Evaluating the Use of Cognitive-Behavioral Treatment Programs in the Federal Probation System

A Thesis submitted
by

Burle G. Steelman
University of Central Oklahoma
Spring 2009

TABLE OF CONTENTS

Introduction 1

Literature Review 6

What works? 6

Criminogenic Needs/Risk Factors 10

Cognitive-Behavioral Treatment Programs 12

Criminal Conduct and Substance Abuse Treatment: Strategies for Self-Improvement and Change (SSC) 16

Thinking for a Change (T4C) 16

Reasoning and Rehabilitation (R&R) 17

Relapse Prevention Therapy (RPT) 20

Moral Reconation Therapy (MRT) 21

Methods 24

Research Questions 24

Sample 25

Measurement 25

Findings 27

Within Respondent 29

Within Program 35

Risk Factors 35

Discussion 37

Cognitive-Behavioral Programs 37

Referral Methods 39

Risk Factors 40

Program Completion and Supervision Completion 41

Limitations 42

Implications for the Field 45

APPENDIX 1: Cognitive Behavioral Treatment Questionnaire 47

APPENDIX 2: Respondent Information 49

REFERENCES 50

Evaluating the Use of Cognitive-Behavioral Treatment Programs in the Federal Probation System

by

Burle G. Steelman

A Thesis
Submitted to the
Graduate Faculty
of
University of Central Oklahoma
In Partial fulfillment of
The Requirements for the Degree
of
Master of Arts
Criminal Justice Management and Administration

Mark R. McCoy, Ed.D., Chair

Elaine Bartgis, Ph.D.

Gary Steward, Ph.D.

Introduction

Approximately 600,000 offenders are released from state and federal prisons each year (Petersilia, 2004). A Bureau of Justice Statistics study of offenders released in 1994 showed that two-thirds of those released reoffended within three years (BJS, 2007). In addition to those reoffending, up to 18 percent of federal offenders whose cases were closed during fiscal year 2004 were revoked for technical violations (U.S. Probation and Pretrial Services, 2004). When offenders commit new criminal conduct, especially if the conduct constitutes a felony, there are few options except to recommend revocation of supervision. However, with technical violations some options generally exist. Some examples of technical violations for federal offenders include: failure to submit monthly reports, associating with felons, failure to notify the probation officer prior to changes in residence and employment, failure to follow the instruction of the probation officer, the use of controlled substances or the excessive use of alcohol, failure to pay fines or restitution, and leaving the district without permission. Attempts to correct violation behavior are pursued with varying degrees of success and range from a verbal warning to a recommendation for revocation. These technical violations of the conditions of supervision are violations, but rarely result in revocation, unless they become chronic and efforts to change the offender's behavior are unsuccessful. When not successful in correcting violation behavior, revocation is pursued (Monograph 109, 2008).

According to a 2008 memorandum from the Administrative Office of the U.S. Courts, the estimated cost to incarcerate offenders is $26,000 per year (Internal agency memorandum, May 2008). That same memorandum advised that the cost of providing community supervision is approximately $3,600 per year. The financial cost of incarceration

alone provides an incentive for us to assist offenders in changing their behaviors in order for them to remain in the community, working, taking care of family responsibilities, and being law-abiding citizens. We have seen that increasing punishments though longer sentences and intermediate sanctions programs including boot camps, and intensive supervision have not demonstrated a positive effect in reducing recidivism (Aos, Miller & Drake, 2006; Taxman, 2002). An exception was noted by Aos et al. (2006), who reported that an intensive supervision program *with treatment provided* produced a 22 percent reduction in recidivism (emphasis added).

Monograph 109: The Supervision of Federal Offenders (2008) outlines six criminogenic needs that contribute to offenders' violations of the conditions of supervision, whether by reoffending or by continuing in technical violations: 1) some offenders reoffend and violate supervision due to a lack of self-control. That self-control is needed for the offender to abstain from the excessive use of alcohol or controlled substances or commit new criminal offenses. 2) Some offenders exhibit anti-social personality traits. Those traits are characterized by a lack of concern about how the offender's actions might negatively impact others. 3) Some offenders possess anti-social values. Those offenders are not involved in a positive way in the community and they have not adopted the social norms and values of the law-abiding community. 4) Some offenders maintain relationships with other convicted felons. These associations can lead to additional illegal activity and is a violation of the conditions of supervision. 5) Some offenders are substance abusers. Substance abuse has been linked to criminal behavior, although no causal or temporal relationships have been determined, and substance abuse is a violation of conditions of supervision. And 6) some offenders may come from dysfunctional families. Part of that dysfunction may involve

criminal activities and substance abuse. These criminogenic needs are consistent with those identified by others (Andrews, Bonta, & Hoge, 1990; Gendreau, Little, & Goggin, 1996; Lowenkamp, Pealer, Smith, & Latessa, 2006).

Identifying the risks and needs of offenders is the first step in the process of confronting the offender's anti-social thinking and behavior. These are the areas that should be targeted by effective programming (Andrews et al., 1990; Bourgon & Armstrong, 2005). Studies have shown the value and positive effect of identifying higher risk offenders and providing an appropriate type and amount of treatment for those offenders (Bourgon & Armstrong, 2005). Cognitive-behavioral treatment programs have been developed based on the premise that thoughts lead to actions and feelings, not vice versa. Those changes in thinking can result in changes in behavior and feelings, even if external circumstances do not change (National Association of Cognitive-Behavioral Therapists, n.d.), and that anti-social thinking is learned and can be changed.

Many years ago, Dr. Herman Jones, a neuropsychologist at the O'Donaghue Rehabilitation Institute in Oklahoma City, when asked about the effectiveness of treatment, responded by saying that there are two extreme views of treatment: (1) that treatment works for everyone all of the time and (2) that treatment will never work for some people. His belief was that treatment was effective for almost everyone at some place and time, and that our hope should be that we can facilitate the convergence of those two events (Personal communication, n.d.) To effectively supervise offenders in the community, our efforts to assist offenders in changing anti-social thinking and anti-social behavior has obvious benefit. To effect that change, high-risk offenders must be identified by accurately assessing risks and

needs, and providing an appropriate type and amount of treatment to address those needs (Andrews & Bonta 2003; Cullen & Gendreau, 2000; Lowenkamp et al., 2006).

One of the functions of the United States Probation System is to provide post-conviction supervision in 94 separate districts throughout the country and three territories (the Virgin Islands, Guam, and the Northern Mariana Islands). Each district is under the authority of the Chief U.S. District Judge for that district. While there are general guidelines for conducting business in similar ways throughout the system, there are also numerous district-by-district idiosyncrasies. Recently the Office of Probation and Pretrial Services (OPPS), the branch of the Administrative Office of the U.S. Courts that provides policy and direction for U.S. Probation Offices, rewrote Chapter 5 of Monograph 119, which deals with treatment issues for offenders under supervision. Specifically, OPPS began an effort to have probation offices system-wide use evidence-based supervision techniques, including cognitive-behavioral treatment programs. In the Western District of Oklahoma, the office sent two senior probation officers to training to become certified in a cognitive-behavioral program named Moral Reconation Therapy (MRT), a program developed by Gregory Little and Kenneth Robinson in 1986. Offenders were identified and referred for participation in the program and MRT began in the Western District of Oklahoma in June 2008.

Reducing the numbers of offenders who reoffend or commit technical violations resulting in revocation is a worthy goal for those in community corrections. In an effort to assist offenders in successfully completing their terms of supervision, and hopefully, changing the thinking and thereby the behaviors that lead to substance abuse and criminal activity, cognitive-behavioral treatment programs can provide offenders with new tools to use in living pro-social lives.

Probation officers often look for alternatives to revocation, while attempting to deal with offenders' noncompliance, depending upon the severity of the noncompliance. Monograph 109 (2008) discusses the use of graduated sanctions to help offenders return to compliance. Examples of these sanctions include: re-instruction of the offender by the probation officer, referrals for counseling services, administrative hearings with the offender and the officer's supervisor, placement on home confinement (with or without electronic monitoring), and placement in a halfway house setting. With the presence of cognitive-behavioral treatment programs, officers will have an additional tool to use with offenders who are having difficulty complying with the conditions of supervision, or who have been identified as having criminogenic needs that can be addressed by cognitive-behavioral treatment programs. The probation system has embraced evidence-based practices and is pursuing the use of cognitive-behavioral treatment programs to effect those positive changes in an identified high-risk population. The use of these programs should reflect an increase in the rate of successful completion of supervision by those completing cognitive-behavioral treatment.

The purpose of this study is to determine which cognitive-behavioral programs are being utilized with offenders under the supervision of federal probation offices across the country, and to determine if those programs have demonstrated positive outcomes within those offender populations.

Chapter 2

Literature Review

What Works?

Researchers and community corrections agencies have long sought to determine the most effective methods of ensuring that offenders are successful in reintegrating into the community. Martinson and his cohorts came to the conclusion that nothing could be proven to work (Martinson, 1974; Lipton, Martinson, & Wilks, 1975). Martinson (1974) evaluated research completed between 1945 through 1967 that was reported in the English language regarding the effectiveness of various attempts at rehabilitation in correctional populations. He evaluated 231 studies and noted that the quality of the research was such that when positive results were reported, there were problems generalizing the results to other populations, there was little replication, and the definitions for the terms used were different in many of the studies. Others characterized Martinson's statements as choosing to look at each study in a critical light, casting doubts on positive results based on small sample sizes, and not even considering studies that lacked control groups or had possible publication bias (Cullen & Gendreau, 2000; McGuire & Priestly, 1995). Specifically, Martinson noted that some treatment programs might be working, but the research on that effectiveness was so poor that we were unable to tell (p. 49).

A consequence of the *nothing works* studies was the increased use of punishment, as evidenced by longer sentences and more punitive community-based programs. Researchers have noted that there are no studies indicating that punishment or more intensive community-based programs were effective in reducing recidivism (Andrews & Bonta, 2003; McGuire & Priestly, 1995; Taxman, 2002).

