# CORRECTIONAL COUSELING

# CHAPTER 1: INTRODUCTION TO CORRECTIONAL COUNSELING AND REHABILITATION

## 1. Introduction

In the start of the late 1960s, the rehabilitative ideal suffered a dramatic decline and was severely criticized for allowing inequality in sentencing; different treatment programs that did not help in reducing recidivism, and coercion inside prisons. The ensued era proved to be a nightmare for policy, mainly marked by mass captivity, ineffective interventions, and the deliberate infliction of pain on offenders. Afterward, elected officials of both political parties agreed to introduce reforms in order to improve lives of offenders by means of a more balanced crime-control approach (Lamb, 2009; Gershowitz, 2016). Conditions were favorable for this policy turning point, and hence opinion polls clearly showed that the American public is in favor of offender rehabilitation as a main correctional goal. Further, there is scientific evidence of achieving lower reoffending by application of a treatment paradigm or the risk-need-responsivity (RNR) model (Feeley & Simon, 1992; Clear & Austin, 2009). However, the implementation of such evidence-based treatment practices remains challenging, and, more importantly, the creation of such legal processes is not an easy task which let the offenders have an opportunity to earn true redemption and hence free from the burdens of a criminal record (Phelps, 2015; 2016; 2017).

In the United States, each day, approximately 6,730,900 residents—or almost 1 in 37 adults among us—are currently under some type of correctional supervision. Almost 4.7 million American are watched on parole or probation and more than 2.1 million Americans are shielded behind prison or bars jail. There is a significant talk on the issue of whether or not such mass imprisonment and mass community supervision represent a major failure of domestic policy. The broad consensus among criminologists and policymakers is that presently, there are excessive levels of correctional intervention. A major task is a determination of how to restrain from such excess, particularly in the use of imprisonment (Murphy, 1992; Petersilia & Cullen, 2014).

Irrespective of whether the correctional population remains at more than 6.7 million or experiences a decline of a million or two, one serious question will persist: How correctional agencies should treat those they lock up or manage in the community? Often, legal theorists try to answer this question by taking one of the following two positions: The aim is the precise retribution on offenders—providing them their deserving deserts—or else the aim is consequentiality or utilitarian where a sanction is a way to accomplish an end like reducing crime. However, in practice, American corrections have long been

an encounter among those who desire to impose punishment on the convicted against those who deem the offender should be rehabilitated (Nagin, 2013; Monahan & Skeem, 2016).

For the previous four decades, the "punitive imperative" was displayed vividly, as policymakers were successful in toughening the retort to crime by taking measures such as the crowding and building of correctional facilities, truth-in-sentencing laws, compulsory minimum sentences, the burden of austere living conditions inside prisons, three-strike laws, boot camps, and intensive parole programs and supervision probation. In this framework, the rehabilitative ideal has lost its capability to work as the governing theory of correctional practice and policy. However, in the middle of a get-tough era, rehabilitation did not disappear in two significant respects (Cullen & Gilbert, 2012; Clear & Frost, 2015).

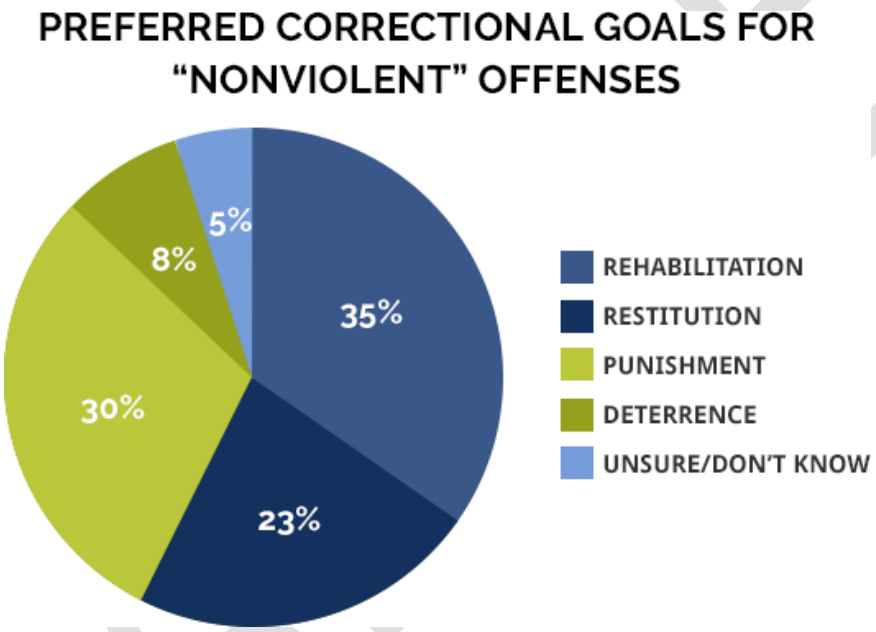


***Fig. 1. Distribution graph of different correctional goals***

[Source: https://transformingthesystem.org/criminal-justice-policy-solutions/public-opinion-report-a-new-sensibility/americans-support-prevention-rehabilitation-and-reintegration/]

First, even though there is a big reservoir of punitive sentiments in the American community, there also exists a permanent commitment to rehabilitation. Frequently, policy debates are cast as a clash of mismatched views, with compassionate liberals battling with punitive conservatives. On the other hand, public-opinion polls have revealed that Americans are both pragmatic and centrist in their correctional attitudes: They wish for punishment imposed on the guilty, but they also desire offenders to be rehabilitated (Cullen et al., 2000; Cullen et al., 2007; Dolovich, 2009). Since the 1960s, there had been a consistent support for rehabilitation when Americans were polled on their chosen goals of imprisonment. Even at the time of the height of the "get tough" era, such approval of treatment of offender remained high (Bates et al., 1995; Unnever et al., 2010).

