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Adopting a 'Creative Corrections' approach for offender treatment programs

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Within the Western world contemporary offender treatment programs take a rehabilitative approach, focused on assessing and managing offender risks and needs. Providing insight, this chapter discusses the developments in offender treatment that have shaped current programs, exploring the *risk-needs-responsivity* model and cognitive-behavioural therapy. Additionally, more recent issues and trends within offender treatment programs are discussed including offending populations experiencing treatment resistance, the Good Lives Model, the trauma-informed care approach and music therapy. Through reviewing the literature, it is asserted that offender treatment is experiencing a shift towards an approach that is individualised, strength-based and multidisciplined. Considering this, it is asserted that further inclusion of innovative and creative approaches to working with offenders can support effective offender treatment.

Contextualising contemporary offender treatment

The *risk-need-responsivity* (RNR) model emerged in the 1990s, working to restore the lost support for offender rehabilitation that had reigned since Martinson's renowned 'nothing works' some 16 years earlier (Taxman, Thanner, & Weisburd, 2006). Upon first presenting the RNR model four principles were outlined for effective rehabilitation of offenders: risk, need, responsivity and professional discretion (Polaschek, 2012). However, refinement of the model led to the principle of professional discretion being removed, leaving just three core principles

of effective offender treatment (Andrews, 2001; Andrews & Bonta, 2006; Andrews, Bonta, & Hoge, 1990; Andrews, Bonta, & Wormith, 2006; Dowden & Andrews, 2004;).

The first principle, risk, can be understood as the importance of accurately assessing the level of risk of an offender so that the appropriate level of treatment/service may be administered (Andrews et al., 1990). This principle emphasises that individuals have differing likelihoods of offending that can be predicted by assessing various attributes/characteristics and offending history (Polaschek, 2012). Significantly, the risk principle advocates that higher levels of treatment should be reserved for high-risk cases, as such offending populations benefit from intensive treatment as opposed to less or minimal treatment (Taxman et al., 2006). Need, the second principle of the model, considers the importance of treatment focusing on an offenders' criminogenic needs (Hollin, Palmer, & Hatcher, 2013). As explained by Polaschek (2012), criminogenic needs are the dynamic attributes of offenders that when changed will incur on changes in recidivism. Thus, the need principle dictates that to effectively achieve a reduction in recidivism, treatment should concentrate on criminogenic needs of the offender (Andrews et al., 1990). The final principle, responsivity, is comprised of two components: general and specific responsivity (Andrews & Bonta, 2006). The latter of the two components emphasises that treatment facilitators are required to ensure that the offender/client can access their treatment, through considering a client's unique elements such as cognitive functioning, disorders, cultural and social status (Marshall & Marshall, 2011). Whereas, general responsivity outlines the significance of employing treatment approaches that have been shown to positively impact recidivism rates (Ward & Willis, 2016).

Offering one of the first meta-analyses on the effectiveness of the RNR model, Dowden and Andrews (2000), revealed that treatment using the model had positive impacts on recidivism rates. Moreover, it was found that adhering to the need principle appropriately ensured lower rates of reoffending (Dowden & Andrews, 2000). In relation to need, it was demonstrated that the treatment programs that addressed both the non-criminogenic and criminogenic needs of offenders were most effective (Dowden & Andrews, 2000). Aligning with this, further meta-analyses that examined the use of the RNR model presented that the principles of need and responsivity had the most influence concerning positive treatment outcomes (Handson et al., 2009; Marshall, Marshall, Serran & O'Brien, 2013). In examining the third principle of the model, responsivity, Marshall and Marshall (2011) argued that this principle had the most positive impact on treatment. Research has continued to support the implementation of the RNR model; however, it is pertinent to acknowledge the indicated importance of the latter two principles.

In accordance to general responsivity, Andrews and Bonta (2006) advocated for the use of cognitive behavioural therapy (CBT) approaches, which is argued to have resulted in its wide employment in current offender treatment programs (Marshall et al., 2013). CBT encompasses an array of approaches, however, there are three underlying propositions: "1. cognitive activity affects behaviour, 2. cognitive activity may be monitored and altered, 3. desired behaviour change may be effected through cognitive change" (Dobson, 2009, p.4). Despite its emergence in the 1960s within various disciplines of human services, CBT strongly features within forensic literature roughly 10 years after the renowned work of Martinson in 1974 (Tafrate & Mitchell, 2014). During the mid-1980s to the late 1990s there were several CBT-based offender treatment programs introduced, a result born from the restoration of evidence-based practice in offender treatment (Vaske, Galyean & Cullen, 2011). Bonta and

Andrews (2016) have continued to support the use of CBT-based approaches, propounding that such approaches are the most effective in aiding offenders to learn new attitudes and behaviours.