Since the *nothing works* report published by Martinson (1974), and the work of Lipton et al. (1975), researchers have dealt with the problems of adequately defining the parameters by which reentry programs and recidivism can effectively be measured (Petersilia, 2004). Cohn (2002) addressed the problem of evaluating the effectiveness of criminal justice programs by stating that we are seeking universal truths about what works in criminal justice. He stated that "We have become more sophisticated in the use of scientific methods, but causal relationships – and truths – may be elusive, and what is true today may not be true tomorrow" (p. 4). He urged the use of program evaluations as tools, used retrospectively to discover the things done right, and using that information as a springboard for future planning. To address some research concerns about the quality of published studies, many researchers have utilized meta-analyses as a method of looking at numerous studies simultaneously to derive a quantitative estimate that is open to replication (Gendreau & Andrews, 1990), as to the effectiveness of treatment in reducing recidivism (Andrews & Bonta, 2003; Cullen & Gendreau, 2000; Lipsey, 1995). Lipsey specifically noted that meta-analysis allows researchers to see broad patterns reflecting overall treatment effect more so than traditional research techniques allow for (p. 66).

Researchers Mitchell, MacKenzie, and Wilson (2006) conducted a meta-analysis of 26 independent studies that evaluated the effectiveness of substance abuse treatment programs in secure facilities. They noted that one of the most important aspects of providing treatment in secure correctional settings is the ability to use "considerable coercive force to encourage substance abusing offenders to engage in treatment" (p. 104). Methodological shortcomings were noted in many of the studies excluded from this analysis. The 26 studies, which evaluated 31 programs, with three studies evaluating effectiveness for males and

females separately (p. 107) were included in the analysis. The number of participants in the studies ranged from a low of 64 to a high of 5746. Recidivism and relapse were two of the outcome measures reported. Recidivism included re-arrest, re-conviction, re-incarceration, and revocation. Relapse was based on self-reported drug usage. Eleven of the studies reported on drug use as an outcome (p. 111), while the balance reported on recidivism. Seventy-five percent of the studies reflected an overall positive effect for treatment groups over the comparison groups (p. 108). The authors noted that effectiveness measures appeared to be influenced by the definition of recidivism used in the study, with the use of re-conviction rates as reflecting the largest treatment effect. Overall, the authors found that therapeutic communities had the highest success in reducing recidivism and subsequent drug use. These programs were intensive and dealt with the numerous personal issues that substance abusers face, and were the most effective. On the other hand, treatment that occurred in boot camp settings was not found to reduce recidivism or dug use. The results are reported as tentative because of noted methodological shortcomings and a lack of "knowledge regarding which components of drug treatment programs are actually responsible for the observed treatment benefits" (p. 113).

Losel (1995) reviewed 13 meta-analyses of offender treatments. He noted that one of the limitations in looking at these studies is that all dealt with studies completed in the English language and were predominantly North American and European in origin (p. 81). He reported that all of the meta-analyses showed a positive effect for treatment (p. 89), and that cognitive-behavioral, skill-oriented and multi-modal programs yielded the best effects (p. 91).

Aos et al. (2006) conducted a meta-analysis of evidence-based adult corrections programs for the State of Washington. They included only program evaluations that had well-matched non-treatment comparison groups. Because the review dealt with offenders already involved in the criminal justice system, they focused on the question of "What works, if anything, to lower the recidivism rates of adult offenders?" (p. 2). Ninety-two evaluations of programs for drug-involved offenders were analyzed. Those studies included adult drug courts, in-prison therapeutic communities with community aftercare, in-prison therapeutic communities without community aftercare, cognitive-behavioral drug treatment in prison, drug treatment in the community, and drug treatment in jail. Generally, offenders receiving drug treatment were less likely to recidivate by a statistically significant amount. An interesting finding in this group was the limited increase in program effectiveness between in-prison therapeutic communities without community aftercare, a reduction rate of 5.3 percent, versus a 6.9 percent reduction rate for in-prison therapeutic communities with community aftercare, prompting the authors to conclude that the greatest degree of effectiveness was achieved while offenders were in custody. For cognitive-behavioral drug treatment while in prison, drug treatment in the community, and drug treatment in jail, each demonstrated a statistically significant reduction in recidivism rates, with community-based drug treatment demonstrating a 12.4 percent reduction in recidivism rates. These authors also analyzed 25 cognitive-behavioral treatment programs for general offender populations. The average reduction in recidivism was 8.2 percent. Three specific cognitive-behavioral treatment programs were identified by researchers, Reasoning and Rehabilitation (R&R), Moral Reconation Therapy (MRT), and Thinking for a Change (T4C). The results for the R&R and MRT programs were similar, and although there was only a single T4C program

evaluated, the authors recommended the use of any of the three programs. Eighteen evaluations of programs for sex offenders were analyzed. The authors noted that psychotherapy/counseling and behavioral therapy for sex offenders provided no reduction in recidivism. However, cognitive-behavioral treatment programs for both incarcerated sex offenders and low-risk sex offenders in the community showed average recidivism reduction rates of 14.9 percent and 31.2 percent respectively.

Aos et al. (2006) also noted that studies on the effectiveness of intermediate sanctions programs (intensive supervision with additional surveillance, intensive supervision with treatment programs, adult boot camps, electronic monitoring, and restorative justice programs for lower-risk offenders) showed no effect on recidivism, with the exception of the intensive supervision with treatment programs that indicated a 21.9 percent reduction in recidivism rates. The type of treatment in the intensive supervision programs was not defined. Taxman (2002) also noted the lack of studies reflecting a positive impact of the types of intermediate sanctions programs noted above.

Criminogenic Needs/Risk Factors

An important area that researchers found needed to be addressed is referred to as criminogenic needs, a subset of risk factors (Andrews et al., 1990). Andrews et al. note that these needs are dynamic factors that, when changed, alter the chances of recidivism (p. 31). Lowenkamp et al. (2006) defined criminogenic needs as "antisocial attitudes, antisocial peers, antisocial personality, poor familial relationships, and low educational or vocational achievement" (p .4). Andrews (1995) included: "A history of antisocial behaviour evident from a young age, in a variety of settings and involving a number and variety of different acts" in his list of factors to be considered (p. 37). A recent training conducted by staff from

the Administrative Office of the U.S. Courts and the Federal Judicial Center also discussed substance abuse, which can exacerbate any of the aforementioned, within the criminogenic needs category (Personal communication, October 2008; Monograph 109, 2008). Gendreau et al. (1996) stated that criminogenic needs of offenders are one of the strongest predictors of recidivism. These are the areas that should be targeted by effective programming (Andrews et al.,1990; Bourgon & Armstrong, 2005). In addition, "higher risk offenders should receive the greater 'dosage' of treatment" (Bourgon & Armstrong, 2005, p. 4). Studies found that it was counterproductive to utilize high levels of programming with low-risk offenders (Andrews et al., 1990; Lowenkamp & Latessa, 2005). They also determined that it was counterproductive to treat non-criminogenic needs, like anxiety and low self esteem, if not treating a greater number of criminogenic needs at the same time (Lowenkamp et al., 2006; Birgden, 2004). Interestingly, Andrews (1995) states that weak motivation on the part of the offender is to be expected and should be seen as an "important intermediate target of change" (p. 57). Lipsey (1995), while not addressing any specific type of treatment modality, found that researcher involvement in treatment design and implementation produced more positive outcomes (p. 76).

To determine relative risk levels, the Risk Predictor Index (RPI) is a tool used within federal probation to identify, during the assessment process, offenders' statistical likelihood of success. Scores are included in the initial case supervision plan. The computed scores range from 0 – 9 with those scoring on the lower end having the greatest likelihood of successfully completing supervision. The RPI score is computed on the following factors: offender age at beginning of supervision, number of arrests (up to 15), whether the offender was employed at the beginning of supervision, whether the offender living with a spouse

and/or children at the beginning of supervision, whether a weapon used in this offense, has the offender ever absconded from supervision, whether the offender have a college degree, and whether the offender have a history of alcohol abuse or drug use (Monograph 109, 2008, Ch. III, p. 11). Generally, offenders receiving scores of 0, 1, or 2 are considered in the low-risk category and are expected to successfully complete supervision at a rate of approximately 90 percent, while offenders receiving scores of 6, 7, 8, or 9 are considered high-risk and revocation rates may be as high as 90 percent (Eaglin, Gilbert, Hooper & Lombard, 1997).

Cognitive-Behavioral Treatment Programs

During a recent training, Charles Robinson, Program Administrator, Administrative Office of the U.S. Courts, stated that we act based on what we think. Using his audience as subjects, he urged trainees to think about a behavior that person would like to change. He then had the group remember the thoughts that preceded that behavior. He advised that the behavior can be changed, if the thoughts that preceding the behavior are changed (Personal communication, October 2008). Cognitive-behavioral treatment is based on the premise that the antisocial thinking exhibited by offenders is learned, and can, in turn, be changed. These treatment programs emphasize individual accountability and attempt to assist offenders in exploring their thought processes and changing the counter-productive ones (Lipsey & Landenberger, 2006). Gendreau and Andrews (1990) recommend focusing on cognitive and skill building strategies intended to change "attitudes, values, and beliefs that support anti-social behavior" (p. 182).

Research on the effectiveness of cognitive-behavioral treatment (CBT) programs, while promising, has not yet been able to demonstrate a cause-and-effect relationship

between the use of CBT programs and reduced recidivism due to a number of factors. Participants were rarely assigned to treatment groups on a random basis and offenders were allowed to choose to participate in treatment. This lack of randomization makes it difficult to assess program effectiveness against a random control group (Milkman & Wanberg, 2007), although the meta-analysis conducted by Landenberger and Lipsey (2005) found "no significant effect size differences between randomized and nonrandomized designs" (p. 470).

