# THINKING FOR CHANGE AGAINST CRIME

## Cognitive Behavioural Therapy

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This proposal is the second of four parts of a Justice Reform Initiative tackling the failure of the penal system to achieve its own goals. We propose a new paradigm of prisoner responsibility - enabling them to change their behaviour instead of passively waiting for time to pass.

# JUSTICE ACTION

**Contents**

## 1. Introduction

If a person develops views and learns sorts of behaviour that offend others who are important to them, they can also learn how to change. This is the common process of parenting or socialisation, but packaged more formally as a therapy. This paper examines cognitive behaviour therapy (CBT) use in prisons; its potential, its misuse and exploitation for power and profit.

We present an analysis of its use worldwide, and with various forms of offending. Every modern prison system has now adopted a psychological approach to “treatment” of prisoners’ recidivism using extra professional staff, often displacing other prisoner services such as education and vocational training. Many prisoners are forced to complete CBT courses before being released. They are a reality that must be analysed.

Some CBT based programs have significantly reduced re-offending. Prison systems have enthusiastically adopted the approach, as it provides legitimacy to their existence, presenting themselves as focussing on changing the individual. This ignores the complex array of social and economic factors that contribute to an offender’s behaviour and status. Unfair discrimination and preventative measures such as improved employment opportunities, access to affordable housing and better education are ignored. The reality of life outside the prison remains.

This paper discusses the flaws of the adopted form of CBT and offers insights into how it could be useful, serving the prisoner and the community. Instead it has become an industry with proprietary “programs” linked to former employees. Research and payments for programs absorb large budgets, but have limited benefit for prisoners. The coercive pressure to complete CBT programs has greatly reduced their effectiveness. Unmotivated prisoners who are forced to participate simply ‘tell them what they want to hear’ in order to gain release. Honesty is punished.

It is only after consideration is given to these flaws that we can begin to consider how CBT can be improved to achieve greater success. Instead of participation through coercion, changes must be made so that it is achieved through the creation of a therapeutic environment based on mutual trust, complete privacy and support from not just staff but a network including family and friends. It must be available throughout one’s incarceration, from apprehension to

parole, rather than being presented as the final turnstile to be endured before release.

This type of therapy assists the change of unhelpful or unhealthy thoughts, feelings, and behaviours. Treatment first identifies problematic thinking and behaviours and then looks to teach and practice more socially acceptable means of overcoming them. It can be implemented through a wide range of treatments and programs, each targeting a specific pattern of offending which range from violent behaviour, drug addiction and sex offences. While it exists in various forms, collectively it is known as Cognitive Behavioural Therapy (CBT).

**2. Cognitive Behavioural Therapy (CBT)**

This paper utilises the Stages of Change model as a basis for providing suggestions to improve how CBT is delivered within a correctional setting. The Stages of Change Model;

> "shows that, for most persons, a change in behaviour occurs gradually, with the patient moving from being uninterested, unaware or unwilling to make a change (pre-contemplation), to considering a change (contemplation), to deciding and preparing to make a change. Genuine, determined action is then taken and, over time, attempts to maintain the new behaviour occur. Relapses are almost inevitable and become part of the process of working toward lifelong change."[1]

CBT can be used to treat an array of problems including anxiety, depression, social phobia, obsessive-compulsive disorder, post-traumatic-stress disorder, schizophrenia, marital distress, anger, sexual offending, low self-esteem, substance abuse, and eating disorders. It involves the use of practical self-help strategies to change thinking, which are designed to bring about positive and immediate changes in the quality of a person's life.[2]

CBT teaches people that it is possible to have control over their thoughts, feelings, and behaviours. It helps the person challenge and overcome automatic beliefs by using practical strategies to modify their behaviour, with the result of increased positive feelings, leading to increased positive thoughts and conduct.[3] CBT is a combination of two therapies – 'Cognitive'

[1] Zimmerman, G., Olsen, C. and Bosworth, M. (2000). A 'Stages of Change' Approach to Helping Patients Change Behaviour, *American Family Physician*, 61(5), pp 1409-1416.
[2] 'Cognitive Behaviour Therapy', retrieved 2 February 2012 from http://www.betterhealth.vic.gov.au/bhcv2/bhcarticles.nsf/pages/Cognitive_behaviour_therapy.
[3] Ibid.

and ‘Behavioural’, both of which will be described below.

### 2.1. Cognitive Therapy

Cognitive Therapy aims to change the way the person thinks about the issue causing concern. Problematic and distorted thoughts cause self-destructive feelings and behaviours. For example, someone who thinks they are unworthy of love or respect may feel withdrawn in social situations and behave in a timidly 0manner. Cognitive Therapy challenges these problematic thoughts, through various techniques. 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 process, known as ‘cognitive restructuring’, helps the person realise that their underlying belief is false. Through this process, a person learns to identify and challenge the problematic thoughts, replacing them with positive thought patterns.

### 2.2. Behavioural Therapy

Behavioural Therapy aims to teach techniques and skills to modify unhelpful behaviour. For example, a person who behaves shyly at a party may possess negative thoughts and feelings about themselves. Behavioural Therapy teaches the person helpful behaviours in order to combat the negativity. The person may be taught conversational skills to practice in therapy and ultimately deploy in social situations. Negative thoughts and feelings gradually reduce as the person increasingly employs the practised behaviour and gains confidence.[4]

A defining feature of CBT is the suggestion that symptoms and dysfunctional habits, beliefs, and behaviours are often cognitively mediated and hence, improvement can be produced by their modification.[5] CBT can be contrasted with behavioural treatments in which cognition is not considered an important explanatory variable and is not identified as a specific target for intervention.[6] 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 (homework).

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[4] Ibid.

[5] Dobson, K. S. and Dozois, D. J. (2001). Historical and Philosophical Bases of the Cognitive Behavioural Therapies. In K. S. Dobson (Ed.), *Handbook of Cognitive Behavioural Therapies* (2nd ed.). New York: Guilford Press.