It is maintained that CBT within the field of offender treatment has a comprehensive theoretical basis that highlights criminal thinking as a significant factor of deviant behaviour (Lipsey, Landenberger, & Wilson, 2007). There are three main elements that CBT-based offender treatment programs concentrate on. Firstly, the importance of identifying high-risk thoughts, situations and feelings that may lead to offending; secondly, aiding offenders in altering criminogenic thinking through presenting a new way of processing high-risk situations; and thirdly, aiding offenders to reduce cognitive processing deficits that are linked to offending (Vaske et al., 2011). CBT programs uphold the premise that antisocial attitudes eventuate to antisocial behaviours (Vaske et al., 2011). Furthermore, such approaches support the concept that high-risk situations generate antisocial thoughts and feelings that lead to an increased risk for antisocial behaviours (Vaske et al., 2011).

Moving from theory to practice, CBT is often depicted as one of the most effective evidence-based offender treatment approaches studied over the last two decades, however, arguably the research has yielded mixed results (Lipsey et al., 2007; Marshall et al., 2013). There are various meta-analyses that have examined the efficacy of CBT-based offender treatment programs, concentrating on the effects on recidivism. For example, the work of Lipsey, Chapman and Landenberger (2001) demonstrated that CBT-based programs had appreciable effects on recidivism, asserting that “the best of them are capable of producing sizable reductions in recidivism” (p.144). However, in expressing the limitations of the

research, it was presented that programs with the superior results were demonstration programs, rather than long-term programs, which were found to have a 'modest' impact on reoffending (Lipsey et al., 2001). Additionally, another meta-analysis offered that, when compared to other approaches such as behavioural modification-based programs, CBT-based programs proved to be most effective at reducing reoffending (Pearson, Lipton, Cleland & Yee, 2002). Although, this was mainly attributed to CBT programs that focused on developing social skills and cognitive skills programs (Pearson et al., 2002). Thus, despite the relatively positive results, these findings uncovered the need to study specific forms and curricular of CBT programs to ensure the consistency of treatment efficacy.

Following this line of inquiry, Landenberger and Lipsey (2005) provided another meta-analysis that examined the factors of CBT-based programs that were associated with higher rates of recidivism reduction. There were three factors that related independently to CBT-based program efficacy: the offender's level of risk; the quality of program implementation; and the inclusion or exclusion of specific intervention elements. Landenberger and Lipsey (2005) stated that the effects of CBT-based interventions were greater on higher-risk offenders, rather than lower-risk offenders. This finding is consistent with the first tenant of the RNR model, risk, as the higher-risk offender benefits from more intensive treatment that targets their criminogenic needs. Regarding program implementation, it was found that programs that were well monitored and included well-trained professionals had the lowest dropout rates, which in turn increased the efficacy of the programs (Landenberger & Lipsey, 2005). Finally, the meta-analysis displayed that CBT programs that included treatment elements of anger management and interpersonal problem-solving methods were more effective in reducing recidivism. These findings are further supported by a systematic review, which determined that the aforementioned factors were the only independent factors related to the effectiveness of CBT-

based treatment (Lipsey et al., 2007). However, as with the meta-analysis of Lipsey et al. (2001), the results presented by Landenberger and Lipsey (2005) stemmed mainly from demonstration programs.

Discussing the wide use of CBT in offender treatment, Marshall et al. (2013) offered a critique positing that some academics have assumed that if treatment has adopted a CBT approach, this will result in the responsivity criteria of the RNR model being met. It is considered that this was a result of Andrew and Bonta's (2006) meta-analysis of offender treatment approaches, which demonstrated that CBT-based programs were most effective in reducing recidivism and adhering appropriately to the responsivity principle. Contesting this assertion, Marshall and Marshall (2011) claimed that it was only those CBT programs – from the range of programs researched that used responsive therapeutic techniques – that comprised of social learning and/or behavioural features which were effective. Thus, it is argued that CBT programs cannot simply be assumed to pass responsivity criteria, unless they utilise the noted features deemed to be effective, as outlined in the work of Marshall et al. (2013) and Marshall & Marshall (2011). Marshall and Marshall (2011), alongside other scholars, have similarly discussed the lack of research and appropriate implementation of the responsivity model within practice (Marshall et al., 2013; Ward & Brown, 2004, Ward et al., 2007). Therefore, although research has depicted the RNR model and CBT-based programs as effective in reducing recidivism, there are limitations with implementation and a lack of research regarding the CBT program curricular.