Andrews and Bonta (2003) and Gendreau and Andrews (1990) address the positive effects of using CBT methods to change offenders' dysfunctional thinking patterns and reducing recidivism. The goal of CBT is to challenge offenders to examine and change the way they think, the choices they make, and the attitudes they possess that have contributed to their antisocial actions and criminal behavior. When addressing recidivism rates as high as the 67 percent noted by the BJS study of 1994 releasees, the effectiveness of CBT in reducing recidivism by as much as 30 percent (Pearson, Lipton, Cleland, & Yee, 2002) is a noteworthy accomplishment and worthwhile pursuit. Landenberger and Lipsey (2005) reported that CBT has been shown to be effective in reducing recidivism and that the effectiveness of the program was not impacted regardless of whether or not it was a brand name program or a generic program.

With the positive impact shown in many studies, and possible reduction in recidivism of 20 percent to 30 percent (Lipsey & Landenberger, 2006), CBT may provide one part of the programming puzzle with which to build an effective recidivism-reduction plan (Golden, 2002; Landenberger & Lipsey, 2005). Given the current number of offenders reentering the community, use of CBT as an integral part of offender supervision appears promising.

In evaluating the effectiveness of cognitive-behavioral therapy, Lipsey and Landenberger (2006) looked at 14 studies conducted between 1973 and 2001 in the U.S. or Canada. Half of the studies were conducted on adult or juvenile offenders in correctional settings while the other half of the studies were conducted on adult or juvenile offenders receiving treatment in the community. All but two of the studies were conducted solely on male subjects (p. 62). Researchers looked at four recidivism outcomes reported in the studies: 1) violations and revocations of probation or parole; 2) arrests or police contacts; 3) court convictions; and 4) incarceration (p. 64). The mean recidivism rate for the control groups in 13 of the studies was 45 percent, while the mean rate for treatment groups was 33 percent, a 12 percentage point reduction, but more noteworthy, a 27 percent reduction from the baseline recidivism rate of 45 percent (p. 65).

One of the critical issues in providing CBT is properly identifying high-risk offenders and providing treatment to that population. Milkman and Wanberg (2007) note that high risk offenders who received CBT were less likely to recidivate than were low-risk offenders who (appropriately) received no treatment.

Timmerman and Emmelkamp (2005) reported on the positive effects of CBT and behavior modification within a forensic hospital setting, including: improved coping skills, interpersonal functioning, and well-being of offenders (p. 600). The study involved 39 patients in a high-security hospital in The Netherlands over a 2½ year period. All had committed serious offenses, had been diagnosed with personality disorders, and participated voluntarily (p. 590). Using staff trained in cognitive-behavioral methods, treatment was directed at reducing recidivism and decreasing oppositional behavior in the institution. Patients were evaluated every six to eight months using a variety of instruments that rated

overall psychoneuroticism, severity of dissociative symptoms, social inadequacy, distrust, egoism, anger, anxiety, and level of coping (pp. 593-594). Results showed improvements in each of the listed areas over time. Sexual offenders showed improvements in fewer areas than either arsonists or violent offenders (p. 596).

Maletzky and Steinhauser (2002) conducted a 25-year follow-up of 7,275 sex offenders who received CBT in a community-based sexual offender program. All subjects were adult males who had offended in one of the following categories:

1. Child molesters, female victims: Men who molested at most two female children in a situational context
2. Child molesters, male victims: Men who molested at most one male child.
3. Heterosexual pedophiles: Men who molested more than one female child and showed a preference for female children or a predatory style of offending.
4. Homosexual pedophiles: Men who molested more than one male child and showed a preference for male children or a predatory style of offending.
5. Exhibitionists: Men who exposed themselves and did not molest children or rape.
6. Rapists: Men who raped and did not molest children or expose. (p. 126).

The study lacked a control group and the average length of treatment was 1¾ years. Treatment included aversive behavior reversal, relapse prevention, and cognitive therapy (p. 127). Treatment failure involved one of the following: 1) self report of sexual deviant behavior; 2) plethysmographic indication of deviant sexual arousal; 3) polygraphic indication of deception; or 4) any new sexual crime charged (p. 128). Of the original study population, researchers were able to follow up with approximately 32 percent of the subjects at 25 years post-treatment. They found that predatory or preferential offenders, including pedophiles and

rapists, exceeded the overall failure rate of child molesters and were more likely to have sexual charges filed against them (p. 138). They also concluded that CBT provided long-lasting, positive results by reducing recidivism and risk to the community and appeared to have a more significant impact in the situational offender category, such as child molesters and exhibitionists (pp. 143-144).

The following describes several CBT programs and research conducted in some of those programs.

Criminal Conduct and Substance Abuse Treatment: Strategies for Self-Improvement and Change (SSC). Wanberg and Milkman (1998) developed Criminal Conduct and Substance Abuse Treatment: Strategies for Self-Improvement and Change (SSC) as a manualized cognitive-behavioral program. Participants attend structured sessions that cover 12 treatment modules. They are expected to read the modules and complete homework assignments in addition to attending sessions. The authors note that we all act on what we believe and how we feel. If those actions have been to the detriment of the participant, that person is challenged to control feelings, thoughts, beliefs, and attitudes in order to experience more control over his or her actions. The program lasts from nine months to one year and is intended for adult substance-abusing offenders. It is divided into three phases: Challenge to Change, a reflective-contemplative process is used while building the relationship with the offender; Commitment to Change moves into the practice and implementation of change; and Ownership of Change is a stabilization and maintenance phase.

Thinking for a Change (T4C). Thinking for a Change is a manualized cognitive-behavioral treatment program developed by Bush, Glick, and Taymans (1997) under the auspices of the National Institute of Corrections (NIC). The program is designed to present

an integration of problem solving skills, cognitive skills, and cognitive restructuring over a 22-lesson curriculum. The authors posit that criminal behavior is subject to pro-social change when the three listed skills are presented in an integrated, seamless program (p. P2).

Golden (2002) conducted a study of the effectiveness of the CBT program Thinking for a Change with 142 adult male and female probationers who had been assessed by their probation officers as either medium risk, high risk, or high needs. Thinking for a Change was presented as a manualized treatment program led by certified facilitators. There were 22, two-hour group meetings over an 11-week period. Beginning sessions urged participants to use self-reflection to evaluate and change dysfunctional or antisocial attitudes, beliefs, and feelings. Subsequent sessions introduced participants to the concepts of empathy and perspective, dealing with stressful situations, and responding effectively. The final sessions focus on problem-solving and decision-making skills.

Golden's (2002) study found that the re-arrest rate for offenders completing the group was 13.2 percent, compared to 18.2 percent for group dropouts, and 20 percent for the comparison group. She noted a lack of statistical significance for the difference in the groups due to the small sample size (p. 72). However, the rate for technical violations for offenders completing the group was 42.1 percent, compared to 77.3 percent for group dropouts, and 45 percent for the comparison group, indicating a significantly higher rate of technical violations among the dropout group compared to the completion group or the comparison group (p. 74).

Reasoning and Rehabilitation (R&R). Ross, Fabiano, and Ewles (1988) conducted research on the effectiveness of Reasoning and Rehabilitation (R&R) as a part of a program of rehabilitation among high-risk adult offenders under intensive supervision. Probation officers were trained in the cognitive-behavioral program and delivered the training to the

probationers. Offenders were assessed relative to level of risk using the Level of Supervision Inventory (LSI). In addition to the R&R group, a regular probation group and a life skills group were used for comparison. LSI scores for each group were comparable. While researchers noted that the skills possessed by the five probation officers who presented the R&R program varied, all were considered cooperative and enthusiastic. The groups were followed over an 18-month period for incidents of recidivism (defined as convictions for a new offense). Recidivism rates for the regular probation group were 69.5 percent, for the life skills group were 47.5 percent, and for the cognitive (R&R) group were 18.1 percent. Subsequent imprisonment rates for each of the three groups was 30 percent for the regular probation group, 11 percent for the life skills group, and 0 percent for the cognitive group (p. 34).

Knott (1995) evaluated the effectiveness of the Straight Thinking on Probation (STOP) program. The program was established in 1991 by the Mid Glamorgan, South Wales, Probation Services (p. 115). She describes Mid Glamorgan as a poor area with a high crime rate. The Probation Service chose the *Reasoning and Rehabilitation (R&R)* model from which to design the STOP program. The R&R model consists of 35 two-hour sessions that are designed to teach offender to identify problem behaviors, explore options, develop plans of actions, evaluate potential consequences, and consider the effect of their actions on others (p. 117). The research evaluated the effectiveness of the STOP program (130 participants) against comparison samples of various other offenders (600 offenders) under various criminal justice sentences with similar risk profiles. Seventy-two percent of those referred to STOP completed the program. When interviewed by the research manager, 90 percent stated that the STOP program had made them think differently. When asked to evaluate the

helpfulness of the program, the responses were generally positive (p. 120). Reconviction rates after 12 months were lower for STOP completers than for comparison groups, and the level of violence for STOP completed who had reconvictions was less than that of STOP program non-completers (p. 122).

Wilkinson (2005) evaluated the effectiveness of Reasoning and Rehabilitation (R&R) in England and Wales during the 1990s in prison and probation populations. R&R is based on the premise that many offenders recidivate due to a lack of social intelligence. The study involved the evaluation of R&R as the primary treatment regimen for adult offenders in a community based day program in London (p. 75). Offenders were referred for participation in the program after assessments by both the probation officer and officers at the center. Of those referred, about half of the group was sentenced to R&R and probation; the control group received other sentences. Reconviction was the chief indicator used by researchers, although additional information was obtained relative to attitudinal changes. An interesting paradox reported by Wilkinson regarding attitudinal changes and reconviction seems to indicate that program completers who were not reconvicted rated the likelihood of getting reconvicted higher than did those who were subsequently reconvicted (p. 79). The author compared reconviction rates of R&R completers, drop-outs, and a control group at nine and twelve months with a separate program Straight Thinking on Probation (STOP) after twelve months. The lowest rate of reconviction occurred with R&R completers.