[6] Butler, A. C., Chapman, J. E., Forman, E. M. and Beck, A. T. (2006). The Empirical Status of Cognitive Behavioural Therapy: A review of meta-analyses, *Clinical Psychology Review,* 26, pp. 17-31.

The client's self-motivation is also a vital component to the success of CBT.

## 3. Critiques of CBT

There have been several criticisms levelled at the workings of CBT programs. The first issue to be discussed focuses less on the actual effectiveness of CBT and more on the ideological underpinnings of CBT programs. Such programs been criticised for placing undue blame on the individual for their criminal behaviour while ignoring the social and economic determinants of crime. Consequently it focuses only on the 'nature' rather than the 'nurture' of the problem, and may be used as an excuse to shift responsibility on individual characteristics. Following this will be a critical examination of evaluations of CBT's effectiveness. The final issue to be examined in this chapter is that of the various financial aspects of researching and delivering CBT.

### 3.1. Other Explanations for Criminal Behaviour.

It is maintained that offenders lack certain cognitive skills and that this predisposes them to a higher risk of criminality.[7] CBT teaches offenders these missing cognitive skills and allows offenders to be rehabilitated. [8] This presents a fundamental limitation. Focussing on the individual as being solely responsible and providing society with a 'free pass' leads to serious issues such as dehumanising the offender who is seen as 'wrong' or 'sick', relative to 'normal' law-abiding citizens.[9]

As cited in Kendall (2002), Fox (2001) concluded that a cognitive behavioural program for violent offenders in America aimed to bribe prisoners into internalising notions of criminal identity.[10] CBT is similar. It aims to induce prisoners into believing that they are criminals, characterised by cognitive deficits.[11] When this is achieved, it is possible for prisoners to undergo the process of self-recovery.[12] One may argue that this mirrors a labelling theory, a fundamental criminological position developed by Howard Becker in 1963. Becker postulated that people who are likely to engage in rule breaking behaviour as essentially different from members of the rule-making or rule-abiding society. Becker uses the term "outsider" to denote

[7] Kendall, K. (2002). Time to Think About Cognitive Behavioural Programmes. In P. Carlen (Ed.), *Women and Punishment: The struggle for justice*, Devon: Willan Publishing, pp. 182.
[8] Ibid pp. 192 – 198.
[9] Ibid.
[10] Ibid.
[11] Ibid.
[12] Ibid.

a labelled rule-breaker or deviant who accepts the label attached to them and views himself or herself as different from "mainstream" society.[13]

CBT fails to acknowledge that social and economic factors influence offender's engagement in crime.[14] In fact, Andrews and Bonta, the pioneers of CBT, argue that social-structural and systemic issues such as inequality, race, culture, unemployment and so forth should not and need not be addressed. Rather, explanations of crime that are based on such ideas should be disregarded.[15] This particularly disadvantages Indigenous offenders whose behaviour arguably cannot be examined without an understanding of the historical relationship between themselves and the white government.

Since CBT focuses solely on an individual's characteristics, it can be perceived as a tool utilised by the government to reduce its responsibility or role in the transitional pathway an individual takes to become an offender. This is indicated by CBT programs for female offenders that teach them that their poverty, drug addiction and abuse are a result of their own misguided thinking, rather than a lack of supportive or educational services.[16] One must also keep in mind that CBT programs have a very real impact on the lives of those who are supposed to receive them. It affects not only their behaviour, but determines their eligibility for parole. Failure to complete a program may contribute to denied or delayed release. Such measures ensure participation in CBT programs. However, coerced participation will always be far less effective than voluntary involvement in a CBT process.

CBT, being based on psychological theory, focuses on the individual's inner workings and is thus, less interested in social or economic factors. The role of government in this regard is paramount. The government must provide funding and develop solutions to address social and economic issues following justice reinvestment models. Increased access to education, jobs and economic productivity is essential within disadvantaged communities. CBT may be viewed as attempting to teach offenders skills and knowledge that society has failed to provide them with.

Birgden argues that rehabilitation programs based on the Risk Needs Responsivity (RNR)

[13] Becker, H. S. (1928). *The Outsiders: Studies in the sociology deviance,* London: Free Press.
[14] Ibid.
[15] Ibid.
[16] Ibid.

model fail to incorporate the role of the broader criminal justice system.[17] Many CBT programs are based on RNR principles and therefore are lacking in external responsivity. With rehabilitation being forced upon offenders in return for their release, one must question whether CBT is actually offering an engaging treatment delivery service, or whether offenders are coerced into these programs in order to be released. Birgden proposes that criminal justice agents need to play a supportive role in encouraging offenders to engage in rehabilitation programs. Furthermore the offenders should not be coerced into undertaking rehabilitation programs, but rather undergo a cognitive change from pre-contemplation to self re-evaluation leading to an inner desire and motivation to change and participate in rehabilitation process.[18]

### 3.2. Measuring Effectiveness

Some meta-analysis studies examining the effectiveness of CBT have been criticised for their bias. For example, most of the research in these studies included only young American males. Gender, race and ethnicity were not considered. Qualitative research is generally not taken seriously or given as much weight as quantitative research. This is unfortunate as qualitative research provides important insight into the effectiveness of CBT as perceived by the offenders whom have undergone it.

### 3.3. Funding of CBT

National spending on corrective services in Australia between 2010-2011 was $2.3 billion.[19] In 2007 the US spent $74 billion on correctional services.[20] Thus, correctional services are a significant burden on the government's budget. The private sector is becoming increasingly involved in research and service provision within this sector. While proving costly for governments, correctional services are a growing market for private parties. One must be reminded that it is within this context that research regarding rehabilitation programs such as CBT is situated.