Exploring offending populations who experience treatment resistance

Adhering to the responsivity principle is core, notably so, when considering offending populations who experience significant levels of treatment resistance. Offenders with mental

health issues, learning disabilities and, indeed, those who present with a range of such needs, often experience treatment resistance (Fazel, Hayes, Bartellas, Clerici & Trestman, 2016; Skeem, Steadman & Manchak, 2015; Skeem, Manchak & Peterson, 2011; McSweeney & Hough, 2006). Exemplifying this, research has depicted that offenders with a mental illness are more likely to fail under correctional supervision, reoffend and be reincarcerated (Skeem, Manchak, & Peterson, 2011). Accordingly, the rate of offenders with mental illnesses in the criminal justice system is steadily increasing (Nicholls et al., 2018; Skeem et al., 2011; Steadman, Osher, Robbins, Case, & Samuels, 2009). Examining the association between offenders with mental illnesses and recidivism rates, Baillargeon et al. (2009) found that offenders with mental illnesses have a higher risk of reoffending. Chiefly, it was demonstrated that offenders with bipolar disorders were 3.3 times more likely to reoffend in comparison to non-mentally ill offenders (Baillargeon et al., 2009).

Focusing on those with complex needs within corrections, Rutherford and Duggan (2011) asserted that it is common for offenders to have multiple needs of varying combinations and severity that need to be addressed (i.e. multiple health issues and/or social-care needs). It is posited that individual offender needs are commonly considered to be 'sub-threshold', meaning that the individual does not qualify for treatment access (Rutherford & Duggan, 2011, p.415). This often results in overlooking the needs of offenders with complex issues; the issues of such individuals are often left unrecognised and untreated, which negatively impacts recidivism rates (Fazel et al., 2016). Additionally, it is maintained that treatment programs are often single need focused, which is problematic for offenders with complex needs and mental health issues (McSweeney & Hough, 2006). Such offending populations require a multidisciplinary approach to their treatment, however, this is commonly not possible to facilitate within 'single need' geared interventions (McSweeney & Hough, 2006). Moreover,

where multidisciplinary approaches have been used, McSweeney and Hough (2006) have argued that there was little thought in the order of implementation.

The development of effective treatment strategies for offenders has been briefly discussed in this chapter through exploring the RNR model and CBT. However, previously discussed studies, models and programs have focused on non-mentally ill offenders (Morgan et al., 2012). Morgan et al. (2012) discussed that the treatment measures, which research has deemed effective, such as CBT-based programs, had not been empirically analysed where offenders with mental illnesses are concerned. It is posited that although treatment programs and methods may be shown effective for offenders without mental illnesses, these same correctional interventions should not be expected to yield the same or similar results for offenders with mental illnesses (Morgan et al., 2012). Morgan et al. (2012) suggested that future research needs to focus on empirically analysing the efficacy of correctional interventions for offenders with mental illness. It can be similarly be considered that the earlier research, often referenced when advocating the use of CBT-based approaches, have limited applicability to those offending populations with complex needs. More contemporary research by Rose (2018) suggested that offender treatment for those with an intellectual disability is required to be adapted to meet the offender's needs and further noted that program adaptation is predominantly left to the practitioner's discretion.

The criminal justice system has been slow to recognise the significance of offenders with mental illnesses and even more so regarding offenders with a learning disability. It is argued that the criminal justice system commonly views 'learning disability' under the broader context of 'mental health' and not as a distinct disability (Hayes, 2007). The work of Hayes (2007) offered five main issues related to offenders with learning difficulties, three of which

relate to treatment. It was found that there were issues with identifying offenders with a learning disability; professionals and practitioners had limited knowledge surrounding learning disabilities; and a scarcity of programs or services that can meet the needs of offenders with a learning disability (Hayes, 2007). Moreover, further research presented that there were limited resources and insufficient staff training, namely, a lack of professional/specialist staff (Talbot & Riley, 2007). It was also found that offenders with learning disabilities had difficulties interacting with peers and comprehending information, predominantly accessing written information (Talbot & Riley, 2007). Thus, similarly to those with mental health and complex needs, this has resulted in an overrepresentation of offenders with learning disabilities within the criminal justice system (Hayes, 2007).

