the usefulness and effectiveness of CBT among offenders.\textsuperscript{18}

One especially optimistic finding is that CBT is also generally well received among those offenders who participate in it.\textsuperscript{19} Treatment facilitators may be the deciding factor in the success of a program. For example, treatment facilitators who exhibit poor performance during program delivery, or who cannot engage and motivate the offender may prevent bringing about change in their clients. Thus, therapists should be warm, open-minded, and enthusiastic, use pro-social models, and be empathetic and skilled in treatment delivery.\textsuperscript{20}

4. CBT Principles and Programs

4.1. Risk Needs Responsivity Model (RNR)

Treatment interventions that have demonstrated the largest net effects in reducing criminal recidivism adhere to the principles of the RNR.\textsuperscript{21} As Olver, Stockdale, and Wormith describe:

“The risk principle states that the intensity of treatment should be matched to the risk level of the offender (e.g., high-risk offenders receive high-intensity services, low-risk offenders receive low-intensity services). The need principle states that effective treatment programs target aspects of the offender’s psychological, social, and emotional functioning that are linked to the development and continuation of criminal behavior, known as criminogenic needs (e.g., attitudes supportive of crime, delinquent peers, substance abuse, unemployment). The responsivity principle states that effective offender treatment programs should be (a) cognitive-behavioral

in nature (i.e., general responsivity) and (b) tailored to the learning style, cognitive capabilities, motivation, personality, and cultural background of clientele (i.e., specific responsivity).”

Meta-analyses regarding treatment outcome research have established that greater adherence to RNR principles corresponds with greater reductions in recidivism including general, violent, sexual, and domestically violent recidivism.

4.2. Other CBT Principles

CBT itself incorporates a wide range of clinical interventions. According to Dobson and Khatri, the common element of these approaches is “an emphasis on broad human change, but with a clear emphasis on demonstrable, behavioral outcomes achieved primarily through changes in the way an individual perceives, reflects upon, and, in general, thinks about their life circumstances”. CBTs are designed to help clients become aware of thought processes that lead to maladaptive behavioural responses and to actively change those processes in a positive way. CBTs employed among correctional populations have been conceptualised as cognitive-restructuring, coping-skills, or problem-solving therapies. As Wilson, Bouffard and MacKenzie express:

“The cognitive-restructuring therapies view mental health problems as a consequence of maladaptive or dysfunctional thought processes, including cognitive distortions,

misperceptions of social settings, and faulty logic. The coping-skills approaches focus on improving deficits in the ability to adapt to stressful situations."

Additionally, Fabiano, Porporino, and Robinson contended that offenders “lack interpersonal problem-solving skills, critical reasoning skills, and planning skills”. Intrinsic to CBT is the theory that cognitive processes influence behaviour. In this sense, offending such as sexual offending is seen as a formed behavioural pattern, or the symptom, attributable to the interaction between learning and reinforcement, maladaptive responses and coping mechanisms. In other words, CBT views sexual offending as the product of the interaction between an individual’s inner mechanics and the environment. Cognitive distortions refer to biased ways which sexual offenders view their victims, so that they perceive the victim as cooperative or mitigate the extent of harm or distress inflicted upon them.

4.3. Moral Reconation Therapy (MRT)

According to Wilson, Bouffard, and MacKenzie the two dominant CBTs for offenders that are structured as well as delivered in groups, are Moral Reconation Therapy (MRT) and Reasoning and Rehabilitation (R & R). MRT is a 12 to 16 Step cognitive skills program where offenders participate in a group setting and focus on thinking errors. Prior to the common usage of the term “ego” in psychology in the 1930s, the term “conation” was employed to describe the conscious process of decision-making and purposeful behaviour. The term “Moral Reconation” was chosen for this system because the underlying goal was to change conscious decision-making to higher levels of moral reasoning.

A typical MRT program aims to improve the social skills, morals, and behaviours of offenders. The program is clearly structured and comes with a manual of lessons and exercises. Sessions are conducted twice a week with groups of 10-15 offenders.

40 Wilson et. al, A quantitative review of structured, group-oriented, cognitive-behavioral programs for offenders.
Participants are given a workbook that contains a variety of exercises such as identifying one’s goals and exploring both the good and bad times in one’s life. These exercises enable offenders to gain more insight into the underlying reasons behind their behaviour.