Wilkinson (2005) also noted that among high-risk violent offenders, those reconvicted were somewhat less likely to be recommitted to custody on a first reconviction, indicating that they were committing less violent offenses. Overall, Wilkinson stated that the results failed to indicate a statistical significance, but the findings were generally positive.

Bush (1995) evaluated the effectiveness of the Cognitive Self Change Program, which was delivered to violent offenders incarcerated in a long-term prison in Vermont. Initially the program was voluntary, but after a period, all offenders wanting parole consideration had to participate in the program. Cognitive Self Change was based on the R&R program and consisted of offenders keeping journals of high-risk thinking or anti-social logic (defined in a victim – blaming – license triangle) (p. 145), then addressing those thought processes by using positive self-talk techniques to question and evaluate those thoughts (p. 147). Practicing these methods enabled participants to control negative and counterproductive thoughts, and provided an avenue to introduce "pro-social thinking as a set of discrete cognitive-behavioural skills" (p. 147).

Bush's (1995) study reported on the incidence of new accusations, as his measure of recidivism, as they related to the length of time the offender participated in the program (no participation, 1-6 months, and 7+ months), over 1-, 2-, and 3-year periods after completion of the program. Although reported as preliminary findings, the promising results showed that program completers were 25-35 percent less likely to have charges filed against them during the noted time frames. Another noteworthy finding was that offenders who participated six months or less had re-accusation rates that were virtually identical to those who did not participate in the program.

Relapse Prevention Therapy (RPT). According to Parks and Marlatt (2000), Relapse Prevention Therapy is a self-control program that teaches participants how to maintain positive changes in their behavior and how to recognize and deal with relapse issues. The treatment program was developed by Marlatt and Gordon (1985). The authors emphasize participants' behaviors and reject the labels of alcoholic and drug addict. RPT provides

training in coping skills, both behavioral and cognitive; cognitive therapy, reframing the process of changing habits and learning from setbacks; and lifestyle modification, emphasizing a balanced approach to strengthening coping capacity.

Irvin, Bowers, Dunn, and Wang (1999) conducted a meta-anaylsis of RPT studies and reported that the treatment was generally effective, although it appeared to be more effective in increasing psychosocial functioning than in reducing substance abuse (p. 7). Those authors also reported that effectiveness was different across different substances.

Moral Reconation Therapy (MRT). According to Little and Robinson (2006) Moral Reconation Therapy (MRT) is a "systematic, cognitive-behavioral, step-by-step treatment strategy designed to enhance self-image, promote growth of a positive, productive identity, and facilitate the development of higher stages of moral reasoning" (n. p.). The authors note that reconation is related to the term conation, which was used prior to the widely accepted use of ego, to describe the conscious process of decision-making and purposeful behavior. Thus, reconation is the process of changing conscious decision-making to higher levels of moral reasoning (n. p.). In the program's workbook, the 12 steps are listed with their corresponding moral and behavioral stage.

In 1993, the Oklahoma Department of Corrections began using MRT in its institutional and community corrections components. The program was implemented in the hope that there would be consistency and continuity between institutional and community corrections components. Its delivery was by trained corrections staff in a series of twelve steps, with two or three meetings per week over several weeks (Milkman & Wanberg, 2007).

Braeme, MacKenzie, Waggoner, and Robinson (1996) evaluated the results of the program for the Department of Corrections. Researchers sought to find out if participation in

MRT reduced problem behaviors in institutional and community corrections settings. Specifically, the program was evaluated as to its effect on misconducts in institutions, probation or parole violations in the community and re-arrests. After evaluating almost three years of data, Braeme et al. reported that MRT participants who were incarcerated had fewer institutional incidents and those who were on community supervision were less likely to be involved in recidivism while in the program. However, due to the lack of randomized program participants and relatively short follow-up period, the authors did not determine that there was sufficient information to establish that MRT was the cause of participants' successes. Since participants chose to be in the program, some of the positive effect could be attributed to the participants' "willingness and desire to have changed for the better" (Milkman & Wanberg, 2007, p. 43). Boston and Meier (2001) found significant reductions in re-arrests and reconvictions in a community-housed offender population receiving MRT.

Little and Robinson (1989) conducted research on a group of convicted drunk drivers serving imprisonment sentences. One hundred fifteen of the convicted drunk drivers participated in MRT while the control group of 65 received no treatment. At six months post-treatment, the authors reported that those who received treatment were rearrested 8 percent less than those in the control group (20 percent for the treatment group, 28 percent for the control group).They concluded that while the study was conducted at a relatively short interval after release, the treatment group showed less involvement with the criminal justice system. They also noted that those in the treatment group who subsequently participated in aftercare treatment were even less likely to be rearrested (pp. 961-962).

The authors followed up with two-year (Little, Robinson, & Burnett, 1990) and three-year (Little, Robinson, & Burnett, 1991a) reports on the above treatment and control groups.

At two years, 10.4 percent of the treatment group had been rearrested for DWI, 15.6 percent of the control group had been rearrested for DWI, and only 4.2 percent of the aftercare group had been rearrested for DWI. The study also reported that 60.9 percent of the treatment group had no new arrests, while 53.8 percent of the control group had no new arrests (Little et al., 1990, p. 1385). At three years, the study reported that 54.8 percent of the treatment group had no new arrests, while only 38.5 percent of the control group had no new arrests (Little et al., 1991a, p. 953).

Little, Robinson, and Burnett (1991b, 1993), also conducted research on a group of incarcerated felony drug offenders. There were 70 male offenders in the treatment group and 82 male offenders in the control group. Three years after treatment with MRT, 39 percent of the treatment group had no new arrests, while only 30 percent of the control group had no new arrests. At five years post-treatment, the authors report that 27 percent of the treatment group remained arrest free, compared with 23 percent of the control group (Little et al., 1993, p. 1090).

With evidence showing the value of using cognitive-behavioral treatment with various offender populations, and with the increased expense of incarcerating offenders who either reoffend or commit technical violations, it is hoped that similar results will be demonstrated among the variety of offenders under federal supervision across the country.

Chapter 3

Methods

This study seeks to describe the number of districts using cognitive-behavioral treatment programs, identify the programs being used, examine the referral processes, and obtain preliminary results regarding the effectiveness of those programs in reducing revocations. Specifically, this is a quantitative study regarding the use of CBT programs throughout the federal probation system.

Research Questions

1) Which cognitive-behavioral programs are being used in U.S. Probation Offices?

2) How are referrals to the programs made?

3) Are risk factors considered in the referral process?

4) How successful are participants in completing the programs?

5) How successful are program completers in completing supervision?

A survey was developed to determine which programs were being used by various districts. Six named programs were listed: Moral Reconation Therapy (MRT), Thinking for a Change (T4C), Aggression Replacement Training (ART), Reasoning and Rehabilitation (R&R), Relapse Prevention Therapy (RPT), and Criminal Conduct and Substance Abuse Treatment: Strategies for Self-Improvement and Change (SSC), to determine if any of the listed programs showed any greater degree of success than any of the others. In order to determine if there were similarities or differences in the method of referral, the survey asked if referrals were made by court order at sentencing, made by officers following a risk/needs assessment, as a part of graduated sanctions, or another method (to be described by the respondent). Respondents were asked to note the total number of referrals to the treatment

program and to provide a breakdown of that total number by risk level. Risk levels were determined using the Risk Predictor Index (RPI), a tool used within federal probation used to identify, during the assessment process, offenders' statistical likelihood of success (Monograph 109, 2008). Risk level was divided into low (RPI scores of 0, 1, or 2), medium (RPI scores 3, 4, 5, or 6), and high (RPI scores of 7, 8, or 9). Research seems to indicate that targeting higher risk offenders with treatment is more effective than providing treatment to lower risk offenders. If identified by risk level, relative success and failure rates across the three levels could be computed. Respondents were further asked to provide the number of program completers and non-completers by risk level, and the number of program completers and non-completers by risk level who successfully completed supervision, again in an effort to determine treatment program effects for various risk levels relative to those groups' successful completion of supervision.

Sample

The sample was a purposive sample of all federal probation offices. The selected group within that sample was U.S. Probation offices using CBT programs with offenders under their supervision. To that end, a survey (see Appendix 1) was prepared and emailed through a Monograph 109 Points-of-Contact listserve to districts across the country. A follow-up email was sent via the same listserve approximately six weeks after the initial mailing.

Measurement

The information provided by responding offices will not be identified with those offices in this study. The responses will be evaluated across all respondents, by respondent and within named program. Options on the survey (see Appendix 1) listed six CBT

programs: Moral Reconation Therapy, Thinking for a Change, Criminal Conduct and Substance Abuse Treatment: Strategies for Self-Improvement and Change, Relapse Prevention Treatment, Reasoning and Rehabilitation, and Anger Replacement Training. Methods of referral in the questionnaire were: ordered by the court at sentencing, referred after risk/needs assessment completed, as a part of graduated sanctions, or other. For purposes of this study, risk levels were broken down into low risk (RPI scores of 0, 1, or 2), medium risk (RPI scores of 3, 4, 5, or 6), and high risk (RPI scores of 7, 8, or 9). The survey also asked about the number of offenders (in general, and by risk level) that completed the program and successfully completed supervision (in general, and by risk level) and the number of non-completers who successfully completed supervision (in general, and by risk level) in order to compare groups that completed to those non-completers across risk levels.

Data will be reported aggregately, with the exception of completion rates, which will be reported by percentage. Specifically, the number of respondents reporting the use of specific CBT programs will be reported, as will the number of respondents using various methods of referrals to the programs. The consideration of risk factors will also be reported aggregately, but successful program completions and subsequent successful completion of supervision will be reported by percentages.