Consequently, a national survey held in 2001 stated that 88% of the respondents are in agreement that it is vital to strive for rehabilitation of adults who have committed wrongs and now are in the correctional system"; in case of juveniles, this figure reached 98%. Latest public-opinion studies persist in showing strong support for rehabilitation together with providing re-entry services to prisoners that are released into the community. For instance, in a national survey held in 2017, 87.2% of people agreed with the same item on the significance of rehabilitation employed in the 2001 study. This public-opinion poll also demonstrated high support for a wide range of policies intended at facilitating the reform of offenders, together with "ban-the-box laws," re-entry services, problem-oriented courts (e.g., for mental health, drug, veterans), decreasing any collateral penalty of conviction that are not exposed to avoid recidivism, and rehabilitation ceremonies declaring offenders cured and free of charge from legal restrictions (Santana et al., 2013; Sundt et al., 2015; Thielo et al., 2016).

Second, although rehabilitation programs were devalued, but they were not fully abolished for multiple reasons: inertia, where maintenance of the status quo needed less effort as compared to any alternative; they served the purpose of occupying inmate time (e.g., work training, schooling); and few jurisdictions remained hard in their dedication to treat offenders. More importantly, a small group of scholars continued their research with the aim of exposing principles that could guide successful intervention with offenders (Boldt, 2013; Jonson & Cullen, 2015). Their research built a solid empirical case that a rehabilitative, human-service approach to corrections is able to decrease recidivism. Their investigation also exhibited that punitive programs were mostly not effective. This scheme has been helpful in restoration of legitimacy to the rehabilitative ideal. However, there is still much more which must be done in order to retain this hard-won credibility (Chin & Holmes Jr, 2001; Logan, 2015).

We can justify correctional rehabilitation on moral grounds as a humane substitute to efforts to impose pain on the offender and for the investment, it makes in improving lives of offenders (for example, improves their mental health, citizenship, human capital). But the legitimacy of the treatment hinges mostly on its capability to fulfill its promise of making offenders less probable to recidivate. This utilitarian claim is eventually an empirical question. Rehabilitation programs either work or they do not work. For that reason, the efficiency of treatment interventions has remained the central policy question of the previous half-century. Rehabilitation was declined to owe to its long-standing liberals, advocates, which came into believing that the expression of good intentions did not match the resultant harm gained when interventions were practiced. Only through demonstration that treatment programs functioned—and functioned even better than compared to punitive programs— could the rehabilitation status be restored (Cullen, 2005; Cullen & Jonson, 2011; 2016).

This chapter discusses the rise of rehabilitation during the initial seven decades of the 20th century, and its rapid decline in the 1970s era and beyond; moreover it briefly discusses the use of evidence-based corrections by rehabilitation for reclaiming legitimacy and become a counterpoint to the punitive imperative (Von Hirsch et al., 1998; Listwan et al., 2008).

Before starting a discussion on rehabilitation, we need to address three important points. First, it is imperative to clearly state what do we mean by the concept of rehabilitation. Cullen and Jonson (2011) have stated the definition of rehabilitation as a scheduled correctional intervention targeting a change in social or internal criminogenic factors with the aim of decreasing recidivism and improving other aspects of the life of an offender wherever possible (Petersilia & Deschenes, 1994; Wodahl et al., 2013). Three main components of this definition are stated below; each of the components carries with it a normative condition:

(1) Treatments for offenders need to be properly planned, containing distinctive features specially designed to decline recidivism.

(2) Treatments must be able to identify the motives behind crime (i.e., such things which are "criminogenic") and must have the capability of curing or else changing them.

(3) Treatments must be concerned with human service and, wherever possible, try to improve offenders' general condition and well-being. On the other hand, it should not be permissible to inflict unnecessary suffering on offenders or continuing harm to them.

In this chapter, we have not discussed the heated debate over which legal theory must govern the approving of offenders, particularly at the sentencing phase; the matter is complicated and still unsettled (Phelps, 2015; 2016). Mostly, the discussion here is more pragmatic. The argument stated is that rehabilitation is at present vital for corrections and that, when carried out in a suitable manner, it greatly improves lives of offenders as well as public safety (Latessa et al., 2002; Rothman, 2017).