4.4 Reasoning and Rehabilitation (R & R)

R & R is based on the idea that prisoners have cognitive and social deficits. However, unlike MRT, which focuses on moral reasoning, R & R focuses on strengthening self-control, critical reasoning, and values. The goal of R & R is to help offenders develop more pro-social and consistent attitudes and beliefs. A typical program runs over 8-12 weeks and is divided into 35 sessions. In each session, participants are involved in activities such as reasoning exercises, role-playing and group discussions.

5. How is CBT Currently Being Implemented in our Prison System

Cognitive behavioural group-work is recognised as the most therapeutic and cost effective means of delivering rehabilitation services to both male and female offenders, and is the basis of offender programs both nationally and internationally. CBT has also been described as being among the more promising rehabilitative treatments for criminal offenders. Overall, CBT in correctional settings consist of highly structured treatments that are detailed in manuals and typically delivered to groups of 8 to 12 individuals in classroom-like settings. According to some researchers, highly individualised one-on-one CBT, provided by clinical psychologists or other mental health workers, are simply not practical on a large scale within our prison system.

5.1. Sex Offenders

In Australia, most treatment programs for sex offenders are based on overseas models that use CBT-based methods to target the criminogenic needs of offenders, such as the MRT and R & R models described above.\(^{46}\) Figure 1 below provides a list of adult sex offender treatment programs currently operating in Australia:\(^{47}\)

<table>
<thead>
<tr>
<th>Jurisdiction</th>
<th>Prison-based</th>
<th>Community-based</th>
</tr>
</thead>
<tbody>
<tr>
<td>Australian Capital Territory</td>
<td>ASOP – Adult Sex Offender Program</td>
<td>ASOP – Adult Sex Offender Program</td>
</tr>
<tr>
<td>New South Wales</td>
<td>CUBIT (Custody Based Intensive Treatment) – high risk offenders/core, CORE (CUBIT Outreach) = low risk offenders/Custodial Maintenance program – for graduates of CUBIT &amp; CORE</td>
<td>Community Maintenance program, Cedar Cottage NSW Pre-Trial Diversion of Offenders/Program – Civil sex offenders Pastoral Counseling Institute (Uniting Church)</td>
</tr>
<tr>
<td>Northern Territory</td>
<td>Sex Offender Treatment Program for Indigenous males – Darwin/Sex Offender Treatment Program for Indigenous males – Alice Springs</td>
<td>Top Level Program, Inmate Program, Sex Offender Program – Victoria High Security Program</td>
</tr>
<tr>
<td>South Australia</td>
<td>Sex Offender Treatment Program/Indigenous Sex Offender Treatment Program</td>
<td>Community Corrections Sex Offender Treatment Program</td>
</tr>
<tr>
<td>Tasmania</td>
<td>Sexual Offending Program – for low, moderate &amp; high risk offenders</td>
<td>SISP – Modular Management Intervention Program/SBP – Skills Based Intervention Program for persons with cognitive impairments</td>
</tr>
<tr>
<td>Victoria</td>
<td>MUP – Modular Management Intervention Program, Skills Based Intervention Program, Maintaining Change program – for graduates of the MMP</td>
<td>MMP – Modular Management Intervention Program, Community-based program, Community-based program for intellectually disabled offenders</td>
</tr>
<tr>
<td>Western Australia</td>
<td>Sex Offender Program/Indigenous Sex Offender Program, Program for intellectually disabled offenders</td>
<td>S A.I.F. Program (SafeCare)</td>
</tr>
</tbody>
</table>

Figure 1. Sex Offender Programs Operating in Australian Prisons

In NSW, the Custody Based Intensive Treatment (CUBIT) program operates for moderate-high risk sex offenders, and the CUBIT Outreach (CORE) program operates for low risk sex offenders. Both programs are prison-based and target the known risk factors for sexual reoffending such as empathy deficits, cognitive distortions and general self-regulation.\(^{48}\)


\(^{47}\) Ibid.

Hoy and Bright (2008)\textsuperscript{49} conducted an evaluation of the CUBIT programs. They found that those treated had a recidivism rate of 8.5% in a follow-up period of 3.75 years compared with the predicted rate of 26%.