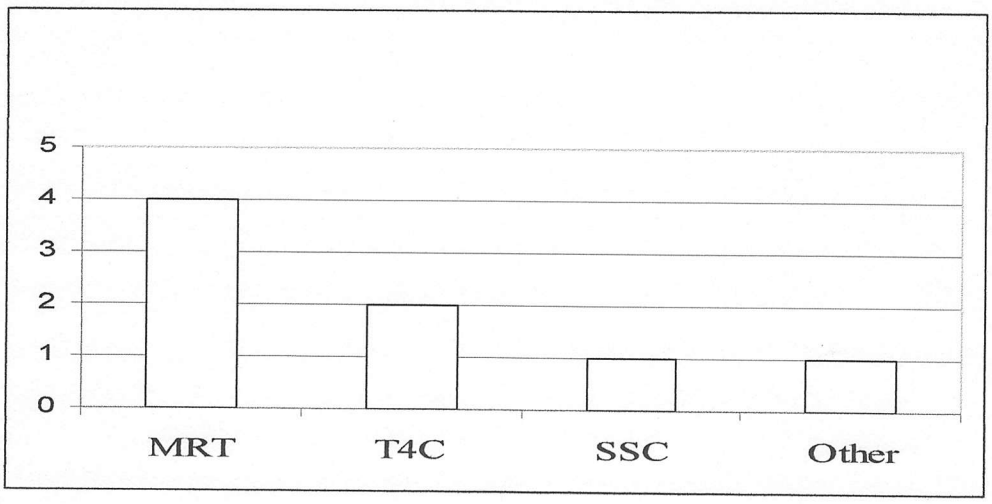
Chapter 4

Findings

Responses were received from 16 offices representing14 districts out of a possible 94 districts for a response rate of 17 percent, while only 8 offices representing 6 districts (see Appendix 2) for a response rate of 6 percent submitted any information requested on the survey. Eight of the respondents indicated that they were using CBT programs and provided at least partial information on the survey. Responses from those eight respondents will be discussed in detail. Two of the other districts indicated that they were just beginning to use CBT programs and had no data to submit at this time, five districts responded that they were not using CBT treatment programs, and one district indicated that they are using CBT treatment programs and planned to respond, but no response was received. Eight offices representing six districts responded to the questionnaire, with seven of the eight submitting at least partial information on the questionnaires. One respondent summarized some of the information requested in an email response.

The cognitive-behavioral programs being used included Moral Reconation Therapy (MRT), Thinking for a Change (T4C), Criminal Conduct and Substance Abuse Treatment: Strategies for Self-Improvement and Change (SSC), and an "in-house developed program with cognitive restructuring and cognitive skills sessions" for relapse prevention. MRT was used in four of the reporting offices, with T4C used in two offices, and SSC and an "in-house developed program with cognitive restructuring and cognitive skills sessions" for relapse prevention being used in one office each (see Chart 1).

Chart 1. CBT Programs Used by Respondents



All but one of the offices indicated multiple referral methods. Six of the eight respondents indicated that offenders were referred as a part of graduated sanctions, five of the eight indicated that referrals were ordered by the court at sentencing, three of the eight indicated receiving referrals after the risk/needs assessment was completed, one indicated an additional referral source as officer referral, and one indicated its only referral method was "in lieu of" referrals to contract treatment programs (Personal correspondence, April 14, 2009). Another respondent indicated that referrals were made based on the offender having a special condition for substance abuse aftercare and the indication of current treatment needs based on an assessment using the Texas Christian University Drug Screen (TCUDS). According to the Knight and Simpson (2009) at the Institute for Behavioral Research at Texas Christian University, the TCUDS is a validated screening tool used in assessing the severity of substance abuse problems.

Regarding the number of offenders referred to CBT programs, the range was from 6 (the program began in September 2008) to 645 (from December 2002 though September

2005), with specific numbers of participants referred provided by some respondents to an estimate of 300+ per year from one respondent.

Three of the eight respondents indicated referring only medium- and high-risk offenders to the programs (although one of the respondents did not specify exact numbers for either category). Three respondents indicated that low-risk offenders were also referred to the program. An unforeseen issue came up in this category, as one respondent indicated that risk levels were determined by the use of an instrument other than the RPI, specifically that respondent noted the use of the Level of Service Inventory – Revised (LSI-R). According to Vose, Cullen, and Smith (2008), the LSI-R is a third-generation risk assessment instrument that targets dynamic risk issues for intervention. Vose et al. noted that 47 studies have been completed on the LSI-R with all indicating that the instrument is a valid predictor of recidivism. However, comparisons across risk levels were not completed due to a lack of knowledge of any direct comparison of risk levels computed by the listed instruments.

Within Respondent

Respondent No. 1 indicated that MRT is the CBT program used in that district. Referrals are made by court order at sentencing, following completion of the risk/needs assessment, and as a part of graduated sanctions. Over 300 medium- and high-risk offenders are referred annually, although the number of program completers by risk category, number of non-completers by risk category, number of completers who successfully completed supervision by risk category, and number of non-completers who successfully completed supervision were not provided. This respondent indicated that the office was working with a local university on some of these questions and much of that information was not readily available, as it is not captured in the automated database (personal communication,

December 4, 2008). Although it appears that this respondent uses MRT on an ongoing basis, further evaluation of this respondent's information was not possible.

Respondent No. 2 indicated that SSC was the program used in that office (this office was one of two offices responding within the same district). The method of referral was listed as "in lieu of" referral to a contract treatment program and 250 offenders had been referred to the program. The risk levels of referred offenders were not reported. However, 200 offenders completed the program, while 50 failed to complete the program. Of the 200 completers, 150 successfully completed supervision. Of the 50 non-completers, 20 successfully completed supervision.

The completion rate for this respondent was 80 percent, with 75 percent of the program completers successfully completing supervision and 40 percent of the non-completers successfully completing supervision (Table No. 1).

Table No. 1

Respondent #2							
	Referrals	Completers	%	% successfully completing supervision	Non-completers	%	% successfully completing supervision
Total	250	200	80	75	50	20	40

Respondent No. 3 indicated that MRT was the program used in that district. Referrals to the program were made by court order at sentencing and as a part of graduated sanctions, and 19 offenders had been referred to the program, 6 of whom were in the low-risk category, 7 were in the medium-risk category, and 6 were in the high-risk category. Six offenders have completed the program, two each from each risk category. One medium- and one high-risk

offender did not complete the program. One of these offenders was revoked and the other was sent for psychiatric evaluation (Personal communication, March 2009). At the time of the response, no offenders had successfully completed the program and subsequently successfully completed supervision. Offenders referred for participation in the program consisted of similar numbers for each risk category.

Respondent No. 4 used MRT as its CBT program with referrals coming after the risk/needs assessment was completed and as a part of graduated sanctions. Six offenders had been referred to the program since its inception in September 2008. Three offenders were listed as medium-risk and three were high-risk. There were no program completers to date. However, offenders referred for participation in this program were all medium- or high-risk offenders by RPI scores.

Respondent No. 5 used an in-house relapse prevention program as its CBT program. Referrals were received by court order at time of sentencing (specifically, the respondent noted that offenders had completed RDAP and were stable). RDAP is the Federal Bureau of Prisons' (BOP) Residential Drug Abuse Program. The program is described by the Bureau of Prisons as providing intensive half-day programming five days per week (BOP, n.d.). The respondent noted that 645 offenders were referred to the program from December 2002 until September 2005. This respondent used the LSI-R to evaluate risk levels and indicated that 170 low-risk, 418 medium-risk, and 57 high-risk offenders had been referred to the program. Of those participants, 122 low-risk, 191 medium-risk, and 15 high-risk offenders completed the program; while 48 low-risk, 227 medium-risk, and 42 high-risk offenders failed to complete the program. Of the 328 program completers all successfully completed supervision. Of the 317 non-completers, only 47 successfully completed supervision (22 low-

risk, 15 medium-risk, and 10 high-risk), and 270 (26 low-risk, 212 medium-risk, and 32 high-risk) had their supervision revoked.

The completion rate for the program was approximately 51 percent for all risk categories, with 72 percent of the low-risk participants completing the program, 46 percent of the medium-risk participants completing, and 26 percent of the high-risk participants completing the program. For those completing the program, 100 percent of the participants successfully completed supervision. For those participants who were non-completers, 46 percent of the low-risk, 7 percent of the medium-risk, and 24 percent of the high-risk participants successfully completed supervision. For this respondent, 65 percent of the referrals for the program were medium-risk offenders. This category also saw the highest percentage of revocations for program non-completers (Table No. 2).

Table No. 2

Respondent #5							
	Referrals	Completers	%	% successfully completing supervision	Non-completers	%	% successfully completing supervision
Total	645	328	51	100	317	49	15
Low	170	122	72	100	48	28	46
Med	418	191	46	100	227	54	7
High	57	15	42	100	42	58	24

Respondent No. 6 used MRT as its CBT program. Referrals were made via risk/needs assessments, graduated sanctions, and officer referral. Eleven offenders had been referred for program participation since its inception in August 2008. Five offenders were medium-risk

and six were high-risk. One medium-risk offender failed to complete the program and his or her supervision was revoked for cocaine usage. One medium-risk offender is listed as not completing the program, but successfully completing supervision. No further evaluation was possible.

Respondent No. 7 used T4C as its CBT program. Referrals were made by court order at sentencing and graduated sanctions. Two hundred forty-five offenders were referred to the program, 44 low-risk, 127 medium-risk, and 74 high-risk. Of those, 206 successfully completed the program (42 low-risk, 118 medium-risk, and 46 high-risk) and 38 did not complete the program (2 low-risk, 9 medium-risk, and 27 high-risk). Twenty-three offenders successfully completed the program and successfully completed supervision (3 low-risk, 17 medium-risk, and 3 high-risk), while 1 high-risk offender did not complete the program, yet successfully completed supervision.

The completion rate for Respondent No. 7 was 84 percent for all risk categories. Ninety-five percent of the low-risk referrals completed the program, 93 percent of the medium-risk referrals completed the program, and 62 percent of the high-risk referrals completed the program. For those completing the program, 23 (3 low-risk, 17 medium-risk, and 3 high-risk) have successfully completed supervision and of the non-completers, 1 high-risk offender successfully completed supervision. Because this is an ongoing program, the percentages of completers and non-completers successfully completing or not successfully completing supervision could not be determined (Table No. 3).