The roots of a rehabilitative ideal lie in the desire of "doing good" for offenders. However, it must be noted that good intentions do not necessarily translate into good results every time. Rehabilitation can turn out to be harmful and coercive if carried out in an inexpert manner or with malice. Moreover, it must be understood that treating offenders instead of punishing them does not really mean that rehabilitation is essentially lenient. Plenty of literature indicates that a lot of times, offenders perceive even prison terms as a better option for interventions which are planned to be less punitive and more supportive. It is not easy to insist offenders to make efforts in changing their behavior as well thinking. In the end, the concern is not whether or not offenders "like" their treatment; instead, it is whether or not rehabilitative interventions are delivered both effectively and ethically (Rothman, 1980; 1982).

## 2. The Rehabilitative Ideal

What is meant by the term "rehabilitative ideal?" In several ways, it is based on the medical model employed for curing physical ailments. Therefore, just like illness, crime is not perceived as picked in the sense that it courses from exercising free will to the point the decision to offend is made. Instead, choices are inclined, if not entirely determined, by causal factors, which presently are frequently termed as "risk factors." It is possible that such factors lie within the individual (psychological or biological);

they can also originate from outside the individual (social). Irrespective of that, if they are not correctly diagnosed and treated, then the rebellious conduct of offenders will continue and they will not be cured. On the other hand, rehabilitation is possible provided the reasons or motives underlying the criminality of an individual are identified and they are afterward prescribed a suitable treatment (Platt, 1977; Feld, 1991; 1998).

The rehabilitative ideal is viewed as a traditional, unscientific legal method of calibrating punishment to the criminal nature, an exercise that is supposed to achieve rightful justice and, some would claim, deterrence. The apparent complexity is that two people committing a similar crime—for instance, burglary—might do so for fairly different reasons (for example, pressured from peers, a desperate need for money, impulsive owing to low self-control). Imposing of a one-size-fits-all agreement does not make any sense; it is the same as treating every patient in the same manner irrespective of his / her disease (Feld, 1977; 1988; Feld & Schaefer, 2010). Likewise, imposing punishment on offenders is irrational—whether this is a prison sentence or a heavy fine. It should be noted that this is one of the reasons why scholars who have embraced rehabilitation foresee that there will be minimal effects of punitive interventions as they do not aim to change the engines of criminal behavior (Citrin, 1974; Lipset, 1987).


***Fig. 2. Percentage-wise role of Rehabilitation Counselors in different sectors in the US***

[Source: https://thecampuscareercoach.com/ask-the-coach/what-can-i-do-with-a-masters-in-hr-rehabilitation-counseling]

Nevertheless, the promise of rehabilitating offenders is centered on two interesting assumptions. Firstly, the rehabilitative ideal makes the assumption that those who undertake rehabilitation have the skill to analyze criminogenic risk factors and afterward to deliver a suitable and effective treatment intervention. As a matter of fact, quite often, treatment knowledge and expertise have been greatly

lacking, with offenders exposed to interventions fulfilling the merit of the designation of "correctional quackery." Secondly, another assumption made by rehabilitative ideal is that correctional staff will exercise their freedom of choice as per therapeutic principles and keep in mind what the best interests of offenders (Morris, 1973; 1974; 1977). Giving this trust is important because discretion is indispensable in delivering customized interventions which can address the motives or reasons of each person entering crime. However, a harsh reality is that rehabilitation takes place within a correctional system where decisions by staff can be greatly influenced not just by legitimate treatment priorities but by custodial and political considerations as well. As Rothman has warned that "conscience" in such circumstances, is often corrupted by the necessity to content "convenience."

In 1870, the first strong statement of the rehabilitative ideal took place at the National Congress on Penitentiary and Reformatory Discipline. As a result of the Civil War, the prisons all over the country were crowded by the so-called "terrifying classes of penurious immigrants." Correctional elites could have termed those offenders as the "other" and as away from redemption. However, this was not the case. Instead in a meeting at Cincinnati, the leading prison reformers and administrators restated that the ultimate purpose of prison discipline is the criminals' reformation and not the infliction of malicious suffering (Burt, 1974; Rothman, 2017). In their Declaration of Principles, correctional elites favored the cataloging of inmates, inmate education as well as their industrial training, the distribution of rewards more than punishments, the distinctive training of guards, and struggle for the reintegration of prisoners back into society by providing them work and necessary encouragement. Nevertheless, their main recommendation was the unstipulated sentence, which would retain offenders in prison not for a fixed time duration based on the gravity of their crime but until they were reformed. According to their observations, this is the only way of placing the destiny of a prisoner in his own hands (Murphy, 1992; Tonry & Petersilia, 1999)

The initial two decades of the 20th century, famous as the Progressive era, was when these ideas came to direct the development of a contemporary correctional system. The rise of social sciences provided required confidence that the motives behind crime might be identified in a more reliable way; moreover, the political environment of this "age of reform" was suitable for social engineering. Particularly, the rehabilitative ideal delivered the conceptual grounds for the restoration of the system. Sentencing became further unstipulated and resulted in the formation of parole boards which were assigned the task to decide when prisoners had been cured and could be unconstrained safely. Logically, parole supervision and probation were necessary since the offenders in the community required assistance to avoid crime in the future and, if failed at that task, they were to be sent to prison. Pre-sentence reports contained the life details of offenders; they were to be compiled by probation officers and were necessary in order to help judges to determine whom to imprison and whom to have in the community. Lastly, a discrete juvenile justice system was vital devoted just to treatment if rebellious children were to be protected and saved (Kennedy, 1976; Alford, 2000).