Another population of offenders who experience treatment resistance is high-risk offenders (HROs), namely, violent and sex offenders. Although this offending population often presents with mental health issues/complex needs (Persson et al., 2017), research has demonstrated that there are broader factors impacting their treatment efficacy. It is maintained that program disengagement has led to moderate to high levels of program attrition rates (Howells & Day, 2006; Bonta & Andrews, 2007). This is also an issue experienced by 30% of the general offending populations in prison programs (Olver, Stockdale & Wormith, 2011). Thus, the importance of treatment readiness and program engagement are considered as being vital elements of treatment, as they link to the level of efficacy (Howells & Day, 2006). This is echoed by Bonta and Andrews (2007), who asserted that motivation is a significant factor in effective offender treatment. Significantly, the factors of motivation and engagement are to be addressed while adhering to responsivity principle, which further demonstrates the negative repercussions of not appropriately employing the principle (Ward & Brown, 2004). It is asserted that focusing on non-criminogenic needs and the accessibility of the treatment

positively impacts on the treatment readiness and engagement of HROs, thus beneficially impacting overall treatment efficacy (Marshall et al., 2013).

Considering the significant population of offenders with mental health needs, complex needs and learning disabilities within the criminal justice system, it is important that treatment is accessible for these individuals. As noted, there is limited research that focuses on treatment programs for such offending populations, there are issues with addressing the offender's range of needs and the treatment responsivity for such offending populations is left wanting. Moreover, HRO populations as well as a portion of the general offending population in prison are experiencing moderate to high levels of program disengagement. The outlined issues suggest that treatment programs for these offenders may not be appropriately adhering to the RNR model, namely, the latter two principles, which are outlined as most significant to effective treatment outcomes. Although contemporary research has outlined the need for practitioner's discretion on program adaptation for such offending populations, it is argued that while this is an important aspect, being reliant on practitioner discretion alone is not a sufficient response. Treatment programs for such offending populations would benefit from taking a multidisciplined, strength-based approach, offering a range of treatment modalities. It is posited, however, that such a positive shift in offender treatment is already underway.

Battling treatment resistance: A shift towards 'creative corrections'

The RNR model, although extensively implemented, is not the only model guiding contemporary offender treatment practice. Since the early 2000s, Ward and his colleagues have been developing the Good Lives Model (GLM); a strength-based framework for offender treatment (Ward & Brown, 2004; Ward & Gannon, 2006; Ward & Stewart, 2003; Ward, Yates & Willis, 2011). In more recent times, the GLM has gained popularity and is considered as the

most influential model for offender treatment (Marshall et al., 2013), however, it is mainly adopted within HRO treatment (Ireland & Ireland, 2018). Stemming from developments seen in positive psychology, the GLM model advocates a positive approach to offender treatment, which focuses on an offender's strengths and aims to provide them with skills to live a personally fulfilling as well as socially acceptable life (Ward et al., 2011). The GLM employs similar components to the RNR model but has an additional focus on personal/primary 'human goods' goals. The crucial difference between the models are that the RNR model focuses on deficits of the offender, while the GLM concentrates on strengths and personal needs of the offender.

Extending on this, Ward and Brown (2004) argued that all the goals advocated by the RNR model "tends to lead to negative or avoidant treatment goals" (p. 254), rather than promoting the positive characteristics and changes desired (e.g. prosocial attitudes and behaviours). It is asserted that by focusing on negative goals, offenders will likely experience issues with treatment motivation and engagement (Ward & Brown, 2004). They explained that this is a failure to adhere to the third principle of the RNR model, responsivity, was defined as ensuring the treatments ability to reach and make sense to the offender. Therefore, the GLM advocates that treatment should be strength-based and encourage positive therapeutic goals, as this will ensure offender treatment engagement and motivation (Ward & Brown, 2004).

Whilst the research on the GLM developed, the creators of the RNR model, Andrews and Bonta, responded to Ward and colleagues' critiques of the RNR model and GLM proposition. They argued that while the GLM may work in a similar fashion to RNR when appropriately executed, "our fear is that crime prevention is easily overlooked if the primary pursuit of therapy is a life fulfilled as completely as possible" (Andrews et al., 2011, p. 750).

This position is similarly held by Cullen (2012), who acknowledged the GLM as being the most advanced perspective emerging from the 'creative corrections movement', however, he suggested caution on employing any 'creative corrections' approaches. Cullen (2012, p. 101) reasoned that previous interventions borne of 'creative corrections', such as bootcamps, had "proved to be examples of quackery" and further took issue with the apparent lack of focus on risk. However, Ward et al. (2011) expressed that the GLM has continuously dictated that criminogenic needs should be at least weighted as important as primary human goods. They posited that GLM concentrates on reaching positive goals, as this provides offenders with the opportunity "to actively approach and practice behaviour associated with the prosocial attainment of goods" (Ward et al., 2011, p.98). Moreover, they argued that this approach is more sustainable, regarding offender treatment motivation and engagement. Accordingly, it is suggested that adopting the GLM for offending populations experiencing treatment resistance may be beneficial, as the core issues thus far discussed for these populations are related to treatment responsivity/accessibility and engagement levels. Moreover, contesting Cullen's (2012) negative perspective on 'creative corrections', recent research upholds that such positive approaches to treatment may 'bring balance' to an area that has been overly focused on risk and the offender deficits (Dickson, Willis & Mather, 2018, p. 43).