CUBIT is a residential therapy program at Metropolitan Special Program Centre (MSPC) accommodating 40 moderate and/or high-risk sex offenders. Participants are required to take responsibility for their offending behaviour; identify their offending cycle; examine victim issues; and develop a relapse-prevention plan. CORE currently runs at Kirkconnell and is a program that targets the core issues common to sex offenders – it is a non-residential therapy program for lower risk sex offenders who continue their regular institutional activities (e.g. education, work release). CORE runs in a group format and can be run 2 half days per week (5 months in length) or one half day per week (10 months in length).\textsuperscript{50}

A number of research projects have been undertaken by CUBIT psychologists in relation to whether treatment is leading to changes in dynamic risk factors (i.e., changes in criminogenic needs). To date the research has found that sex offender treatment programs (i.e., CUBIT/CORE) were effective in targeting inadequate coping strategies and attitudes and beliefs condoning sexual violence. Offenders who had completed treatment had significantly reduced their use of sexual coping around abusive themes and offence specific and general cognitive distortions.\textsuperscript{51} Thus, the current rehabilitation efforts in NSW targeting sexual offending are highly promising.

\textbf{5.2. General Offender Population}

CBT principles have also been applied to the general offender population in Australia. Offender treatment programs that target cognitive skills training are now a common feature (implemented or planned) in every Australian correctional management strategy. Most jurisdictions have developed detailed program manuals, which include detailed theoretical and empirical rationales, descriptions of therapeutic principles and notes for facilitators.

\textsuperscript{49} A. Hoy and D. A. Bright, ‘Effectiveness of a Sex Offender Treatment Programme: A Risk Band Analysis’ (2008).
\textsuperscript{51} Ibid.
involved with individual sessions. Figure 2 lists the cognitive skills programs currently being administered in Australian prisons.

<table>
<thead>
<tr>
<th>Jurisdiction</th>
<th>Program Name</th>
<th>Type</th>
<th>Specific Target</th>
<th>Duration</th>
<th>Risk Need Assessment</th>
<th>Pre-Post Measures of Change</th>
<th>Evaluation</th>
</tr>
</thead>
<tbody>
<tr>
<td>SA</td>
<td>Making Choices—being developed</td>
<td>Maintenance</td>
<td>25 hours</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Vic</td>
<td>Maintaining Change</td>
<td>Motivational</td>
<td>12 hours</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Entering Change</td>
<td>Therapeutic</td>
<td>Woman</td>
<td>60 hours</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Cognitive Skills</td>
<td>Therapeutic</td>
<td>Kooringai men</td>
<td>60 hours</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Cognitive Skills</td>
<td>Therapeutic</td>
<td>Women—pilot</td>
<td>100 hours</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Making Choices</td>
<td>Therapeutic</td>
<td>100 hours</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>NSW</td>
<td>Think First</td>
<td>Therapeutic</td>
<td>60 hours</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>ACT</td>
<td>Cognitive Self Change</td>
<td>Therapeutic</td>
<td>100 hours</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Qld</td>
<td>Making Choices</td>
<td>Therapeutic</td>
<td>100 hours</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Making Choices</td>
<td>Program</td>
<td>16–24 hours</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>NT</td>
<td>Cognitive Skills</td>
<td>Psycho-educational</td>
<td>24 hours</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Tas</td>
<td>Making Choices</td>
<td>Therapeutic</td>
<td>100 hours</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>WA</td>
<td>BOAS</td>
<td>Psycho-educational</td>
<td>Indigenous</td>
<td>20 hours</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Cognitive Brief Intervention</td>
<td>Motivational</td>
<td>20 hours</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Think First</td>
<td>Therapeutic</td>
<td>60 hours</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Legal and Social Awareness</td>
<td>Therapeutic</td>
<td>Intellectually disabled</td>
<td>60 hours</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
</tbody>
</table>

Figure 2. Cognitive Skills Programs Operating in Australian Prisons

The Think First program was implemented in five NSW correctional centres between 2003 and 2007. An evaluation of the Think First program revealed a significant change in pro-social direction with completion of Think First improving impulsivity levels, criminal thinking styles and some aspects of social problem solving ability. The aim of Think First is to help group members develop their skills for thinking about problems and for solving them in real life situations, and to apply these skills to the problem of offence behaviour and reduce the risk of re-offending. The content of Think First includes social problem-solving skills, self-management and self-control, social behaviour and social interaction skills, values, beliefs, and attitudes.

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53 Ibid.
Nearly half (47%) of all sentenced prisoners in Australia are in custody for crimes of violence.⁵⁶ Like sex offender programs and cognitive skills programs aimed at general offenders, violent offender programs within Australia are also underpinned by cognitive behavioural strategies and target a wide range of criminogenic needs. Violent offenders routinely undertake an offence-specific assessment to determine program suitability, typically involving a structured clinical assessment and the use of psychometric assessment tools to assess their level of risk and criminogenic needs. Readiness and responsivity factors are also routinely assessed.⁵⁷ Figure 3 lists the violent offender programs used in Australia.