There was a strong appeal of rehabilitative ideals. Therefore, embracing rehabilitation—the paradigm of individual treatment—appeared civilized and logical, and not vengeful or irrational. Secular humanism, with its major focus on science, as well as sacred belief, having its focus on the universal potential to be saved, combined into a positive correctional paradigm—a model in which the aim was to improve lives of offenders. The special attention would be provided to the children, again through a justice system particularly designed for their needs. All of this would be realized without having to sacrifice social defense. Ever-vigilant parole and probation officers would carefully watch over offenders incapable of remaining crime-free in the community, and wayward inmates would be retained behind bars—for whole life if required—until they were cured (Berman & Lief, 1975; Berman, 1979).

This was the leading ideology across the majority of the initial seven decades in the 20th century. The term "corrections", by the 1950s, was in practice and exemplified the nature of the enterprise: correcting the offenders found guilty of a crime. However, any of this does not suggest that criminal sanctions—and particularly prisons—lived up to the rehabilitative ideal. Regardless, there was little disagreement about the necessity to pursue this ideal in many elected officials amongst correctional elites, and nearly all criminologists (Berman et al., 1972; 1995). Then, within a very small time period—approximately from the last part of the 1960s till the mid-1970s—the legality of the rehabilitative ideal collapsed to the level that it was now commonly asked: "Is rehabilitation dead?" This setback of fortunes for treatment of offender was striking and consequential.

## 3. Two Critiques

Two comprehensive critiques made a major contribution to the declining of the rehabilitative ideal: (1) a critique of public discretionary power fueled by a decreasing confidence in the government, and (2) the "nothing works" critique stimulated by review program of Robert Martinson on evaluations claiming to demonstrate that "nothing works" in order to rehabilitate offenders. Each of these critiques will be briefly discussed (Kruttschnitt & Gartner, 2005).

### 3.1. The abuse of discretionary powers

The roots of a rehabilitative ideal lie in the individual treatment model. However, Individual interventions are dependent on judges who give them and on, parole boards as well as correctional staff. As physicians need the flexibility to suggest services or medication exclusive to each patient, in a similar manner, those administering rehabilitation need the flexibility to intervene with each offender. Assigning essentially unrestricted discretionary powers undertakes that officials of state can be trusted to make such decisions which are accurate scientifically and support the reform of offenders—they are assumed to be well-intended and smart, not quacks and insensitively self-interested. Advocates of rehabilitation had long agreed that this standard was more frequently a target than a reality. Nevertheless, imperfection was not viewed as a basis to abandon the rehabilitative ideal but instead, it was viewed as a way to intensify its pursuit (Lipton et al., 1995; Page, 2011; 2012).

By the end of the 1960s, trust in the state was declining quickly. The polls of data showed a "virtual blast in antigovernment feeling." There was a legitimacy crisis or confidence gap. While, in 1958, 73% of the public assumed that government officials would always or at least some of the times do what is right; whereas, by the mid-1970's, this figure had fallen below 40% (Martinson, 1974; 1978; Petersilia & Cullen, 2015). The bases of this change in public opinion are well reported as a chain of significant social events disturbed the nation: brutal subdual of civil-rights protests, political murders, continual protests of the Vietnam War, violent rebellions in inner cities, and exposes of political corruption epitomized by the Watergate scandal. In this regard, criticisms and disapproval of the rehabilitative ideal found a more and more receptive audience. Hence, the reputation of rehabilitation shifted from a liberal ideal providing guidance to reform efforts, to a mask of compassion or "noble lie" that was being utilized to allow and hide the suppression of those trapped in the iron fist of the state (Cullen & Gendreau, 2001; Cullen, 2013).

In brief, blame was put on rehabilitative ideal for putting trust in state officials to do good when, in reality, they were misusing their discretionary powers. Partially, this abuse was owing to lack of competence: Government officials in the correctional counseling system did not have the requisite scientific expertise to provide effective treatment or to identify when someone was cured. However, the more profound critique was that those officials had evil intentions. For instance, judges were accused of using their discretionary powers not to customize treatment but to differentiate between the racial and poor minorities. Prisons were a distinctive object for inspection, illustrated as being essentially inhumane (as an experiment of Philip Zimbardo's Stanford Prison appeared to show). In such a miserable environment, correctional officers would utilize the threat of everlasting imprisonment not as an inducement in a treatment routine but as a way to force compliance to their authority (Palmer, 1991; Weisburd, 2016).