Moving forward from positive-based treatment models to exploring emerging approaches, attention can be turned to trauma-informed care (TIC). Miller and Najavits (2012) discussed that a TIC approach recognises how institutions may unintentionally recreate or trigger traumatic dynamics for offenders and advocated taking an approach to treatment that minimises this impact on offenders. The impact of trauma conditions on offenders has been described by noting several factors: issues of disengagement, isolation, mistrust, decreased sense of control, identifying with the aggressor, impaired social skills and lowered self-esteem

(Ricci & Clayton, 2018). It was argued that prisons and other forensic environments are problematic due to the many unavoidable elements that can trigger offenders with trauma (Miller & Najavits, 2012). Many of these noted impacts of trauma were presented as issues that were experienced by the discussed treatment resistant offending populations, thus, it is reasoned that a TIC approach may be beneficial for such offenders.

In relation to HROs, it was argued that treatment for such offenders should include TIC elements, as early trauma experiences such as childhood sexual assault can cause interpersonal deficits and maladaptive coping, which then may lead to high-risk behaviour (Levenson, 2014). Levenson (2014) asserted that sex offender treatment has focused on cognitive and behavioural change, with limited attention to the offenders' developmental history, despite the evidence of early trauma's impact on offending. Additionally, a TIC approach is effective within the broader framework of RNR, as it works to reduce responsivity barriers caused by trauma (Levenson, 2014). It was argued that TIC has the potential to increase treatment readiness, motivation as well as treat underlying trauma-related issues that have impacted the offending behaviour (Ricci & Clayton, 2018). Although this is of significance to HROs, this is also of import to general offending populations, as research has demonstrated that 48% of inmates presented with post-traumatic stress disorder (Briere, Agee & Dietrich, 2016). It is suggested that TIC can be considered as another valuable step in the broader perspective shift in contemporary offender treatment that aims to improve the offenders' quality of life, readiness and motivation, which aligns with the overarching positive position of the GLM.

Another 'creative corrections' approach that is currently developing is music therapy within prisons and forensic settings. It is noted that despite the growing research within offender treatment, there is a need for further research into 'less conventional treatment

modalities' (Hakvoort, Bogaerts, Thaut & Spreen, 2015, p. 811). Researchers in the field expressed that music therapy is indeed being utilised within these settings, however there is a dearth of research (Hakvoort et al., 2015; Sicard, 2016). Music therapy is a goal-directed intervention that is implement by a registered music therapist according to the clients' specific needs, aiding positive change in the clients' cognition, skills, thoughts and/or behaviours (Peters, 2000). Research in this field has, thus far, demonstrated that music therapy can positively impact an offenders' coping and anger management skills as well as reduce withdrawal from social situations (Hakvoort et al., 2015). Music therapy has been linked to improving the mental health needs of offenders, with research demonstrating a significant impact on self-esteem and promising outcomes with offenders with anxiety and depression (Chen, Leith, Aarø, Manger, & Gold, 2016). Chen et al. (2016) further asserted that music therapy fostered a positive therapeutic environment for offenders to develop prosocial skills, thus, this may prove to be a treatment approach that can support a TIC approach.

Contemporary forensic music therapy research has argued that this therapy works within the RNR framework. Moreover, there are emerging forensic music therapy models that have goals that address the criminogenic needs and risk factors of offender, including cognitive behavioural music therapy and cognitive analytical music therapy (Compton Dickinson & Hakvoort, 2017). Forensic music therapy goals are commonly concentrated on building self-management, problem-solving, anger management and coping skills, that align with need factors (Hakvoort & Bogaerts, 2013). It is proposed that music therapy may play a supportive role to HRO treatment as a motivator and reinforcer for offenders during other CBT-based treatment. It is asserted that, where included within a suite of offender treatment programs, music therapy can support the provision of an individualised, strength-based and multidisciplined approach that may aid in reaching those experiencing treatment resistance.

Conclusion

Offender treatment has experienced significant development since its re-emergence in the 1990's. The RNR model has provided a solid framework for treatment implementation and has research to support its continued use. Although depicted in research as having mixed results, CBT is advocated as an effective approach if implemented in strict accordance to the RNR model. However, there are offending populations who are demonstrating treatment resistance, specifically, offenders with mental health issues, complex needs, learning disabilities and HROs. As a consequence, research is emerging within the field of offender treatment providing evidence for an individualised, strength-based approach that is multidisciplined in nature. Despite those who critique this developing positive perspective or creative corrections movement, there are emerging models and approaches within research and practice that display great potential in breaking the barriers of treatment responsivity and broader engagement experienced by such populations. Thus, it is argued that practitioners and researchers continue to embrace the exploration of new treatment modalities such as TIC and music therapy in conjunction with the continued use of the GLM, as this may enhance treatment outcomes for offenders, in particular resistant offenders.