The first issue considered when discussing financing programs, particularly CBT, is the role of the government. While some private involvement in the funding and provision of

[17] Birgden, A. (2004). Therapeutic Jurisprudence and Responsivity: Finding the will and the way in offender rehabilitation, *Psychology, Crime and Law,* 10(3), pp. 238-295.
[18] Ibid.
[19] Chapter 8: Corrective Services. Volume 1: Report on Government Services 2012, Australian Government Productivity Commission, retrieved on 2 May 2012 from http://pc.gov.au/gsp/rogs/2012.
[20] 'Direct Expenditures By Criminal Justice Function, 1982–2006'. U.S. Bureau of Justice Statistics, retrieved on 2 February 2012 from http://bjs.ojp.usdoj.gov/content/glance/tables/exptyptab.cfm.

correctional services seems unavoidable, there are numerous risks associated with a diminished role of the government and the insidious increase of a focus on profit. Can a social issue such as recidivism, that requires lengthy, expensive, multi-disciplinary approaches, be adequately addressed by market driven forces whose objective is to secure profit? The development and delivery of CBT programs is time consuming and expensive. While minimizing some of the expenses associated with such development and delivery of CBT may make programs such as this more cost effective, it may also diminish the effectiveness in rehabilitation. This may create difficulties when program developers are pressured to achieve quick and significant success.

Addressing the causal factors for offending behaviour and preventing reoffending offers numerous benefits for the individual and society alike. Regardless of whether the private sector becomes involved, achieving this should continue to be a responsibility of the government. The relationship between the private sector and the government becomes more complex when attention is drawn to funding for research into rehabilitation. While not always the case, much of the initial research into development of rehabilitation programs is carried out by academics working in government-funded universities. Treatment programs and products such as interviewing guides, user manuals and screening instruments based on this research are then developed and marketed privately with little transparency in regards to where they were developed.

As with much developing academic research, there is little consensus regarding the most effective delivery of CBT programs. One example of such contestation between researchers is the ongoing debate between the RNR Model of delivery for rehabilitation programs versus The Good Lives Model. (Both of which will be described further in the paper.) What is important to note here is that contestation between these two theories no longer exists solely as a dispute within the academic field. Given the context of increasing privatisation in a lucrative market, such difference in theories also translates to be a contest between researchers each trying to sell their program as a product. While the expertise of the researchers involved and the quality of their work is significant, the fact that their research exists in a marketplace with considerable profits at stake raises several critical issues.

One must consider whether a researcher is burdened with a conflict of interest between the need to ensure that they apply critical responsivity towards their own work and ensuring they market a strong product. To put it differently, can a researcher recognise and address a weakness in their own research without being seen as acknowledging a potential flaw in their product? Ultimately, this market driven arena does not allow for a flexible, critical evaluation of

a programs success.

Moreover, now that such research operates within a marketplace, researchers find themselves working under new pressures. Whereas previously the question may have been 'what works', an academic developing such programs may also be forced to consider 'what's affordable'.

The discussion of how the development and delivery of CBT programs are financed highlights the need for transparency. To know how, why and by whom a rehabilitation program such as CBT has been developed and delivered is crucial. With a basic understanding of the critiques and limitations of CBT, the use of this method of therapy among the offender population will now be examined.

## 4. CBT Principles and Programs

Cognitive Behaviour Therapy aims to reduce recidivism and rehabilitate offenders by navigating them through several motivational stages. At present there are many CBT based programs but they are limited in achieving their potential. For example, these programs are only voluntary in title. In reality participation is achieved through coercion, threat of denied parole or as an strict requirement before release. Consequently there are many offenders who revert back to the cycle of previous lifestyles. For Cognitive Behaviour Therapy to be effective there must be changes to the present practices. They need to arouse and encourage individual motivation to change. Additionally there must be improvements in accessibility of the programs, increased support from professional and non-prison personnel.

### 4.1. CBT As It Should Be

Firstly, for the programs to be effective there must be voluntary participation from the offenders. Research indicate that forcing or banning a particular behaviour does not necessarily work. For example, the majority of consumers who are forced to quit smoking in mental health units resume smoking immediately upon release.[21] Many complete rehabilitation programs to gain release. With such coercion, it is questionable as to whether an offender's motivation to participate is based on a true desire for change, or the ineffective desire to simply 'tick the boxes' to gain release. And if the latter is the case, it is only a matter of time

[21] Ibid.

before the offenders go back into the cycle of old habits.

Thus if long-lasting change is to occur it must come from within rather than being imposed. Ideally the implementation and delivery of CBT programs must encourage the participants to navigate through several motivational stages. These stages are the pre-contemplating, contemplating and planning, and action stages.[22]

Rehabilitation will be most effective when individuals participate for the right reasons. Prisoners are forced to complete rehabilitation programs in order to gain release. With such coercion, it is questionable as to whether an offender's motivation to participate is based on a true desire for change, or the ineffective desire to simply 'tick the boxes' to gain release. Rehabilitation in prisons must therefore be optional, not forced. This would not create internal inconstancy within in the prison system. It is already the case that justifications for prison sentences reflect societies mixed desire to punish (under the 'Just Desserts' model), rehabilitate and protect itself. This is evident in the *Crimes (Sentencing Procedure) Act 1999* (NSW) s 3A, which clarifies that the purpose of sentencing is

" (a) to ensure that the offender is adequately punished for the offence,
(b) to prevent crime by deterring the offender and other persons from committing similar offences,
(c) to protect the community from the offender,
(d) to promote the rehabilitation of the offender,
(e) to make the offender accountable for his or her actions,
(f) to denounce the conduct of the offender,
(g) to recognise the harm done to the victim of the crime and the community."

Enabling prisoners to make their rehabilitation effective through choice would merely articulate that there are differing objectives for different offenders.

Secondly CBT programs to be effective, support from private and non-prison personnel support are essential. Private and trusting environments are essential to allow prisoners to undertake cognitive changes and self-development. Treatment facilitators in this respect are important as they play a vital role in the creation of supportive and engaging environments for treatment delivery. Likewise non-prison personnel who are independent and unbiased are of utmost importance in creating these productive and therapeutic environments. A close examination of funding provided to corrective services for rehabilitation purposes is required, i.e. from the purchasing of criminogenic need assessment tests to employing program facilitators. Accountability mechanisms and transparency within corrective services is required.