Progressive reformers and scholars who were inspired by this mindset started efforts to inhibit discretion. The cornerstone of their chosen "justice model" was determinate sentencing, which included fixed terms of prison written into the decree. Conservatives happily jumped on this cause. On the other hand, liberals disapproved of the rehabilitative ideal for allowing the oppression of offenders, conservatives perceived it as allowing the victimization of innocent citizens. They had reviewed the discretion long ago as permitting judges to announce lenient sentences and susceptible parole boards to be defrauded into prematurely releasing killers (Gendreau & Ross, 1979; 1987; Marlowe, 2002). A huge sentencing reform movement was underway by the mid-1970's in order to strip discretion from the system and was backed by liberals who hoped for short prison sentences as well as conservatives who hoped for longer ones. During the period of next few decades, every state restrained the discretion of parole boards and judges through practices such as sentencing, determinate sentencing, and parole procedures, three-strike laws, compulsory minimum sentences, and truth-in-sentencing laws (Cullen & Gendreau, 2000). Reforms such as these concentrated power in the legislator's hands (who was

responsible for writing requisite punishments into statutes) and of prosecutors (who utilized the threat of definite punishment to encourage plea bargains). In the dominant political context, liberal concerns about honesty were mostly ignored, whereas conservative inclinations to get tough on crime were noticed as well as written into law after law. Even though other factors were significant, hence, the attack on the rehabilitative ideal assisted to usher in a punitive movement that employed imprisonment in unparalleled methods (Lipsey et al., 2000; Lipsey & Cullen, 2007).

### 3.2. Nothing works

In 1974, Robert Martinson published a classic essay named "What Works?" in *The Public Interest;* Questions and Answers about Reforms of Prison." Martinson, in collaboration with Douglas Lipton and Judith Wilks, evaluated 231 studies assessing correctional interventions, which were afterward published in a dense, lengthy, and occasionally consulted book (Lipton et al., 1975; Manchak & Cullen, 2015). Martinson's essay in the more widespread forum of *The Public Interest* was short, provocative, and extensively read. Certainly, his chief conclusion was unambiguous and italicized for highlighting which stated that with isolated and few exceptions, so far, there had been no substantial effects of rehabilitative efforts on recidivism. The concluding heading in his essay further raised a question, "Does Nothing Work?" It was evident from the comments which followed both in the media as well as in the text that Martinson was declaring that hard work to reform offenders had proven nothing but a failure. Surely, the message that "nothing works" took hold rapidly and became an unquestionable principle in the field (Craig et al., 2013; McGuire, 2013).

Prominently, Martinson's study did not activate the decline of the rehabilitative ideal. As eminent, due to prevalent mistrust in the state as well as in welfare ideology, already a major loss of faith in the therapeutic model was well thriving. Instead, numerous policymakers and skeptical scholars involved in a cooperative incident of confirmation bias by appending the scientific custom of systematized skepticism in approval of the uncritical acceptance of the nothing-works motto (Cullen et al., 2009; MacKenzie & Farrington, 2015).

For them, Martinson's observations merely told them what they already analyzed, hence, only adding the distinction of scientific legitimacy. In other words, his essay proved to be the shutting nail of the rehabilitative ideals' coffin (Boldt, 2013; Cullen et al., 2011).

In 1979, Martinson did follow-up analysis of 555 studies which encouraged him to moderate his conclusion by stating that opposing to his previous statement, few treatment programs *do* make a substantial effect on recidivism. After that, he explicitly renounced the idea that all interventions were "ineffective." However, at that time nobody was listening since these facts did not approve the near-universal belief in the nothing-works rule. The original 1974 study of Martinson continued to be quoted as proven truth, whereupon, his latter study would be mainly ignored (MacKenzie, 2000; Cullen, 2005; Lipsey, 2009).

Therefore, the lasting effect of Martinson's essay was that it *reframed* the discussion over rehabilitation from a critique of an unrestricted system into a heated debate over the *effectiveness of the program*. Firstly, this emphasis on effectiveness was an obvious benefit for critics of the rehabilitative ideal, since they could simply inquire that how anyone can favor something which doesn't work. However, ironically, reframing the debate in this manner delivered hope to the other side (Durand & Merges, 2001; Van Voorhis et al., 2004). If advocates of rehabilitation treatment could arrange empirical evidence exhibiting that, as a matter of fact, such intervention programs were effective, then they would be in a position to turn the tables on opponents by asking how anyone cannot be in favor of something which does work. As discussed in the following section, this empirical reversal is exactly what happened (Andrews et al., 1990; Andrews & Bonta, 2010).

## 4. Overview of the Speculative and Empirical Issues

Two significant occurrences—one theoretical, one empirical were vital in efforts to reaffirm rehabilitation. Firstly, advocates needed to show that treatment programs "worked" and afterward, they had to create a practical model for implementation of treatment within the domain of the correctional system. Both of these happened (Salisbury et al., 2009).

### 4.1. Showing That Rehabilitation Works

Showing that "rehabilitation works" happened in two stages—the second stage was most significant. First, advocates of treatment studied the prevailing body of studies and established that many of these evaluations produced the positive result of a decline in recidivism (Gendreau, 1996). In 1975, another researcher named Palmer reanalyzed Martinson's set of studies and demonstrated that 48% had positive results. After that, in 1979, Ross and Gendreau delivered "bibliotherapy for cynics" by reviewing abundant studies in which programs were observed to be effective (Gendreau & Ross, 1979; Palmer, 1991).