### Table 4: Violent offender programs

<table>
<thead>
<tr>
<th>Jurisdiction</th>
<th>Program title</th>
<th>Duration</th>
<th>Risk/need assessment for entry</th>
<th>Pre-post test</th>
<th>Evaluation</th>
</tr>
</thead>
<tbody>
<tr>
<td>NSW</td>
<td>VOTP—high</td>
<td>240 hours</td>
<td>√</td>
<td>√</td>
<td>√</td>
</tr>
<tr>
<td></td>
<td>VOTP—moderate</td>
<td>100–120 hours</td>
<td>√</td>
<td>√</td>
<td>√</td>
</tr>
<tr>
<td></td>
<td>VOTP—maintenance</td>
<td>Ongoing</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Qld</td>
<td>Cognitive Self Change</td>
<td>100 hours</td>
<td>√</td>
<td>√</td>
<td>√</td>
</tr>
<tr>
<td>WA</td>
<td>Violent Offender Treatment Program</td>
<td>316 hours</td>
<td>√</td>
<td>√</td>
<td>√</td>
</tr>
<tr>
<td></td>
<td>Medium Intensity Violence</td>
<td>132.5 hours</td>
<td>√</td>
<td>√</td>
<td>√</td>
</tr>
<tr>
<td>Tas</td>
<td>Planned</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Vic</td>
<td>VIP—high intensity</td>
<td>180 hours</td>
<td>√</td>
<td>√</td>
<td>√</td>
</tr>
<tr>
<td></td>
<td>VIP—moderate intensity</td>
<td>120 hours</td>
<td>√</td>
<td>√</td>
<td>√</td>
</tr>
<tr>
<td>ACT</td>
<td>Cognitive Self Change</td>
<td>100 hours</td>
<td>√</td>
<td>√</td>
<td></td>
</tr>
<tr>
<td>NT</td>
<td>Planned</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>SA</td>
<td>VIP</td>
<td>330 hours</td>
<td>√</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Figure 3. Violent Offender Programs Operating in Australian Prisons

The objective of the NSW Violent Offenders Therapeutic Program (VOTP) is to reduce further violent offending by developing pro-social behaviour, attitudes and beliefs. VOTP involves cognitive-behavioural treatment delivered in a residential setting.⁵⁸

### 6. Can Non-Professionals Deliver CBT-based Programs?


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⁵⁶ AIC (2007)
Correctional Offender Rehabilitation Programs: The 2009 national picture in Australia provides an updated account of the nature and scope of custodial-based offender rehabilitation programs in Australia. The report found that formal training and professional qualification are central qualities to facilitators of CBT-based programs used in the Australian offender population. Clients within correctional settings are required to attend such programs as part of their sentence. Much emphasis has been placed on the counsellor’s role and counsellor-client relationship in determining the success of CBT-based interventions. However, this poses the question of how offenders, once released from correctional centres such as prisons, can continue developing coping skills and focus on prosocial skill building in order to live in harmony within their community, engage in behaviours that contribute to positive outcomes in society, and avoid re-offending. Since CBT involves the use of practical self-help strategies, it would appear essential for offenders to continue working on responsible patterns of thinking and behaving, empathy building, victim awareness and developing attitudes that focus on responsibility towards others and concern for their safety and welfare. More importantly, it is vital for ex-offenders to have a strong network of family and peer-support, thus it would be extremely valuable if CBT strategies were available to be utilised by non-professional members of the community.

6.1. CBT Programs Used Overseas

In the international arena, particularly in the U.S.A, the six primary CBT programs most widely utilised within the criminal justice system (similar to NSW’s CUBIT/CORE, Think First and VOTP programs) are: Aggression Replacement Training (ART); Criminal Conduct and Substance Abuse Treatment; Strategies for Self-Improvement and Change (SSC); Moral Reconciliation Therapy (MRT); Reasoning and Rehabilitation (R & R); Relapse Prevention Therapy (RPT) and Thinking for a Change (T4C). ART, SSC, MRT, R & R, and RPT all require facilitators to undergo professional training by attending training seminars or workshops, and/or completing additional hours of study. Thinking for a Change (T4C) on the other hand, is available online and training for facilitators includes a 2-day curriculum along with a PowerPoint presentation, an in-depth manual for how the T4C program is utilised (including an overview of Cognitive Self Change, the Thinking Report, Cognitive Check-ins;


delivery of the program, case management, program standards, and administrative procedures; admission, discharge, and transfer procedures; group delivery, program management, and supervision; and helpful forms and program memoranda), and a 32-hour training program designed to teach the theoretical foundations of CBT and specifically the basic components of T4C, including cognitive self-change, social skills, problem solving, and implementation of the program. Figure 4 below gives an overview of the T4C program.