References

Andrews, D. A. (2001). Principles of effective correctional programs. In L. L. Motiuk & R. C. Serin (Eds.), *Compendium 2000 on effective correctional programming* (pp. 9-17). Ottawa, Ontario: Correctional Services of Canada.

Andrews, D. A., & Bonta, J. (2006). *The psychology of criminal conduct* (4th ed.). Newark, NJ: LexisNexis/Matthew Bender.

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

Andrews, D. A., Bonta, J., & Wormith, J. S. (2006). The recent past and near future of risk and/or need assessment. *Crime & Delinquency*, *52*(1), 7-27.

Baillargeon, J., Binswanger, I. A., Penn, J. V., Williams, B. A., & Murray, O. J. (2009). Psychiatric disorders and repeat incarcerations: the revolving prison door. *American Journal of Psychiatry*, *166*(1), 103-109.

Bonta, J., & Andrews, D. A. (2007). Risk-need-responsivity model for offender assessment and rehabilitation. *Rehabilitation*, *6*, 1-22.

Bonta, J., & Andrews, D. A. (2016). *The psychology of criminal conduct*. Routledge.

Briere, J., Agee, E., & Dietrich, A. (2016). Cumulative trauma and current posttraumatic stress disorder status in general population and inmate samples. *Psychological Trauma: Theory, Research, Practice, and Policy*, *8*(4), 439-446.

Chen, X. J., Leith, H., Aarø, L. E., Manger, T., & Gold, C. (2016). Music therapy for improving mental health problems of offenders in correctional settings: systematic review and meta-analysis. *Journal of Experimental Criminology*, *12*(2), 209-228.

Compton Dickinson, S. J. & Hakvoort, L. (2017). *The clinician's guide to forensic music therapy.* London, UK: Jessica Kingsley Publishers.

Cullen, F. T. (2012). Taking rehabilitation seriously: Creativity, science, and the challenge of offender change. *Punishment & Society*, *14*(1), 94-114.

Cullen, F. T., & Gendreau, P. (2001). From nothing works to what works: Changing professional ideology in the 21st century. *The Prison Journal*, *81*(3), 313-338.

Cullen, F. T., & Gendreau, P. (1989). The effectiveness of correctional rehabilitation treatment: Reconsidering the "nothing works" debate. In L. Goodstein & D. L. MacKenzie (Ed.*) The American prison: Issues in research and policy* (pp. 23-39). New York, America: Plenum Press.

Dickson S. R., Willis G. M., & Mather D. (2018). Protective factors and the good lives model: Combining positive approaches to assessment and treatment. In Jeglic E., Calkins C. (eds) *New frontiers in offender treatment*. New York, Ny: Springer, Cham.

Dobson, K. S. (Ed.). (2009). *Handbook of cognitive-behavioral therapies*. New York, NY: Guilford Press.

Dowden, C., & Andrews, D. A. (2000). Effective correctional treatment and violent reoffending: A meta-analysis. *Canadian Journal of Criminology*, *42*, 449.

Dowden, C., & Andrews, D. A. (2004). The importance of staff practices in delivering effective correctional treatment: A meta-analysis of core correctional practices. *International Journal of Offender Therapy and Comparative Criminology*, *48*, 203-214. doi:10.1177/0306624X03257765

Fazel, S., Hayes, A., Bartellas, K., Clerici, M., & Trestman, R. (2016). Mental health of prisoners: Prevalence, adverse outcomes, and interventions. *The Lancet Psychiatry*, *3*(9), 871-881. Retrieved from https://doi.org/10.1016/S2215-0366(16)30142-0

Hakvoort, L. G. & Bogaerts S. (2013). Theoretical foundations and workable assumption for cognitive behavioural music therapy in forensic psychiatry. *The Art in Psychotherapy*, 40*(1), 192-200*.