[22] Ibid.

Similarly family and friends must be allowed physical access to provide support for the offenders who are undertaking rehabilitation. According to the Australian Institute of Criminology, while CBT has shown to reduce re-offending during the first year after release, benefits of the program may not be maintained over a longer period.[23] This demonstrates that CBT is limited in providing a long lasting treatment for rehabilitating behaviour. However, arguably this finding merely demonstrates the need for ongoing CBT post release. Supportive non-professionals could potentially conduct such treatment.

Also for CBT programs to be effective the offenders must be equipped and surrounded in the right environment. For example computers in cells provide an additional access point whereby prisoners may receive support from family and friends and other supportive networks within the community. Computers can also allow prisoners to access CBT programs independently, and interact with CBT content through maintaining progress diaries, reading course content and completing homework.

4.2. 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.[24] 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 behaviour, 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 behavioural in nature (i.e., general responsivity) and (b) tailored to the learning style, cognitive capabilities,

[23] 'Prison-Based Correctional Offender Rehabilitation Programs: The 2009 national picture in Australia', retrieved on 25 April 2012 from http://www.aic.gov.au/publications/current%20series/rpp/100-120/rpp112.aspx.

[24] Andrews, D. A. and Bonta, J. (2006). *The Psychology of Criminal Conduct* (4th Edition). Cincinnati, OH: Anderson; Andrews, D. A. and Bonta, J. (2010). Rehabilitating Criminal Justice Policy and Practice, *Psychology, Public Policy, and Law,* 16, pp. 39–55.

motivation, personality, and cultural background of clientele (i.e., specific responsivity)." [25]

This reduction in recidivism when RNR is applied includes general [26] [27] violent [28], sexual [29], and domestic violence [30] recidivism. However, recent developments in the Good Lives Model of treatment have lead proponents to suggest it be employed instead.

4.3. Good Lives Model (GLM)

The GLM differentiates itself from the RNR approach by making offender autonomy and self-determination paramount. A key assumption made within the GLM is that if an offender's quality of life is improved, reoffending is less likely. By improving, "…skills, values, opportunities and social context," offenders are better equipped to pursue their needs by more socially positive means. [31] Offenders participating in programs based on a GLM ideally ask themselves; "How can I live my life differently?" Once this level of motivation is achieved, plans and decisions are made by an engaged and autonomous individual rather than being based on the coercion of, "…reward and punishment." [32]

Advocates of the GLM argue that it is the issue of motivation that highlights a departure from RNR models. Proponents of the latter hold that decreased motivation to engage in a program such as CBT is a criminogenic need, thus treatment should be tailored to suit this. A CBT program based on the tenants of the GLM would hold that low participant motivation is a

[25] Olver, M. E., Stockdale, K. C. and Wormith, J. S. (2011). A Meta-Analysis of Predictors of Offender Treatment Attrition and Its Relationship to Recidivism. *Journal of Consulting and Clinical Psychology,* 79, pp. 6–21.

[26] Andrews, D. A., Zinger, I., Hoge, I. D., Bonta, J., Gendreau, P. and Cullen, F. T. (1990). Does Correctional Treatment Work? A clinically relevant and psychologically informed meta-analysis, *Criminology,* 28, pp. 369–404.

[27] Landenberger, N. A. and Lipsey, M. W. (2005). The Positive Effects of Cognitive Behavioural Programs for Offenders: A meta-analysis of factors associated with effective treatment, *Journal of Experimental Criminology,* 1, pp. 451–476.

[28] Dowden, C. and Andrews, D. A. (2000). Effective Correctional Treatment and Violent Reoffending: A meta-analysis, *Canadian Journal of Criminology,* 42*,* pp. 449–467.

[29] Hanson, R. K., Bourgon, G., Helmus, L. and Hodgson, S. (2009). The Principles of Effective Correctional Treatment Also Apply to Sexual Offenders, *Criminal Justice and Behaviour,* 36, pp. 908.

[30] Babcock, J. C., Green, C. E. and Robie, C. (2004). Does Batterers' Treatment Work? A meta-analytic review of domestic violence treatment, *Clinical Psychology Review,* 23, pp. 1023–1053.

31 Brigden, A. (2004). Therapeutic Jurisprudence and Responsivity: Finding the will and the way in offender rehabilitation, Psychology, Crime and Law, 10(3), pp. 238-295.

32 Andrews, D. A., Bonta. J. and Wormith, J. S. (2011). The Risk-Need-Responsivity (RNR) Model: Does adding the good lives model contribute to effective crime prevention? Criminal Justice and Behaviour, 38, pp. 735-755.

hindrance to improvement that must be overcome before reoffending can be addressed.[33] Correctional staff and clinicians can use motivating interviewing techniques [34] at different stages of the offender's sentence to encourage engagement based on the autonomous decisions making. It has been argued that while the RNR model encourages offenders to practice reflexivity, correctional staff fail to turn the lens on themselves and consider how they might change and improve their own practices.[35] This practice of external reflexivity by correctional staff is central to encouraging the motivation of inmates. Stressing the potential benefits of such a cultural shift, Farrall asks us to;

''imagine the therapeutic atmosphere likely to be gained. Imagine the cumulative effect of (offenders) being surrounded by firm, fair, respectful empathic staff who are modeling pro-social behaviors every minute of their working day.'' [36]

While the theoretical strengths of the GLM are clear, it is not without its critics. Just as proponents of the GLM have criticised the lack of external responsivity shown in the 'on-the-ground' workings of RNR programs, it too may face the same obstacle. One must seriously question what the likelihood is of creating the utopian like cultural reform discussed by Farrall upon which the GLM relies on. In responding to criticisms of their RNR model, Andrews, Bonta and Wormith (2011) have also argued that when the recently revised GLM is closely examined, one can see very little clearly distinguished difference between what the workings of the GLM and what has already been developed and implemented under the RNR model.