Nevertheless, these reviews failed to settle the matter. Where one side was viewing the treatment glass as half full, the other side at the same time was seeing it as half empty. The side seeing half-full was using the positive outcomes to simply falsify the statement that "nothing works." However, the original point of Martinson was more subtle. Even though his work is little understood by those reading it, he categorized interventions into 11 classes (e.g., life skills, individual counseling, and casework, free time activities, group methods,). However, it could not be demonstrated inside each category that the interventions were consistently effective. Although, if some programs—for instance, a counseling program—were able to reduce recidivism some of the time, quite often they failed in doing so. Thus, Martinson concluded that nobody is able to tell a policymaker that an explicit program would function all the time. Therefore, exposing offenders to any particular treatment program was hopeless (Kellermann et al., 1992; Lowenkamp et al., 2006).

This bottleneck was mostly settled when the evaluation literature of the program was subjected to an evolving statistical method called meta-analysis. This technique quantitatively combines various effects of treatment which are reported by evaluations, eventually reporting an "average effect size". Put another way, this method results in a precise number which tells whether a rehabilitation program has a negative, positive, or null relationship with the dependent variable, which in this case is some measure of recidivism (for example, incarceration, arrest). Subject to the strength of this relationship as well as the size of the sample, we can calculate a larger or a narrower confidence interval—which is the range/interval within which real effect likely arises. Thus, we can say that a meta-analysis is just like the computation of a batting average for the sake of a treatment program across all the studies which have tested its impacts. A high batting average is the one which continually produces high declines in recidivism in study after study. It must be noted that Martinson basically projected that the batting average of rehabilitation would be zero, with studies presenting effective results canceled out by those studies that were not effective. Therefore, "Nothing works" implies no effect overall across all types of programs, as well as no effect for any given modality or program type (Cullen et al., 2013; Klingele, 2013; 2015).

Various meta-analyses were performed that reached the similar conclusion: treatment programs, across all sorts of correctional interventions, were effective in dropping recidivism by around 10%. One of the meta-analyses was performed by Mark Lipsey together with his associates in which they used a big sample size of the studies which were evaluated as well as more sophisticated methods. That meta-analyses particularly proved to be convincing (Lipsey et al., 200; Lipsey, 2009). Lipsey's integrity could not be questioned as well since he had no dog in the hunt—further, he was not a distinguishable treatment advocate. Nevertheless, the effect size of 0.01 is modest, maybe enough to silence the crowd yelling the slogan of nothing works but not adequate to resuscitate the rehabilitative ideal and direct implementation of the program. However, notably, the meta-analyses demonstrated that the effects were not homogenous across all kinds of treatment, rather they were *heterogeneous*. Which means that some intervention modalities were very effective, while some were ineffective, if not completely criminogenic. Two important insights were achieved from these treatment effects (Miller & Alexander, 2015; Sobol, 2015).

First, punitive interventions that focus on discipline, deterrence, or surveillance have insignificant, weak, or iatrogenic impacts on recidivism (for instance, scared-straight programs, boot camps, severe supervision). In order to assess "what works to decline re-offending," McGuire analyzed 100 systematic reviews or meta-analyses and concluded that the only persistently negative mean effect sizes informed so far are the ones acquired from criminal authorizations or deterrence-based approaches. Punitive sanctions have frequently appeared as a failed strategy to alter the behavior of offenders. Second, such interventions which are therapeutic and put emphasis on a human-service tactic are most probable to attain significant reductions in recidivism (Jonson et al., 2013; Eisen, 2015). These observations, when

taken together, directly challenged not just the nothing-works motto but on the other hand, claims that punishment was an effective correctional method to increase public safety through specifical deferral of offenders (Smith et al., 2004; Robinson et al., 2011; 2012).

The empirical evidence has assisted in the re-establishment of the legitimacy of the rehabilitative ideal. It cannot claim to be the dominant model now, but it is obviously the case that treatment of offender is viewed as an important correctional goal in most places. Partly, the ideal's reaffirmation is owing to the movement during the previous two decades—not just within correctional counseling but in medicine, corrections as well—to formulate decisions on evidence. Therefore, with the gathering of the supportive data of treatment, evidence-based corrections itself were arising. In this regard, claims to state that treatment works took on improved salience (Krisberg, 2006; Lowenkamp et al., 2006). However, the difficulty lied in moving from this general conclusion to the implementation of programs in the domain of correctional agencies. It is one thing to state that rehabilitation programs work better unlike punishment, but it is somewhat another thing to educate correctional staff how explicitly they must treat each offender. Notably, Canadian scholars accepted this challenge, which has been discussed in the subsequent section (Smith et al., 2004; 2012; Gleicher et al., 2013).

### 4.2. The Canadians' RnR Model

Physicians while delivering medical treatments reserve the most severe interventions (such as emergency-room services, modern testing, and hospitalization) for the sickest patients. Patients who are experiencing low-risk diseases either receive nominal interventions or else get better on their own through their natural resistance to diseases (Levitt, 2004; Desmarais et al., 2012; 2016). Once a patient suffering from high-risk is seen, the doctor analyzes the individual in order to discover the reason for his illness. After the identification of the causes, a doctor then prescribes a medical intervention that is responsive to the factors responsible for causing disease, that is, a prescription capable of curing such deficits (Provost, 2009; All of this seems logical and as a matter of fact, it is hard to think of any alternative strategy to the following: (1) focus on high-risk cases; (2) find the factors recognized by science which is responsible for causing the disease; and (3) choose treatment verified by science for elimination of the disease-causing factors (Austin et al., 2016; Vazquez, 2016).