Hakvoort, L., Bogaerts, S., Thaut, M. H., & Spreen, M. (2015). Influence of music therapy on coping skills and anger management in forensic psychiatric patients: an exploratory study. *International Journal of Offender Therapy and Comparative*

Criminology, *59*(8), 810-836. Retrieved from https://doi.org/10.1177/0306624X13516787

Hanson, R. K., Bourgon, G., Helmus, L., & Hodgson, S. (2009). The principles of effective correctional treatment also apply to sexual offenders: A meta-analysis. *Criminal Justice and behavior*, *36*(9), 865-891. Retrieved from https://doi.org/10.1177/0093854809338545

Hayes, S. (2007). Missing out: offenders with learning disabilities and the criminal justice system. *British Journal of Learning Disabilities*, *35*(3), 146-153.

Hollin, C. R., Palmer E. J. & Hatcher R. M. (2013). Efficacy of correctional cognitive skills programmes. In L. A. Craig, L. Dixon & T. A. Gannon (Eds.), *What works in offender rehabilitation: An evidence-based approach to assessment and treatment* (1st ed., pp. 117-128). West Sussex, UK: John Wiley & Sons, Ltd.

Howells, K. & Day, A. (2006). Affective determinants of treatment engagement in violent offenders. *International Journal of Offender Therapy and Comparative Criminology, 50*(2), 174-186. Retrieved from https://doi.org/10.1177/0306624X05281336

Ireland, J. L. & Ireland C. A. (2018). Therapeutic treatment approaches for violence some essential components. In J. L. Ireland, C. A. Ireland & P. Birch (Eds.), *Violent and sexual offenders: Assessment, treatment and management* (2nd ed., pp.18-35). Oxon: Routledge.

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*(4), 451-476.

Levenson, J. (2014). Incorporating trauma-informed care into evidence-based sex offender treatment. *Journal of Sexual Aggression, 20*(1), 9-22.

Lipsey, M. W., Chapman, G. L., & Landenberger, N. A. (2001). Cognitive behavioral programs for offenders. *The Annals of the American Academy of Political and Social Science, 578*(1), 144-157. Retrieved from https://doi.org/10.1177/000271620157800109

Lipsey, M. W., Landenberger, N. A., & Wilson, S. J. (2007, August 9). Effects of cognitive-behavioral programs for criminal offenders. *Campbell Systematic Reviews 2007 10*(4073), 1-27. doi: 10.4073/csr.2007.6**b**

Marshall, L. E., & Marshall, W. L. (2011). The risk/needs/responsivity model: The crucial features of general responsivity. In *Perspectives on evaluating criminal justice and corrections* (pp. 29-45). Emerald Group Publishing Limited.

Marshall, W. L., Marshall, L. E., Serran, G. A., & O'Brien, M. D. (2013). What works in reducing sexual offending. In L. A. Craig, L. Dixon & T. A. Gannon (Eds.), *What works in offender rehabilitation: An evidence-based approach to assessment and treatment* (pp. 173-191). Canada: John Wiley & Sons, Ltd.

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

McSweeney, T., & Hough, M. (2006). Supporting offenders with multiple needs: Lessons for the 'mixed economy' model of service provision. *Criminology & Criminal Justice*, *6*(1), 107-125. Retrieved from https://doi.org/10.1177/1748895806060669

Miller, N. A., & Najavits, L. M. (2012). Creating trauma-informed correctional care: A balance of goals and environment. *European Journal of Psychotraumatology, 3*(1), 17246. doi: 10.3402/ejpt.v3i0.17246

Morgan, R. D., Flora, D. B., Kroner, D. G., Mills, J. F., Varghese, F., & Steffan, J. S. (2012). Treating offenders with mental illness: a research synthesis. *Law and Human Behavior*, *36*(1), 37. Retrieved from http://dx.doi.org/10.1037/h0093964

Nicholls, T. L., Butler, A., Kendrick-Koch, L., Brink, J., Jones, R., & Simpson, A. I. (2018). Assessing and treating offenders with mental illness. In *The Practice of Correctional Psychology* (pp. 9-37). New York, NY: Springer, Cham.

Olver, M. E., Stockdale, K. C., Wormith, S. J. (2011). A meta-analysis of predictors of offender treatment attrition and its relationship to recidivism. *Journal of Consulting and Clinical Psychology, 79,* 6-21.

Pearson, F. S., Lipton, D. S., Cleland, C. M., & Yee, D. S. (2002). The effects of behavioral/ cognitive-behavioral programs on recidivism. *Crime and Delinquency*, *48*(3), 476-496. Retrieved from https://doi.org/10.1177/001112870204800306

Persson, M., Belfrage, H., Fredriksson, B., & Kristiansson, M. (2017). Violence during imprisonment, forensic psychiatric care, and probation: Correlations and predictive validity of the risk assessment instruments COVR, LSI-R, HCR-20V3, and SAPROF. *International Journal of Forensic Mental Health, 16*(2), 117-129.