### 4.4. 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, behavioural outcomes achieved primarily through changes in the way an individual perceives, reflects upon, and, in general, thinks about their life circumstances".[37]

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33 Brigden, A. (2004). Therapeutic Jurisprudence and Responsivity: Finding the will and the way in offender rehabilitation. Psychology, Crime and Law, 10(3), pp. 238-295.
34 Ibid.
35 Ibid.
36 Farrall, M. (2001). Motivational Crossovers: A brief look at MI in ''non standard'' areas. MINUET Motivational Interviewing Newsletter: Updates, Education and Training, 8(3), pp. 8-12, retrieved on 25 June 2003 from http:\\motivationalinterview.org/mint/MINT8_3.PDF.
37 K. S. Dobson, and Khatri, N. (2000). Cognitive Therapy: Looking backward, looking forward, *Journal of*

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.[38] CBTs employed among correctional populations have been conceptualised as cognitive-restructuring, coping-skills, or problem-solving therapies.[39] 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."[40]

Additionally, Fabiano, Porporino, and Robinson contended that offenders "lack interpersonal problem-solving skills, critical reasoning skills, and planning skills".[41] 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,[42] attributable to the interaction between learning and reinforcement, maladaptive responses and coping mechanisms[43]. In other words, CBT views sexual offending as the product of interaction between a individual's inner mechanics and the environment.[44] 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.[45]

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*Clinical Psychology*, 56, pp. 907-923.

[38] Meichenbaum, D. H. (1995). Cognitive Behavioural Therapy In Historical Perspective. In B. Bongar and L. Beutler (Eds.), *Comprehensive Textbook of Psychotherapy: Theory and practice* (pp. 140-158). New York: Oxford University Press.

[39] Mahoney, M. J. and Arnkoff, D. B. (1978). Cognitive and Self-Control Therapies. In S. L. Garfield and A. E. Bergin (Eds.), *Handbook of Psychotherapy and Behaviour Change: An empirical analysis* (pp. 689-722). New York: John Wiley.

[40] Wilson, D. B., Bouffard, L. A. and MacKenzie, D. L. (2005). A Quantitative Review of Structured, Group-Oriented, Cognitive Behavioural Programs for Offenders, *Criminal Justice and Behaviour,* 32, pp. 172-204.

[41] Fabiano, E. A., Porporino, F. J. and Robinson, D. (1991). Canada's Cognitive Skills Program Corrects Offenders' Faulty Thinking, *Corrections Today*, 53(5), pp. 104.

[42] Ward, T. and Beech, A. (2006). An Integrated Theory of Sexual Offending, *Aggression and Violent Behaviour*, 11(1), pp. 44-63.

[43] Yates, P. (2003). Treatment of Adult Sexual Offenders: A therapeutic cognitive behavioural model of intervention. *Journal of Child Sexual Abuse*, 12(3), pp. 195-232.

[44] Ward, T. and Beech, A. (2006). An Integrated Theory of Sexual Offending, *Aggression and Violent Behaviour,* 11*,* pp. 44–63.

[45] Feelgood, S., Cortoni, S. and Thompson, A. (2003). Sexual Coping, General Coping and Cognitive Distortions In Incarcerated Rapists and Child Molesters, *Journal of Sexual Aggression*, 11(2), pp.157-170.

4.5. 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).[46] MRT is a 12 to 16 step cognitive skills program conducted in a group setting, during which offenders 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.[47]

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. 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.

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

The debate surrounding the effectiveness of rehabilitation efforts for criminal offenders has transitioned from the rather pessimistic perspective of the 1970s and 1980s to an optimistic research-driven perspective.[48] A consistent theme in numerous reviews of the rehabilitation

[46] Wilson, D. B., Bouffard, L. A. and Mackenzie, D. L. (2005). A Quantitative Review of Structured, Group-Oriented, Cognitive Behavioural Programs For Offenders, *Criminal Justice and Behaviour,* 32(2), pp. 172-204.

[47] 'Moral Reconation Therapy', retrieved on 22 January 2012 from http://www.doc.wa.gov/facilities/cjc/tacomacjc/docs/TCJCTherapy.pdf.

[48] Wilson, D., Bouffard, L. and Mackenzie, D. (2005). A Quantitative Review of Structured, Group-Oriented, Cognitive Behavioural Programs For Offenders. *Criminal Justice and Behaviour*, 32(2), pp. 172-204.

literature is the positive effects of CBT approaches to offender populations in reducing recidivism.[49]

5.1. Sex Offences

A vast array of research has been conducted on the employment of CBT for people who have committed a sex offence. Hall conducted a meta-analysis of 92 published studies on sex offender treatment outcomes since 1988.[50] 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%) samples when compared to treated (19%) samples. 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[51] and 50% who began with hormonal treatment discontinued it.[52] On the other hand, refusal and dropout rates for CBT are about one third.[53] 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) and their suppressant effect on not only deviant, but also appropriate forms of sexual arousal.[54]

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.[55] 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