The logic stated in the above paragraph reflects the logic of the governing rehabilitation tactic, popular by the acronym of its three major principles: the risk-need-responsivity model or the RNR model. Therefore, this viewpoint claims that treatment programs will be utmost effective if they comply with the above mentioned three principles. The first principle is *the risk principle* (R) which recommends that correctional interventions must aim at high-risk offenders. Whereas, low-risk offenders should be given little or almost no attention and definitely not be imprisoned. The second principle is *the need principle* (N) which recommends that interventions must focus on changing the empirically proven predictors of recidivism which can be changed or are "dynamic". For instance, age or race is "static"

risk factors. In comparison, pro-criminal associates or pro-criminal attitudes can be changed or else replaced by pro-conventional associates and friends (Marsh, 2009; Frese, 2009; Millkey, 2009). The emphasis is on giving priority to such factors which demonstrate strong relations with recidivism.

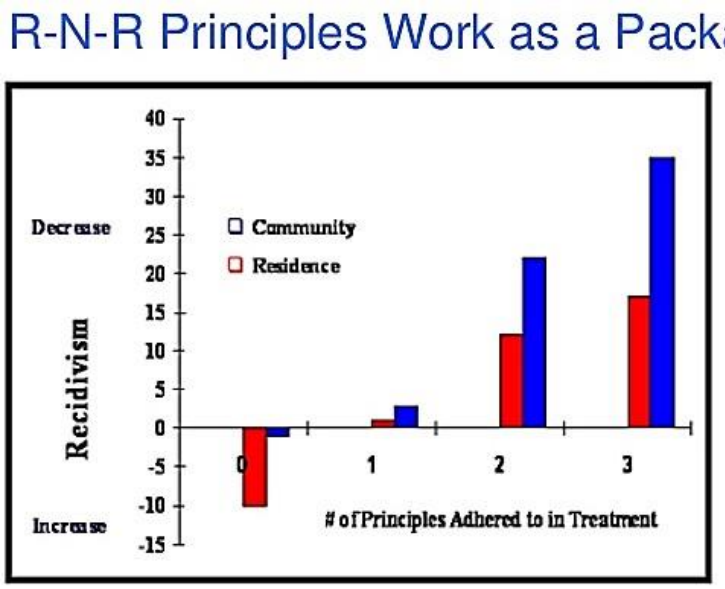


***Fig. 3. The TJC Model for Constructing Jail-to-Community Transition Systems***

[Source: https://www.slideshare.net/UCFCJ/orlando-jail-reentry-jannetta-v2-2]

Lastly, the third principle is *the responsivity principle* (R) which suggests that staff make use of such treatments that have the capability of altering dynamic risk factors— that is to say, treatments that are "responsive" to them. The strategies which are most effective fall into the classification of cognitive-behavioral therapy (Schoenfeld, 2010; Drescher & Byne, 2012). Particularly, the inventors of the RNR model made use of arduous science, including meta-analyses, for identification of risk factors which needs to be targeted in order to change and further identification of treatments which must be employed when intervening with offenders (Simon & Rosenbaum, 2015).

### 4.3. Cognitive-behavioral therapy

Cognitive-behavioral therapy is also widely known as "CBT". It is an extensively used treatment method that is applied to reduce a variety of behavioral problems and psychological disorders. Its main idea is that maladaptive or incorrect cognitions result in as well as help to maintain problematic behavior and emotions. There are two major approaches to CBT as explained by Guevremont and Spiegler:

The first model is known as Cognitive restructuring therapy and educates clients to change flawed and inaccurate cognitions responsible for maintaining their problematic behaviors. Cognitive restructuring encompasses recognition of maladaptive cognitions and replacing them with more adaptive cognition. This technique is mainly used when clients' complications are maintained through an excess of maladaptive feelings and thoughts (Simon, 2005; 2014; Petersilia & Cullen, 2014).

The second model is cognitive-behavioral coping skills therapy and it educates adaptive responses to clients —both cognitive as well as behavioral—to face difficult situations they encounter in an effective manner. This model is suitable for such problems which are maintained by arrears in adaptive cognitions (Bosworth & Kaufman, 2011; Aviram, 2015).

Both of the above-mentioned methods are used with offenders (29). An example can be taken of Anger Control Therapy (abbreviated as "ACT") which comprises of five main steps intended for educating rebellious youths as how they can control their anger underlying their delinquent and aggressive behavior. In this model, the following sequential steps are taught to these youths: (1) how they can recognize external events as well as internal self-statements responsible for triggering their anger; (2) how they can identify the physiological indications, such as a "flushed face," or a "tense jaw" that aware them to the beginning of their anger; (3) how they can rely on tactics to deal with the recognized anger, such as "self-statements" to cool off or calm down; (4) how they can make use of certain "reducers", like counting backward and visualizing peaceful scenes that help in lowering their anger levels; and (5) how they can evaluate that how well they handled the anger and afterwards to praise themselves if they performed reasonably well (Alper et al., 2016; Rhine & Taxman, 2017).