Table No. 3

Respondent #7							
	Referrals	Completers	%	% successfully completing supervision	Non-completers	%	% successfully completing supervision
Total	245	206	84	11	38	16	3
Low	44	42	95	7	2	5	0
Med	127	118	93	14	9	7	0
High	74	46	62	7	27	38	4

Respondent No. 8 did not complete the survey, but provided the following information via email (personal communication, March 25, 2009). This respondent also used T4C as its CBT program. Referrals were made based on court orders for a substance abuse treatment conditions and an assessment using the Texas Christian University Drug Screen the current need for treatment. If an offender was initially referred for urine surveillance only and tested positive for illegal drug use, that offender is referred for T4C. From July 2007 through January 2009, 284 referrals had been made to the program, with 143 completing the program. The respondent advised that program completions are estimated, because some offenders may have been moved into another group or into individual counseling. No information was provided regarding RPI scores or number of program completers who have successfully completed supervision or program non-completers who successfully completed supervision.

Within Program

For the offices that responded to the questionnaire, MRT was the program of choice for four of the eight respondents, with two respondents using T4C, and one respondent each using SSC and an in-house relapse prevention program. The information provided by the four respondents using MRT varied broadly and an evaluation within the program was not possible, as was the information provided by the two respondents using T4C. The evaluations of the other programs were conducted in the within respondent section.

Risk Factors

For three of the eight respondents, referrals were made for medium- and high-risk offenders, while three respondents referred some offenders from each category, and two did not indentify the risk levels of those referred. While research seems to indicate that higher-risk offenders are in need of higher levels of treatment, Respondent No. 3 had approximately one-third of referrals from each risk category; Respondent No. 5 had 26 percent low-risk, 65 percent medium-risk, and 9 percent high-risk referrals; and Respondent No. 7 had 18 percent low-risk, 52 percent medium-risk, and 30 percent high-risk referrals. Respondents Nos. 2 and 8 did not identify the risk levels for offenders referred to the CBT programs.

In reviewing the data from Respondent No. 5, it appears that low-risk referrals (computed using the LSI-R) completed the program at a rate of 72 percent (122 of 170), with 100 percent of program completers successfully completing supervision. But for those low-risk referrals not completing the program, only 46 percent went on to successfully complete supervision. Medium-risk offenders completed the program at a rate of 46 percent (191 of 418), again with 100 percent of program completers successfully completing supervision. For medium-risk program non-completers, only 7 percent successfully completed supervision.

High-risk offenders completed the program at a rate of 42 percent (15 of 57), with 100 percent of program completers successfully completing supervision. For high-risk program non-completers, 24 percent successfully completed supervision.

Respondent No. 7 had completion rates of 95 percent for low-risk offenders, 93 percent for medium-risk offenders, and 62 percent for high-risk offenders. At the time the results were submitted, only 7 percent (3 of the 42) of the low-risk program completers had successfully completed supervision, only 14 percent (17 of 118) of the medium-risk completers had successfully completed supervision, and 7 percent (3 of 46) of the high-risk completers had successfully completed supervision.

Chapter 5

Discussion

The purpose of this study was to provide a description of the use of cognitive-behavioral treatment programs with offender populations under supervision in federal probation offices across the country, and to determine if those programs have demonstrated positive outcomes within those offender populations. Cognitive-behavioral treatment programs have been developed to change anti-social behaviors by changing anti-social thinking patterns (Lipsey & Landenberger, 2006).

Cognitive-Behavioral Programs

For those districts that responded to the questionnaire, the CBT program most frequently used was MRT (4 of 8 respondents, with 2 of the respondents representing satellite offices of the same district). However, responses were not consistent across the four respondents and an evaluation of the effectiveness of MRT using multiple respondents was not possible. In addition, only one of the four respondents has been using MRT for more than one year. That respondent (No. 1) did not provide any information about the number of program completers by risk level, the number of program non-completers by risk level, the number of program completers by risk level who successfully completed supervision, or the number of non-completers by risk level who successfully completed supervision. Respondent Nos. 3, 4, and 6 all indicated that they began using MRT within the past year, and between the three, only reported one non-completer as successfully completing supervision. As these offices continue to use MRT, research regarding offender outcomes should be pursued.

Respondent No. 2 provided information regarding outcomes for participants in Strategies for Self-improvement and Change (SSC), without providing any risk level

breakdown. For program completers successfully completing supervision at a much higher rate than non-completers, it appears that the SSC program, when successfully completed, is effective in assisting offenders in successfully completing supervision. However, without any information on the relative risk levels for the offenders referred, it is not possible to evaluate how the successful completion of supervision rate has been affected, since low-risk offenders are generally expected to successfully complete supervision with no treatment intervention and have been shown to be less successful if provided too much treatment.

The most complete information was provided by Respondent No. 5. That office used an "in-house developed program with cognitive restructuring and cognitive skills sessions" for relapse prevention. The data provided was for a period between December 2002 and September 2005. This respondent reported the largest number of referrals to any program, with an overall completion rate of 51 percent, with varying completion rates among the various risk level groups as computed using the LSI-R, rather than the RPI (72 percent of low-risk cases completed, 46 percent of medium-risk cases completed, and 42 percent of high-risk cases completed). In reviewing program outcomes, program completers from all risk levels successfully completed supervision in all cases. However, in reviewing outcomes for program non-completers, levels of successful completion seem to be fairly low for low- and medium-risk offenders (low-risk non-completers successfully completed supervision 46 percent of the time, medium-risk non-completers successfully completed supervision 7 percent of the time, and high-risk non-completers successfully completed supervision 24 percent of the time). Due to a lack of familiarity with the LSI-R as it compares with the RPI, it is difficult to assess whether the rate at which low-risk offenders should successfully complete supervision is higher of lower than 46 percent. Without additional information, it is

not possible to determine the reason(s) for the lower rate of successful completion by medium-risk non-completers than for the high-risk non-completers, although it seems reasonable to expect that medium-risk offenders will generally complete supervision successfully at higher rates than high-risk offenders, all things being equal.

Respondents Nos. 7 and 8 reported using the T4C treatment program. Respondent No. 7 referred offenders from all risk levels and Respondent No. 8 did not report on risk levels for referrals. While the respondent reported 245 program referrals with 206 completers and 38 non-completers, the numbers provided for completers and non-completers successfully completing supervision seem to indicate that only a small number of program completers have completed their terms of supervision.

For responding offices, the CBT program most often used was MRT. Research conducted by the program's developers (Little & Robinson, 1989; Little et al.,1990; Little el al.,1991a; Little et al.,1991b; Little et al.,1993) as well as independent research conducted by others (Braeme et al., 1996; Boston, 2001) indicates that MRT is effective in reducing recidivism for those on community supervision. It appears to be a good choice for use by probation offices attempting to assist offenders in successfully completing supervision and maintaining law-abiding lifestyles following supervision.

Referral Methods

Offenders were referred to CBT programs: by court order at sentencing by 62.5 percent (5 of 8) of the respondents, referred after risk/needs assessment completed by 12.5 percent (1 of 8) of the respondents, as a part of graduated sanctions by 62.5 percent (5 of 8) of the respondents, and other (officer referral, "in lieu of," and due to positive urine sample) by 37.5 percent (3 of 8) of the respondents. It is unclear what the criteria are for the

respondent who reported referrals by "officer referral" as opposed to referrals as a part of graduated sanctions or referrals following a risk/needs assessment. Additionally, the report of referrals following offenders' submission of urine samples that tested positive for controlled substances seems to fall into the graduated sanctions category, but was not reported in that manner.

Risk Factors

Six of the eight respondents appear to be tracking the relative risk levels of offenders referred to their programs. However, it appears that three of the respondents (Nos. 3, 5, and 7) refer low-risk cases to their respective programs at a rate of 18 to 32 percent of total referrals to the CBT program. Three respondents (Nos. 1, 4, and 6) noted referrals for only medium- and high-risk offenders, which is more consistent with the concept of referring higher risk offenders for increased amounts of treatment. Research by Andrews, Zinger et al. (1990) indicates that treatment should target criminogenic needs because those needs are dynamic and when addressed reduce recidivism (Andrews et al., 1990). Bourgon and Armstrong (2005) found that higher risk offenders should receive higher levels of treatment for treatment to be effective, while lower risk offenders have fewer of these needs. And Andrews et al. (1990) and Lowenkamp and Latessa (2005) noted that lower risk offenders may be negatively affected by referrals for higher levels of treatment.

As noted earlier in the data provided by Respondent No. 5, low-risk offenders successfully completed the CBT program at a higher rate (72 percent) than did medium-risk offenders (46 percent) or high-risk offenders (42 percent). However, for those low-risk offenders who did not complete the program, over half (54 percent) of those supervisions ended in revocation. The overall success for all low-risk cases referred to the CBT program

by this respondent was 84 percent. Noting that risk levels were determined using the LSI-R, rather than the RPI, no evaluation as to whether the successful completion rate for low-risk offenders is higher or lower than would be expected if no referral for treatment had been made.

Based on the noted literature, it appears to be prudent that risk levels are considered prior to referring offenders for CBT programs or other treatment services. Probation officers must resist the temptation to refer low-risk offenders for inappropriate program participation. The recent emphasis on evidence-based practices, including cognitive-behavioral treatment, by the Administrative Office seems to be received positively by various probation offices, as evidenced by the relative youth of three of the respondents to this research. However, rather than having another "tool in the tool belt," officers need to ensure that the right offenders are being referred for the right treatment. As previously noted, six of the eight respondents used cognitive-behavioral treatment programs as a part of the graduated sanctions interventions used in their offices. Additional research regarding the effectiveness of CBT programs as a part of graduated sanctions might provide insight into the appropriateness of such referrals.

Cognitive-behavioral treatment programs have been shown to be effective in reducing recidivism in higher-risk offender populations. With the annual cost of incarcerating offenders at approximately $26,000 versus $3,600 for supervising offenders in the community, it appears worthwhile to provide offenders with treatment aimed at changing thinking patterns that lead to revocations and incarceration.