[49] Gendreau, P. and Ross, R. (1987). Revivification of Rehabilitation: Evidence from the 1980's, *Justice Quarterly,* 4, pp. 349-408.
[50] Hall, G. N. C. (1995). Sexual Offender Recidivism Revisited: A meta-analysis of recent treatment studies. *Journal of Consulting and Clinical Psychology*, 63, pp. 802-809.
[51] Meyer, W. J., Cole, C. and Emory, E. (1992). Depo Provera Treatment For Sex Offending Behaviour: An evaluation of outcome, *Bulletin of the American Academy of Psychiatry and the Law,* 20, pp. 249-259.
[52] Langevin, R., Paitich, D., Hucker, S. J., Newman, S., Ramsay, G., Pope, S., Geller, G. and Anderson, C. (1979). The Effect of Assertiveness Training, Provera, and Sex of Therapist In the Treatment of Genital Exhibitionism, *Journal of Behaviour Therapy and Experimental Psychiatry,* 10, pp. 275-282.
[53] Chaffin, M. (1992). Factors Associated With Treatment Completion and Progress Among Intrafamilial Sexual Abusers. *Child Abuse & Neglect,* 16, pp. 251-264.
[54] Hall, C. G. N., Shondrick, D. and Hirschman, R. (1993). Conceptually-Derived Treatments for Sexual Aggressors. *Professional Psychology: Research and Practice,* 24, pp. 62-69.
[55] Maletzky, B. M. and Steinhauser, C. (2002). A 25-Year Follow-Up of Cognitive/Behavioural Therapy With 7,275 Sexual Offenders. *Behaviour Modification,* 26, pp. 123–147.

paedophiles 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. These findings suggest the importance of the previous argument that market driven CBT programs are less likely to be effective, due to their diminished power of review.

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[56]; Yates[57]; Brooks-Gordon, Bilby & Wells [58]; Looman, Dickie & Abracen [59]; Duwe & Goldman [60]).

5.2. General Offender Population

CBT has also been found to be one of the most effective treatments in reducing recidivism among criminal offenders of all types. 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

[56] Marshall, W. and Serran, G. (2000). Current Issues In The Assessment and Treatment of Sexual Offender, *Clinical Psychology and Psychotherapy*, 7(2), pp. 85-96.
[57] Yates, P. (2003). Treatment of Adult Sexual Offenders: A therapeutic cognitive behavioural model of intervention, *Journal of Child Sexual Abu*se, 12(3), pp. 195-232.
[58] Brooks-Gordon, B., Bilby, C. and Wells, H. (2006). A Systematic Review of Psychological Interventions for Sexual Offenders I: Randomised control trials. *Journal of Forensic Psychiatry and Psychology,* 17(3), pp. 442-466.
[59] Looman, L., Dickie, I. and Abracen, J. (2005). Responsivity Issues In the Treatment of Sexual Offenders, *Trauma, Violence, and Abuse*, 6(4), pp. 330-353.
[60] Duwe, G. and Goldman, R. (2009). The Impact of Prison-Based Treatment On Sex Offender Recidivism: Evidence from Minnesota. *Sex Abuse*, 21(3), pp. 279-307.

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.[61]

One especially optimistic finding is that CBT is also generally well received among those offenders who participate in it.[62] 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.[63]

**6. 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.[64] CBT has also been described as being among the more promising rehabilitative treatments for criminal offenders.[65] In light of this, some offenders are unable to make use of CBT due to a short sentence or lengthy waiting list. 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.[66] Individualised one-on-one CBT, provided by clinical psychologists or other mental

[61] Lipsey, M. W., Landenberger, N. A. and Wilson, S. J. (2007). Effects of Cognitive Behavioural Programs for Criminal Offenders, *Campbell Systematic Reviews,* 6, pp. 1-27.
[62] Colton, M., Roberts, S. and Vanstone, M. (2009). Child Sexual Abusers' Views On Treatment: A study of Convicted and Imprisoned Adult Male Offenders. *Journal of Child Sexual Abuse*, 18(3), pp. 320-338.
[63] Marshall, W. and Serran, G. (2004). The Role of the Therapist In Offender Treatment, *Psychology, Crime and Law*, 10(3), pp. 309-320.
[64] Community Development and Justice Standing Committee. 'Making Our Prisons Work: An inquiry into the efficiency and effectiveness of prisoner education, training and employment strategies,' *Government of Western Australia, Department of Corrective Services' Submission February 2010*.
[65] Lipsey, M. P., Landenberger, N. A. and Wilson, S. J. (2007). Effects of Cognitive Behavioural Programs for Criminal Offenders, *Campbell Systematic Reviews,* 6, retrieved on 6 February 2012 at http://www.campbellcollaboration.org/reviews_crime_justice/index.php
[66] Dobson, K. S. and Khatri, N. (2000). Cognitive Therapy: Looking backward, looking forward. *Journal of Clinical Psychology*, 56, pp. 907-923.

health workers, are simply not practical on a large scale within our prison system.[67]

6.1. Treatment for People Charged With a Sex Offence

In Australia, most treatment programs for people who have committed a sex offence 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.[68] Figure 1 below provides a list of adult sex offender treatment programs currently operating in Australia:[69]

| *Jurisdiction* | *Prison-based* | *Community-based* |
|---|---|---|
| Australian Capital Territory | ASOP - Adult Sex Offender Program | ASOP – Adult Sex Offender Program |
| New South Wales | CUBIT (Custody Based Intensive Treatment) – high risk offenders<br>CORE (CUBIT Outreach) – low risk offenders<br>Custodial Maintenance program – for graduates of CUBIT & CORE | Community Maintenance program<br>Forensic Psychology Services – low risk offenders<br>Cedar Cottage NSW Pre-Trial Diversion of Offenders Program – Child sex offenders<br>Encompas (Catholic Church)<br>Pastoral Counselling Institute (Uniting Church) |
| Northern Territory | Sex Offender Treatment Program for Indigenous males - Darwin<br>Sex Offender Treatment Program for Indigenous males - Alice Springs | |
| Queensland | Queensland Corrective Services -<br>MISOP - Medium Intensity<br>HISOP - High Intensity<br>ISOP – Program for low cognitive functioning sexual offenders<br>IMISOP - Indigenous Medium Intensity<br>IHISOP - Indigenous High Intensity | Medium Intensity Sexual Offending Program<br>Sexual Offending Maintenance Program |
| South Australia | Sex Offender Treatment Program<br>Indigenous Sex Offender Treatment Program | Community Corrections Sex Offender Treatment Program |
| Tasmania | Sexual Offending Program – for low, moderate & high risk offenders | |
| Victoria | MMIP - Modular Management Intervention Program<br>Skills Based Intervention Program<br>Maintaining Change program – for graduates of the MMIP | MMIP - Modular Management Intervention Program<br>SBIP - Skills Based Intervention Program for persons with cognitive impairments |
| Western Australia | Sex Offender Program<br>Indigenous Sex Offender Program<br>Program for intellectually disabled offenders | Community-based Maintenance program<br>Community-based program<br>Community-based program for intellectually disabled offenders<br>S.A.I.F. Program (Safecare) |