### 4.4. Components of RNR Model

The roots of the RNR model prolong to the 1980s and to an association of Canadian psychologists who worked in a correctional environment. Guileless by the nothing-works motto presiding among their southern neighbors, three psychologists named James Bonta, Paul Gendreau, Donald Andrews, and their colleagues started their efforts on creating a systematic and efficient model of offender assessment as well as treatment (Bonta & Andrews, 2016). This model encompasses 15 principles in total, with the 3 key RNR principles (Aeibi et al., 2015; Doherty, 2015). Nonetheless, its first principle known as "Respect for the Person and the Normative Climate" is likewise significant. The delivery of services is carried out with respect for the person, as well as respect for personal autonomy, being humane, and being otherwise normative. Condescending and imposing gratuitous agony on offenders is strongly rejected (Adelman. 2012; Taxman, 2012; Kohler-Hausmann, 2013).

The strong point of the RNR model is that it is composed of three components which are inter-related, the first two of which have been already mentioned: correctional, criminological, and technological (Jones, 2008; Lynch & Verma, 2016).The *criminological component* discusses the model's fundamental theory of crime. Notably, this is not a comprehensive causal explanation, nevertheless, instead of a treatment theory as it emphasizes on dynamic, close risk factors which can be altered. It does not take into account static factors (age, for instance); it further ignores distal factors, like neighborhood social disorganization, which are far from correctional intervention (Ritter, 2006; Tonry, 2011; Adelman, 2012).

The Canadians, being followers of cognitive-social learning theory, adhere to the assumption that all behavior, together with criminal behavior, is learned. Risk factors are significant as they affect the cognitive decision of committing a crime by making it less costly or more rewarding (Sundt et al., 2015; Thielo et al., 2016). Research has established the fundamental significance of eight factors, however, two of them seem mainly important—first, pro-criminal attitudes and second, associates. The remaining six predictive factors are: criminal history, rebellious personality patterns (for example, callousness, low level of self-control), school/work quality of interactive performance and relationships, marital/family quality of interactive relationships, leisure/ recreation involvement, substance abuse, and satisfaction (Monahan & Skeem, 2013; Tonry, 2014; Starr, 2015). These risk factors are referred to as the "central eight," and are also known as "criminogenic needs" since they are deficits that should be fixed if we want to reduce recidivism. For instance, we can address the effects of pro-criminal associates by an intervention which decreases these interactions and substitutes them with pro-social relationships. Lastly, even though criminal history is not clearly a dynamic risk factor, still, it demonstrates a hopeful target for change. As Bonta and Andrews stated that through history cannot be changed, however, suitable intermediate targets for change consists of building new noncriminal behaviors in high-risk conditions and building self-efficiency principles that support rehabilitation (Dagan & Teles, 2014; Beckett et al., 2016)

Second, the *correctional component* is the RNR model which has been described above. Since the fundamental criminological component is grounded in cognitive social learning theory, therefore, desired interventions lie under the classification of cognitive-behavioral therapies. Such treatments are "responsive", that is, they can alter the "criminogenic requirements" characterized by the central eight risk factors (Hamilton, 2015; Fazel et al., 2016; Scurich & Monahan, 2016). Once more, this model obligates to follow the risk principle, which means that services must be delivered to high-risk offenders. These offenders have considerable criminogenic requirements which must be addressed. Emphasizing low-risk offenders is just like hospitalizing patients suffering from a cold. Medically, the intervention is not needed and might expose them to circumstances that will worsen their health (Sève, 1993; Jonson et al., 2013; Petersilia, 2014).

Third, the *technological component* indicates the instruments that are required to make sure that the treatment is carried out with integrity. In brief, it is not enough to know what to do; it is also necessary to know how to do it." Therefore, a distinctive contribution of the Canadians is that they established two technologies that would permit the RNR model to be employed by practitioners in the field. First, the RNR model is dependent on an assessment of the offender in order to deliver the treatment to high-risk offenders (Murphy, 1979; 1994; 1998). For this purpose, the Canadians planned the Level of Service Inventory, which has gone through different advances. The Level of Service Inventory-Revised is called as the LSI-R; it has been employed in the majority of the states (more than half) and various other nations (Braithwaite & Mugford, 1994; Braithwaite, 1999; Daly, 2000).

Second, the Canadians also established the technology to analyze the level to which an agency as a whole was sticking to the RNR model. The Correctional Program Assessment Inventory, known as The CPAI, is composed of 10 subscales employed by trained evaluators to analyze an organization's ability to deliver treatment with integrity (for example, program maintenance/implementation, organizational culture, use of fundamental correctional practices) (Nagin, 2004; 2007; Bushway et al., 2007).

In brief, Bonta, Andrews, Gendreau, together with their Canadian colleagues stimulated the treatment enterprise further than the common statement that "rehabilitation works." In a hypothetically formulated and evidence-based model, they delivered both solid instructions as to how to intervene with offenders (follow the RNR principles) as well as the technology required to undertake such intervention. As a result, presently, the Canadians' RNR model is the leading treatment model in North America and, gradually, across the globe (Bushway & McDowall, 2006); Murphy, 2006; Apel & Nagin, 2011).

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