Program Completion and Supervision Completion

Generally offenders referred to CBT programs successfully completed those programs. Respondent No. 2 referred offenders to Strategies for Self-improvement and

Change and reported an 80 percent completion rate with 75 percent of program completers subsequently successfully completing supervision. Respondent No. 5 used an "in-house developed program with cognitive restructuring and cognitive skills sessions" for relapse prevention. Fifty-one percent of all offenders referred to the program successfully completed the program and all program completers subsequently successfully completed supervision. Respondent No. 7 used the Thinking for a Change program and reported an 84 percent completion rate for all offenders referred to the program. For this respondent, it does not appear that all program completers have completed supervision at this time.

Limitations

There are 94 separate U.S. Probation Offices, defined by judicial districts, across the United States, with many districts having multiple satellite offices. The attached questionnaire was emailed to those districts through a point-of-contact listserve, with a request that districts using CBT programs fill out the questionnaire and return it to this researcher. Responses were received from 16 offices representing 14 of the 94 districts for a response rate of almost 17 percent, while only 8 offices (6 percent of the districts) submitted information on programs in their districts. The possibility of multiple offices within districts responding, or that separate offices within the same district might use different CBT programs (as occurred with Respondent Nos. 2 and 5) was not foreseen. The email and follow-up email failed to request a response from all districts as to whether or not that district was using a CBT program. Due to that oversight, a complete picture of the total number of districts using CBT programs was not gathered. Further research into the overall utilization of CBT within federal probation is still needed.

In assessing the response rate, it appears that very few districts responded with an indication that they either were or were not using CBT programs with offenders under their supervision. Specifically, two districts indicated that they were just beginning to use CBT programs and had no data to submit at this time, four districts responded that they were not using CBT treatment programs, and one district indicated that they are using CBT treatment programs and planned to respond, but no response was received. The email itself did not make that request clear. In retrospect, it would be prudent to request, from that same listserve, acknowledgement of receipt and an indication from that district's representative as to whether or not the district was using CBT programs, either within the office or through contracted vendors. That would provide a more thorough picture of the utilization of CBT programming throughout the system.

In reviewing the questionnaire, it appears that securing the requested information regarding risk levels for referred offenders was not available by simply querying the database. It would have required looking at each referred offender individually, unless that information was collected on the front end of the referral process, as appears to be the case for Respondents 5 and 7, and perhaps for Respondents 3, 4, and 6. The time necessary to go back and try to put together the information may have dissuaded some districts from responding. It is not likely that many districts have the luxury of having staff on hand to assist with this type of research request.

In addition, the questionnaire presented some challenges both for the respondents and for evaluation purposes due to the questions not being exhaustive or mutually exclusive for response options.

An additional consideration in looking at the low response level was the lack of a local sponsor within districts, generally the Chief U.S. Probation Officer for each district, prior to making the request for information. Districts answer directly to their chiefs and the researcher failed to secure any of those endorsements.

It should be noted that setting the low-, medium-, and high-risk categories was based on conversations with others over the years in the federal probation office, and they were set as noted previously: the low-risk category comprised those whose RPI scores were 0, 1, or 2; the medium-risk category comprised those whose RPI scores were 3, 4, 5, or 6; and the high-risk category comprised those whose RPI scores were 7, 8, or 9. Following the preparation of the questionnaire, which included the breakdown of categories based on the above-noted criteria, an evaluative report prepared for the Federal Judicial Center by Eaglin et al.(1997) was discovered in which the authors placed the RPI score of 6 with 7, 8, and 9, the high-risk category, rather than with 3, 4, and 5, the medium-risk category. For the purposes of this study, it does not appear that this discrepancy affects any results, in part because there was little computation that could be completed across all risk levels for program completers.

The request for data from responding districts failed to detail the timeframe from which the data should be drawn. In order to evaluate program effectiveness, the email and questionnaire should have requested data regarding program completers or non-completers whose supervision had been closed during a certain timeframe. Failure to do so resulted in several responses from districts who provided information about new and ongoing programs with some program completers and non-completers not having completed supervision, either successfully or unsuccessfully, which limits the possibility of evaluating the effectiveness of

the programs in reducing the number of offenders reoffending or committing technical violations leading to revocations of supervision.

Implications for the Field

Cognitive-behavioral treatment programs appear to provide probation offices with an additional tool to use in assisting offenders in changing anti-social thinking and behaviors. Those changes in thinking should reduce recidivism and violation behavior in that population, thereby reducing revocation and increasing successful completion of supervision rates. However, further research into the application of these programs would be beneficial. Specifically, whether or not referrals of low-risk offenders increases or decreases the likelihood of successful completion of supervision. Researchers have indicated that higher risk offenders should be referred for the greatest amount and intensity of treatment for the largest positive effect, and responses received do not show that all offices are using risk levels to assist in determining appropriate referrals to the programs. In fact, only 3 of the 8 respondents indicated referrals for medium- and high-risk offenders only.

While those in federal probation are attempting to use evidence-based practices to increase their effectiveness and increase offender successes on supervision, attention to ongoing evaluation of the programs initiated may be lacking. One respondent noted that much of the information requested in the questionnaire had been turned over to a local university for evaluation. Another respondent indicated that data was collected from December 2002 until September 2005, but none was available since that time. Another noted that it took a lot of time to put the information together. If using evidence-based practices, like cognitive-behavioral treatment programs is important in the federal probation system, efforts to measure and monitor the programs being implemented, the methods for referral,

and the risk levels of those referred to ensure quality delivery of quality programs designed to improve the lives of offenders needs to be implemented. In order for evidence-based practices to be effective, probation offices need to evaluate the implementation and effectiveness of these programs on an ongoing basis to determine if, in fact, these programs are effective in producing the intended goals. After all, things that are important get measured and things that get measured get done.

Appendix 1

Cognitive Behavioral Treatment Questionnaire

1. Which cognitive-behavioral treatment program is being used in your district?

    a. Moral Reconation Therapy

    b. Thinking for a Change

    c. Aggression Replacement Training

    d. Reasoning and Rehabilitation

    e. Relapse Prevention Therapy

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

2. How are offenders referred for participation in the program?

    a. Ordered by the court at sentencing

    b. Referred after risk/needs assessment completed

    c As a part of graduated sanctions

    d. other. Please elaborate:

3. Total number of offenders referred for participation? _____

4. What number of offenders with the following risk levels (if available) of those referred to the program? Note: If risk level is not available, please provide total number_____

    a. low (RPI scores of 0, 1, or2) _____

    b. medium (RPI scores of 3, 4, 5, or 6)_____

    c. high (RPI scores of 7, 8, or 9) _____

5. How many completed the program?

If risk level is not available, please provide total number_____

a. low (RPI scores of 0, 1, or2) _____

b. medium (RPI scores of 3, 4, 5, or 6)_____

c. high (RPI scores of 7, 8, or 9) _____

6. How many did not complete the program? _____

a. low (RPI scores of 0, 1, or2) _____

b. medium (RPI scores of 3, 4, 5, or 6)_____

c. high (RPI scores of 7, 8, or 9) _____

7. How many successfully completed and successfully completed the term of supervision? -

_____

a. low (RPI scores of 0, 1, or2) _____

b. medium (RPI scores of 3, 4, 5, or 6)_____

c. high (RPI scores of 7, 8, or 9) _____

8. How many did not complete the program and successfully completed

supervision?_____

a. low (RPI scores of 0, 1, or2) _____

b. medium (RPI scores of 3, 4, 5, or 6)_____

c. high (RPI scores of 7, 8, or 9) _____

Appendix 2

Respondent	#1	#2	#3	#4	#5	#6	#7
CBT program	MRT	Crim cond and SAT: Strategies for self-improvement	MRT	MRT	Relapse prevention	MRT	T4C
Method of referral	Ct order Risk/needs Grad sanction	In lieu of	Ct order Grad sanctions	Risk/need Grad sanctions	Ct order (completed RDAP and stable)	Risk/need Grad sanctions Officer referral	Ct order Grad sanctions
# of offenders referred	300+/year	250	19	6	645 (from 12/02 – 9/05)	11	245
Risk level (RPI)	Medium & high	Not identified	6-low 7-med 6-high	0-low 3-med 3-high	*170-low 418-med 57-high	0-low 5-med 6-high	44-low 127-med 74-high
# completers (by risk level)	Unk	200 not identified by risk level	2-low 2-med 2-high	NA (new program – began 9/08)	122-low 191-med 15-high	NA (new program – began 8/08)	42-low 118-med 46-high
# of non-completers (by risk level)	Unk	50 not identified by risk level	1-med 1-high	1-high	**26-low 212-med 32-high	1-med (revoked-cocaine usage)	2-low 9-med 27-high
# completers who successfully completed supervision (by risk level)	Unk	150 not identified by risk level	0	NA	122-low 191-med 14-high	0	3-low 17-med 3-high
# non-completers who successfully completed supervision (by risk level)	Unk	20	0	NA	22-low 15-med 10-high	0-low 1-med 0-high	0-low 0-med 1-high

- *Used LSI-R for risk assessment.
- ** non-completers who had supervision revoked
- Response from Respondent No. 8 is not included in this chart

References

Andrews, D. A. (1995). The psychology of criminal conduct and effective treatment. In *What works: Reducing reoffending – Guidelines from research and practice.* West Sussex, England: John Wiley and Sons Ltd.

Andrews, D. A., & Bonta, J. (2003). *The psychology of criminal conduct.* (3rd ed.). Cincinnati, OH: Anderson Publishing Company.

Andrews, D. A., Bonta, J., & Hoge, R. D. (1990). Classification for effective rehabilitation: Rediscovering psychology. *Criminal Justice and Behavior, 17*(1), 19-52.