**Figure1. Sex Offender Programs Operating in Australian Prisons**

In NSW, the Custody Based Intensive Treatment (CUBIT) program operates for moderate-

[67] Wilson, D. B., Bouffard, L. A. and MacKenzie, D. L. (2005). A Quantitative Review of Structured, Group-Oriented, Cognitive Behavioural Programs for Offenders. *Criminal Justice and Behaviour,* 32, pp. 172-204.

[68] Australian Institute of Criminology, (2008). Sex offender Treatment Programs: Effectiveness of prison and community based programs in Australia and New Zealand, retrieved on 5 December 2012 from http://www.indigenousjustice.gov.au/briefs/brief003.pdf.

[69] Ibid.

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 re-offending such as empathy deficits, cognitive distortions and general self-regulation.[70] Hoy and Bright (2008)[71]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).

CUBIT psychologists have undertaken a number of projects examining 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 , 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.[72] Thus, the current rehabilitation efforts in NSW targeting sexual offending are highly promising.

### 6.2. 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 involved

[70] Ibid.
[71] Hoy, A. and Bright, D.A. (2008) Effectiveness of a Sex Offender Treatment Programme: A risk band analysis (unpublished).
[72] Ibid.

with individual sessions.[73] Figure 2 lists the cognitive skills programs currently being administered in Australian prisons. [74]

**Table 2: Cognitive skills programs**

| Jurisdiction | Program title | Type | Specific target | Duration | Risk need assessment for entry | Pre-post measures of change | Evaluation |
|---|---|---|---|---|---|---|---|
| SA | Making Choices—being developed | | | | | | |
| Vic | Maintaining Change | Maintenance | | 25 hours | √ | | |
| | Exploring Change | Motivational | | 12 hours | √ | | |
| | Cognitive Skills | Therapeutic | | 60 hours | √ | | √ |
| | Cognitive Skills | Therapeutic | Women | 60 hours | √ | | |
| | Cognitive Skills | Therapeutic | Koori men | 60 hours | √ | | √ |
| | Making Choices | Therapeutic | | 100 hours | √ | √ | |
| | Making Choices | Therapeutic | Women—pilot | 100 hours | √ | √ | |
| NSW | Think First | Therapeutic | | 60 hours | √ | √ | √ |
| ACT | Cognitive Self Change | Therapeutic | | 100+ hours | √ | √ | Planned |
| Qld | Making Choices | Therapeutic | | 100 hours | √ | √ | √ |
| | Making Choices Programme | Maintenance | | 16–24 hours | √ | √ | |
| NT | Cognitive Skills | Psycho-educational | | 24 Hours | √ | | √ |
| Tas | Making Choices | Therapeutic | | 100 hours | √ | | Planned |
| WA | BOAS | Psycho-educational | Indigenous | 20 hours | √ | √ | Planned |
| | Cognitive Brief Intervention | Motivational | | 20 hours | √ | | |
| | Think First | Therapeutic | | 60 hours | √ | √ | √ |
| | Legal and Social Awareness | Therapeutic | Intellectually disabled | 60 hours | √ | | |

**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.[75] 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,

[73] Heseltine, K., Sarre, R. and Andrew. D. (2011). Prison-Based Correctional Rehabilitation: An overview of intensive interventions for moderate to high-risk offenders, *Trends & Issues in Crime and Criminal Justice*, 412, pp. 1-6.
[74] Ibid.
[75] APS Forensic Psychology National Conference. (2011). *Diversity and Specialism in Forensic Psychology*, presented between 4 – 6 August 2011.

and attitudes.[76]

Nearly half (47%) of all sentenced prisoners in Australia are in custody for violent crimes.[77] 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.[78] Figure 3 lists the violent offender programs used in Australia.

**Table 4: Violent offender programs**

| Jurisdiction | Program title | Duration | Risk/need assessment for entry | Pre-post test | Evaluation |
|---|---|---|---|---|---|
| NSW | VOTP —high | 240 hours | √ | √ | √ |
| | VOTP—moderate | 100–130 hours | √ | √ | √ |
| | VOTP—maintenance | Ongoing | | | √ |
| Qld | Cognitive Self Change | 100 hours | √ | √ | √ |
| WA | Violent Offender Treatment Program | 316 hours | √ | √ | √ |
| | Medium Intensity Violence | 132.5 hours | √ | √ | √ |
| Tas | Planned | | | | |
| Vic | VIP —high intensity | 180 hours | √ | √ | √ |
| | VIP—moderate intensity | 120 hours | √ | √ | √ |
| ACT | Cognitive Self Change | 100 hours | √ | √ | |
| NT | Planned | | | | |
| SA | VPP | 330 hours | √ | √ | Planned |

**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.[79]

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

A report published in 2011 by the Australian Institute of Criminology provides an updated account of the nature and scope of custodial-based offender rehabilitation programs in Australia.[80] The report found that formal training and professional qualification are central

[76] Department of Corrective Services W.A. (2010). Offender Services Prison and Community Programs Guide 2009/10. Offender Management and Professional Development, 4 June 2009.
[77] Australian Institute of Criminology. (2007). Trends and Issues in Crime and Criminal Justice, No. 412, May 2011.
[78] Ibid.
[79] The Department of Corrective Services W.A. (2010). Making Our Prisons Work: An inquiry into the efficiency and effectiveness of prisoner education, training and employment strategies, *Community Development and Justice Standing Committee,* Submission February 2010.
[80] Australian Institute of Criminology. (2011). Prison-Based Correctional Offender Rehabilitation Programs:

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 pro-social 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.