![EXHIBIT 3: Overview of Thinking for a Change](image)

**6.2 Effectiveness of Thinking for a Change (T4C)**

Two evaluations have been conducted on the efficacy of T4C. The University of Texas Southwestern Medical Centre conducted a study using 42 adult male and female high-risk offenders, who were on probation. Completers and dropouts of the T4C program were compared to a control group that did not take part in the program on the variables of social
skills, interpersonal problem-solving skills and procriminal attitudes. The study found that the recidivism rates were 33% lower for the treatment group than the control group. Completers of the program also showed a significant improvement in interpersonal problem-solving skills while no such improvement was observed for the dropouts. The second evaluation, conducted in Indiana, examined 233 probationers and found a significant reduction in recidivism over an average of 26 months for those who participated in the program (18%) compared with those who did not (35%).  

The strength of T4C comes from its approach and focus. Unlike the other five dominant CBT programs currently used in the U.S criminal justice system, and the CBT-based offender rehabilitation programs currently being used in Australian correctional settings, T4C emphasises the role that family and other peers and members of the community, as well as offenders themselves, can play in implementing CBT techniques and strategies outside of a professional context. Evidence shows that cognitive and behavioural change is more likely to occur when an individual has the self-motivation to improve. Since T4C does not require facilitators to have any specific credentials or level of education, it is community rather than institutional based, thus may motivate individuals to voluntarily seek positive change in their lives upon their release.

7. Conclusion

Drawing from a canvas of empirical evidence, the current paper asserts the view that CBT programs have significant benefits for individuals in the prison system such as reducing recidivism. However, in Australia, these programs have traditionally been limited to an institutional context due to an emphasis on the counsellor’s role and counsellor-client relationship in determining the success of CBT-based interventions. As a result, while proven to be extremely effective in correctional settings, these programs are unable to help individuals, who on their own accord and/or with peer/family support, are motivated to continue working on responsible patterns of thinking and behaving once they are released.

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from prison. This has major implications for the rehabilitative process when considering the finding that the risk of recidivism increases with the duration of time after treatment. The T4C program however, has provided a solution for this problem by providing a CBT-based program that is readily accessible online and can be operated by non-professional members of the community such as family and peers. The 2-day facilitator-training curriculum entitled ‘What Are They Thinking?’ is available at http://www.nicic.org/Library/020100 and a PowerPoint presentation for use with the curriculum can be found at http://www.nicic.org/downloads/ppt/020100-ppt.ppt. An in-depth guide to utilisation of the T4C program entitled ‘A Manual for Delivery of Cognitive Self Change’ is available in PDF format at http://www.nicic.org/Library/021558. Finally, the 32-hour training program including the lesson plans for T4C is available in ZIP format at http://www.nicic.org/Library/017124.

T4C adopts a manualised, structured treatment curriculum with measurable goals and objectives for each session, which is identified as a principal ingredient of successful treatment, however also comes with a unique advantage of having a broader application than most rehabilitation programs that are limited to correctional settings only. Furthermore, T4C has the flexibility to be administered by self-trained facilitators with no specific credentials, such as family, peers and other community members, thus equipping ex-offenders with the tools for self-assessment and self-regulation, and incremental skill development in the areas of interpersonal, intrapersonal, and community functioning. These productive and meaningful learning experiences need not be restricted to a time frame, and instead may facilitate positive cognitions and behaviours that have a lifelong persistence.

For the Australian offender population, T4C provides the tools to take pro-social action and change their offending ways in instances where CBT-based programs may not be as flexible or accessible. The program was developed to be appropriate for a wide-range of offender groups. In the U.S, it has been used with juvenile and adult offenders, and has been implemented in all phases of the juvenile and adult criminal justice systems including probation, in prisons and jails, as well as in the community (i.e., aftercare and parole). The format of T4C is designed so that sessions are accessible and meaningful for offenders of varying social, emotional and intellectual/academic abilities. The self-insight and interpersonal skills offenders learn in this program are also applicable to other treatment

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programs. Due to the success and effectiveness of T4C in the U.S, this paper recommends that programs such as T4C receive greater awareness in Australia in order to assist ex-offenders and their transition to community life.

References


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