Andrews, D. A., Zinger, I., Hoge, R. D., Bonta, J., Gendreau, P., & Cullen, F. T. (1990). Does correctional treatment work? A clinically relevant and psychologically informed meta-analysis. *Criminology, 28*(3), 369-404.

Aos, S., Miller, M., & Drake, E. (2006). Evidence-based adult corrections programs: What works and what does not. Retrieved October 24, 2008, from http://www.wsipp.wa.gov/rptfiles/06-01-1201.pdf

Birgden, A., (2004). Therapeutic jurisprudence and responsivity: Finding the will and the way in offender rehabilitation. *Psychology, Crime & Law, 10*(3), 283-295.

Boston, C. M., & Meier, A. L. (2001). Changing offenders' behavior: Evaluating Moral Reconation Therapy (MRT) in the *Better People* program. Retrieved October 26, 2008, from http://www.betterpeople.org/docs/evaluation.pdf

Bourgon, G., & Armstrong, B. (2005). Transferring the principles of effective treatment into a "real world" prison setting. *Criminal Justice and Behavior, 32*, 2-25.

Braeme, R., MacKenzie, D. L., Waggoner, A. R., & Robinson, K. D. (1996). *Moral reconation therapy and problem behavior in the Oklahoma Department of Corrections.* Retrieved from www.doc.state.ok.us/offenders/ocjrc/96/moral%20Reconation%20Therapy%20and%20Problems%20Behavior.pdf

Bureau of Justice Statistics (2007). Retrieved on September 23, 2007, from http://www.ojp.usdoj.gov/bjs

Bureau of Prisons (n.d.). Retrieved April 7, 2009, from http://www.bop.gov/inmate_programs/substance.jsp

Bush, J. (1995). Teaching self-risk management to violent offenders. In *What works: Reducing reoffending – Guidelines from research and practice.* West Sussex, England: John Wiley and Sons Ltd.

Bush, J., Glick, B., & Taymans, J. (1997). Thinking for a change: Integrated cognitive behavior program. Retrieved February 15, 2009, from http://www.nicic.org/Downloads/PDF/TrainingResources/016672/016672-Full.pdf

Cohn, A. W. (2002). Managing the correctional enterprise – The quest for "What Works." *Federal Probation, 66*(2), 4-9.

Cullen, F. T., & Gendreau, P. (2000). Assessing correctional rehabilitation: Policy, practice and prospects. Retrieved November 14, 2008, from http://www.ncjrs.gov/criminal_justice2000/vol_3/03d.pdf

Eaglin, J. B., Gilbert, S., Hooper, L., & Lombard, P. (1997). *RPI profiles: Descriptive information about offenders grouped by their RPI scores.* Federal Judicial Center publication, prepared May 1997.

Gendreau, P., & Andrews, D. A. (1990). Tertiary prevention: What the meta-analysis of the offender treatment literature tells us about "what works." *Canadian Journal of Criminology, 32*, 173-184. Retrieved November 14, 2008, from Questia.com

Gendreau, P., Little, T., & Goggin, C. (1996). A meta-analysis of the predictors of adult offender recidivism: What works! *Criminology, 34*(4), 575-607.

Golden, L. (2002). Evaluation of the efficacy of a cognitive behavioral program for offenders on probation: Thinking for a Change. Retrieved on October 26, 2008, from http://www.nicic.org/pubs/2002/018190.pdf

Irvin, J. E., Bowers, C. A., Dunn, M. E., & Wang, M. C. (1999). Efficacy of relapse prevention: A meta-analytic review. *Journal of Consulting and Clinical Psychology, 67(4),* 563-570. Retrieved March 8, 2009, from http://homepage.psy.utexas.edu/homepage/Class/Psy394Q/Behavior%20Therapy%20Class/Assigned%20Readings/Substance%20Abuse/Irvin99.pdf

Knight, K., & Simpson, D. D., (2009). TCU Drug Screen Evaluation. Retrieved April 5, 2009, from http://www.ibr.tcu.edu/projects/crimjust/tcuds.html

Knott, C. (1995). The STOP programme: Reasoning and Rehabilitation in a British setting. In *What works: Reducing reoffending – Guidelines from research and practice.* West Sussex, England: John Wiley and Sons Ltd.

Landenberger, N. A., & Lipsey, M. W. (2005). The positive effects of cognitive-behavioral programs for offenders: A meta-analysis of factors associated with effective treatment. *Journal of Experimental Criminology, 1*, 451-476.

Lipsey, M. W. (1995). What do we learn from 400 research studies on the effectiveness of treatment with juvenile delinquents? In *What works: Reducing reoffending – Guidelines from research and practice.* West Sussex, England: John Wiley and Sons Ltd.

Lipsey, M. W., & Landenberger, N. A. (2006). Cognitive-behavioral interventions. In *Preventing crime.* Dordrecht, The Netherlands: Springer.

Lipton, D., Martinson, R., & Wilks, J. (1975). *The effectiveness of correctional treatment: A survey of treatment evaluation studies.* New York: Praeger.

Little, G. L., & Robinson, K. D. (1989). Treating drunk drivers with Moral Reconation Therapy: A one-year recidivism report. *Psychological Reports, 64*, 960-962.

Little, G. L., Robinson, K. D. & Burnette, K. D. (1990). Treating drunk drivers with Moral Reconation Therapy: A two-year recidivism study. *Psychological Reports, 66*, 1379-1387.

Little, G. L., Robinson, K. D. & Burnette, K. D. (1991a). Treating drunk drivers with Moral Reconation Therapy: A three-year report. *Psychological Reports 69*, 953-954.

Little, G. L., Robinson, K. D. & Burnette, K. D. (1991b). Treating drug offenders with Moral Reconation Therapy: A three-year recidivism report. *Psychological Reports, 69*, 1151-1154.

Little, G. L., Robinson, K. D. & Burnette, K. D. (1993). Cogitive behavioral treatment of felony drug offenders: a five-year recidivism report. *Psychological Reports, 73*, 1089-1090.

Little, G. L., & Robinson, K. D. (2006). *How to escape your prison: A Moral Reconation Therapy workbook.* Memphis, TN: Eagle Wing Books.

Losel, F. (1995). The efficacy of correctional treatment: A review and synthesis of meta-evaluation. In *What works: Reducing reoffending – Guidelines from research and practice.* West Sussex, England: John Wiley and Sons Ltd.

Lowenkamp, C. T., & Latessa, E. J. (2005). Increasing the effectiveness of correctional programming through the risk principle: Identifying offenders for residential treatment. *Criminology & Public Policy, 4*(2), 263-290.

Lowenkamp, C. T., Pealer, J., Smith, P., & Latessa, E., J. (2006). Adhering to the risk and need principles: Does it matter for supervision-based programs? *Federal Probation, 70*(3), 3-8.

Maletzky, B. M., & Steinhauser, C. (2002). A 25-year follow-up of cognitive behavioral therapy with 7,275 sexual offenders. *Behavior Modification, 22,* 123-147.

Marlatt, G. A., & Gordon, J. R. (1985). *Relapse prevention: Maintenance strategies in the treatment of addictive behaviors.* New York:Guilford.

Martinson, R. (1974). What works? Questions and answers from prison reform. *The Public Interest, 35,* 22-54.

McGuire, J., & Priestly, P. (1995). Reviewing 'What Works': Past, present and future. In *What works: Reducing reoffending – Guidelines from research and practice.* West Sussex, England: John Wiley and Sons Ltd.

Milkman, H., & Wanberg, K. (2007). Cognitive-behavioral treatment: a review and discussion for corrections professionals. Washington, DC: U.S. Department of Justice, National Institute of Corrections.

Mitchell, O., MacKenzie, D. L., & Wilson, D. B. (2006). Incarceration-based drug treatment. In B. C. Welsh & D. P. Farrington (Eds.), *Preventing crime: What works for children, offenders, victims, and places.* (pp. 103-116). The Netherlands: Springer.

Monograph 109: The supervision of federal offenders. (2008). Washington, DC: Office of Probation and Pretrial Services, Administrative Office of the U.S. Courts.

National Association of Cognitive-Behavioral Therapists. (n.d.). Retrieved April 5, 2009, from http://www.nacbt.org/whatiscbt.htm

Parks, G. A., & Marlatt, G. A. (2000). Relapse prevention therapy: A cognitive-behavioral approach. *The National Psychologist.* Retrieved March 9, 2009, from http://www.nationalpsychologist.com/articles/art_v9n5_3.htm

Pearson, F. S., Lipton, D. S., Cleland, C. M., & Yee, D. S. (2002). The effects of behavioral /cognitive-behavioral programs on recidivism. *Crime & Delinquency, 48(3)*, 476-496.

Petersilia, J. (2004). What works in prisoner reentry? Reviewing and questioning the evidence. *Federal Probation, 68(2),* 3-8.

Ross, R. R., Fabiano, E. A., & Ewles, C. D. (1988). Reasoning and rehabilitation. *International Journal of Offender Therapy and Comparative Criminology, 32(1),* 29-35.

Taxman, F. S. (2002). Supervision – Exploring the dimensions of effectiveness. *Federal Probation, 66(2)*, 14-27.

Timmerman, I. G. H., & Emmelkamp, P. M. G. (2005). The effects of cognitive-behavioral treatment for forensic inpatients. *International Journal of Offender Therapy and Comparative Criminology, 49*, 590-606.

United States Probation and Pretrial Services System. (2004).Year-in-review report: Fiscal year 2004. Retrieved November 15, 2008, from http://www.uscourts.gov/publication/YearEndReport04.pdf

Vose, B., Cullen, F. T., & Smith, P. (2008). The empirical status of the Level of Service Inventory. *Federal Probation, 72(3),* 22-29.

Wanberg, K. W., & Milkman, H. B. (1998). Criminal conduct and substance abuse treatment: Strategies for self-improvement and change: The participant's workbook. Thousand Oaks, California: Sage.

Wilkinson, J. (2005). Evaluating evidence for the effectiveness of the Reasoning and Rehabilitation programme. *The Howard Journal, 44(1),* 70-85.