### 7.1. 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 Reconation Therapy (MRT); Reasoning and Rehabilitation (R & R); Relapse Prevention Therapy (RPT) and Thinking for a Change (T4C).[81] 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

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The 2009 national picture in Australia, No. 112, May 2011.

[81] U.S. Department of Justice. (2007). Cognitive behavioural Treatment: A review and discussion for corrections professionals, *National Institute of Corrections*, May 2007.

implementation of the program. Figure 4 below gives an overview of the T4C program.

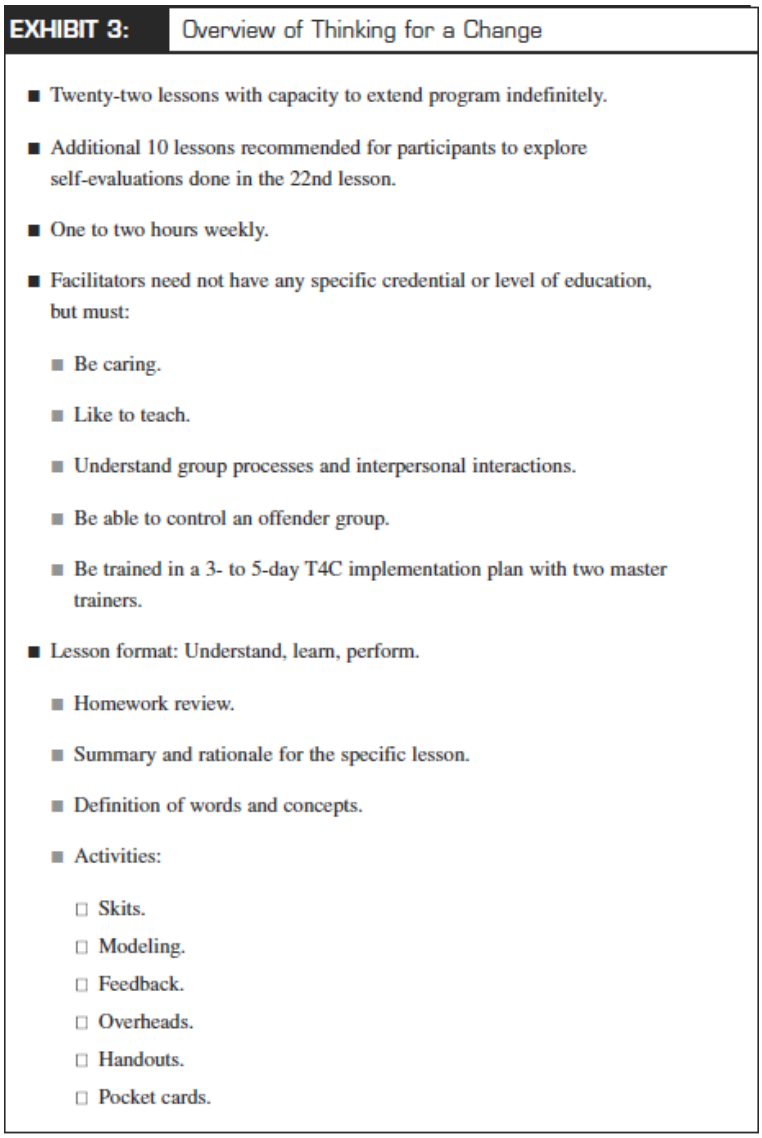

**EXHIBIT 3:** Overview of Thinking for a Change

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

**Figure 4. Overview of Thinking for a Change (T4C) Program**

7.2. 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. The offenders who completed the T4C program, as well as those who dropped out, 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 pro-criminal attitudes. The study found that the recidivism rates were 33% lower for the treatment group than the control group. Offenders who completed the program also showed a significant improvement in interpersonal problem-solving skills while no such improvement was observed for those who

dropped out. 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%).[82]

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.[83] 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.

Drawing from a comprehensive range of empirical evidence, the current paper asserts the view that CBT programs have significant benefits for individuals in the prison system; including improving interpersonal, pro-social and coping skills and other cognitive skills that are aimed at reducing recidivism. However, in Australia, emphasis on the counsellor's role and counsellor-client relationship in determining the success of CBT-based interventions has limited these programs to an institutional role. As a result, while demonstrably 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 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

[82] Lowenkamp, C.T. and Latessa. E.J. (2006). Evaluation of Thinking for a Change: Tippecanoe County, Indiana. Unpublished data, University of Cincinnati.

[83] Bogue, B., Clawson, E. and Joplin, L. (2005). Implementing Evidence-Based Practice In Community Corrections: The principles of effective intervention. *M. A: Crime and Justice Institute,* Retrieved on 2 February 2012 at www.cbhc.org.

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.

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 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.

**8. Conclusions**

This paper has outlined a proposal for a new approach to implementing CBT within a prison context. It has been argued that CBT should be accessible by choice to offenders at all stages from their arrest to reintegration into society. The coercive nature of current rehabilitation approaches to prisoners is counter-productive to supporting prisoners through personal decisions to change and improve themselves.

Programs should be facilitated in a safe, private and trusting environment where participants can freely engage in positive change and development. With many programs being available online, computers offer a revolutionary step in how offenders may access and interact with programs and program material. Consequently, the proposals in this paper act in conjunction with those of the Computers in Cells publication. Support people were identified as important players in offender rehabilitation. Families and friends must have access to prisoners to assist in the rehabilitation process. Rehabilitation programs must be culturally appropriate, particularly for Aboriginal people.

T4C provides a model that tackles some of the weaknesses and limitations of Australia's

current rehabilitation approach to offenders. It would be beneficial to adapt a similar model in our Australian criminal justice system.

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**Legislation**

*Crimes (Sentencing Procedure) Act 1999* NSW.

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