Polaschek, D. L. L. (2012). An appraisal of the risk-need-responsivity (RNR) model of offender rehabilitation and its application in correctional treatment. *Legal and Criminological Psychology, 17*(1), 1-17. Retrieved from https://doi.org/10.1111/j. 2044-8333.2011.02038.x

Ricci, R. J. & Clayton, C. A. (2018). Using offence drivers to guide conceptualisation and treatment of trauma in male sex offenders. In J. L. Ireland, C. A. Ireland & P. Birch (Eds.), *Violent and sexual offenders: Assessment, treatment and management* (2nd ed., pp.18-35). Oxon: Routledge.

Rose, J. (2018). Adapting and evaluating treatment approaches for intellectually disabled sex offenders. In J. L. Ireland, C. A. Ireland, & P. Birch (Eds), *Violent and sexual offenders: Assessment, treatment and management* (2nd ed., 357-369). New York: Routledge.

Rutherford, M., & Duggan, S. (2009). Meeting complex health needs in prisons. *Public Health, 123*(6), 415-418. Retrieved from https://doi.org/10.1016/j.puhe.2009.04.006

Sicard, L. A. (2016). Examining music as a therapy for complex needs and offending behaviour. *Journal of Criminological Research, Policy and Practice, 2*(4), 291-302. Retrieved from https://doi.org/10.1108/JCRPP-04-2016-0005

Skeem, J. L., Manchak, S., & Peterson, J. K. (2011). Correctional policy for offenders with mental illness: Creating a new paradigm for recidivism reductions. *Law and Human Behaviour, 35*(2), 110-126. doi: 10.1007/s10979-010-9223-7

Skeem, J. L., Steadman, H. J. & Manchak S. M. (2015). Applicability of the risk-need-responsivity model to persons with mental illness involved in the criminal justice system. *Psychiatric Services 66*(9), 916-922. doi: 10.1176/appi.ps.201400448

Steadman, H. J., Osher, F. C., Robbins, P. C., Case, B., & Samuels, S. (2009). Prevalence of serious mental illness among jail inmates. *Psychiatric services*, *60*(6), 761-765.

Sturgess, D., Woodhams, J., & Tonkin, M. (2016). Treatment engagement from the perspective of the offender: Reasons for noncompletion and completion of treatment—a systematic review. *International Journal of Offender Therapy and Comparative Criminology*, *60*(16), 1873-1896. doi: 10.1177/0306624X15586038

Tafrate, R. C., & Mitchell, D. (Eds.). (2014). *Forensic CBT: A handbook for clinical practice*. Oxford, UK: John Wiley & Sons.

Talbot, J., & Riley, C. (2007). No One Knows: offenders with learning difficulties and learning disabilities. *British Journal of Learning Disabilities*, *35*(3), 154-161. Retrieved from https://doi.org/10.1080/17449200903115797

Taxman, F. S., Thanner, M., & Weisburd, D. (2006). Risk, need, and responsivity (RNR): It all depends. *Crime & Delinquency*, *52*(1), 28-51. Retrieved from https://doi.org/10.1177/0011128705281754

Vaske, J., Galyean, K., & Cullen, F. T. (2011). Toward a biosocial theory of offender rehabilitation: Why does cognitive-behavioral therapy work? *Journal of Criminal Justice*, *39*(1), 90-102. Retrieved from https://doi.org/10.1016/j.jcrimjus.2010.12.006

Ward, T. & Brown, M. (2004). The good lives model and conceptual issues in offender rehabilitation. *Psychology, Crime & Law*, *10*(3), 243-257. Retrieved from https://doi.org/10.1080/10683160410001662744

Ward, T., Mann, R. E., & Gannon, T. A. (2006). The good lives model of offender rehabilitation: Clinical implications. *Aggression and Violent Behavior*, *12*(1), 87-107. Retrieved from https://doi.org/10.1016/j.avb.2006.03.004

Ward, T., & Stewart, C. (2003). Criminogenic needs and human needs: A theoretical model. Psychology, *Crime & Law*, *9*(2), 125-143. Retrieved from https://doi.org/10.1080/1068316031000116247

Ward, T., Yates, P. M., & Willis, G. M. (2011). The good lives model and the risk need responsivity model: A critical response to Andrews, Bonta, and Wormith (2011). *Criminal Justice and Behavior*, *39*(1), 94-110.

Ward, T. & Willis G. M. (2016). Responsivity dynamic risk factors and offender rehabilitation: A comparison of the good lives model and the risk-need model. In R. S. Laws & W. O'Donohue (Eds.), *Treatment of sex offenders: Strengths and weaknesses in assessment and intervention* (pp.175-190). Switzerland: Springer, Cham.