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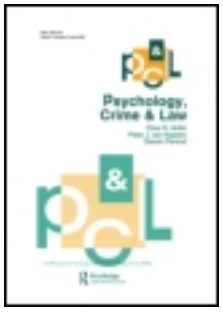

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The Violence Reduction Programme: a treatment programme for violence-prone forensic clients

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The Violence Reduction Programme: a treatment programme for violence-prone forensic clients

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The Violence Reduction Programme (VRP) is a treatment programme designed to reduce the risk of violence for individuals with antisocial and/or violent histories. The VRP was developed based on integrating the risk, need and responsivity (RNR) principles with contemporary clinical and offender rehabilitation techniques such as using cognitive-behavioural, relapse prevention and motivational interviewing approaches. Further the integration of risk assessment and treatment was achieved within the VRP by using the Violence Risk Scale, also developed based on RNR principles, to assess violence risk, criminogenic needs treatment responsivity and treatment changes. Unlike highly scripted programmes, treatment progress in the VRP is assessed based on achieving specific treatment goals rather than completing a specific number of sessions. As such, the VRP is sufficiently flexible to accommodate participants with quite diverse needs. Results of programme evaluations with long-term follow-up and the inclusion of control groups indicates that programme participation was linked to the reduction of general and violent reoffending. The programme also appears to be effective in treating offenders with significant psychopathic traits.

Keywords: violence; treatment; risk; offender; rehabilitation; psychopathy

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The World Health Organization has identified violence as a public health issue and has urged 'the health sector (in conjunction with the criminal justice sector) . . . to take a much more proactive role in violence prevention . . .' (Krug, Dahlberg, Mercy, Zwi, & Lozano, 2002, p. 246). While primary violence prevention can be undertaken through early intervention for at-risk families, the present paper focuses on tertiary prevention. We describe a treatment programme, the Violence Reduction Programme (VRP), for forensic clients with a history of violent behaviours.

Programme objectives

The VRP was developed to provide a theoretically based and empirically validated treatment programme to address explicitly the causes or associates of antisocial and violent behaviours in individuals in order to reduce the risk of similar behaviours occurring in the future. The programme strongly advocates the need to work collaboratively with programme participants, to assist them in identifying and

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mitigating criminogenic factors associated with violence such as antisocial beliefs and attitudes, substance use and criminal associates while enhancing their strengths by acquiring pro-social inter-personal, cognitive and vocational skills that are effective in reducing the frequency and intensity of future violence (Andrews & Bonta, 1994–2010; Gendreau, Little, & Goggin, 1996). Essential attributes of the VRP include assisting programme participants to work on their criminogenic needs and to enhance their strengths, while putting into practice what they learn in treatment in their day-to-day activities and interactions with others.

Development of the VRP

The forerunner of the VRP, the Aggressive Behavioural Control (ABC) Programme, was developed in the mid-1990s at the Regional Psychiatric Centre in Saskatoon, Canada, by a mental health team, including the first author, to provide an intensive treatment programme for high-risk and personality disordered offenders[1] in a correctional cum mental health setting. It then evolved based on research and developments in the field and contributions from both authors. The VRP, described herein, is based on an updated version of the ABC programme, lessons learned in the delivery of the ABC programme and recent developments in the field. As such, the VRP is different (and hopefully better!) in many respects from the ABC programme, which, due to a changing client profile,[2] is no longer being offered.

Theoretical underpinning of the VRP

For some of those with entrenched patterns of violence or aggression, behavioural intervention is one of the few options available for their rehabilitation. There is no universally accepted method of intervention to reduce violence and reoffending, in part, because of the heterogeneity of these individuals. No one approach would likely provide all the answers as 'one size doesn't fit all'. The VRP was developed by incorporating key principles of offender rehabilitation from a number of theoretical or evidence-based approaches discussed below.

The Psychology of Criminal Conduct (PCC) and the risk, need and responsivity principles

The PCC is an approach to understand the criminal behaviours of individuals through empirical research, the construction of rational explanatory systems, attending to individual differences and the application of this knowledge to reduce the human and social costs of crime (Andrews & Bonta, 1994–2010). The risk, need and responsivity (RNR) principles form part of a model of correctional assessment and rehabilitative programming derived from the PCC. The PCC and RNR provide the central conceptual underpinnings for the VRP. The extensive 'What Works' literature has indicated that RNR-based treatment approaches are generally more effective in reducing the risk of recidivism in adult and young offenders than non-RNR-based approaches (see Andrews, Bonta, & Wormith, 2010). The intensity of treatment should match the clients' risk level (risk principle). The individual's criminogenic needs linked to violence or criminality (e.g., criminal attitudes and peer groups) must be identified and targeted for treatment (need principle). Service

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delivery must accommodate the clients' idiosyncratic characteristics (e.g., their learning style, readiness for treatment and cultural background; the general and specific responsivity principles).

The VRP is a treatment regime designed for medium- to high-risk offenders (risk principle). The VRP uses the Violence Risk Scale (VRS; Lewis, Olver, & Wong, 2012; Wong & Gordon, 1999–2003, 2006; Wong & Parhar, 2011) to assess systematically the level of risk and criminogenic needs linked to violence – which become treatment targets (risk and need principles) – and also to assess the offender's readiness for change (responsivity principle). The VRP also recognises the heterogeneity of violence-prone offenders and acknowledges that one size does not fit all. For example, the VRP uses a goal-based rather than session-based approach in treatment delivery. Since everyone is not expected to progress at the same rate, those who complete certain programme requirements (intermediate goals) can progress while others may need more time.

Like RNR, the VRP also recognises and strongly supports focusing on the offender's strengths, which can be used together with risk reduction work in helping the offender progress towards building a repertoire of pro-social behaviours (see the Good Lives Model, Ward & Brown, 2004: also see Andrews, Bonta, & Wormith, 2010, for a comparison of the two models). For example, low scores on the VRS risk factors highlight the offender's strengths and both strengths and deficits are considered together in the assessment of treatment changes (also see the section *From talking the talk to walking the walk*).

Recently, the UK National Institute of Health & Clinical Excellence (*NICE*; 2009) published a set of guidelines for the treatment of antisocial personality disorder (APD) and psychopathy based on a review of the literature. The VRP treatment approaches are consistent with *NICE* recommendations such as focus on offence reduction work, adjusting treatment intensity to client's needs, providing staff support, training and so forth.

Multisystemic Therapy (MST)

MST is a social–ecological and evidence-based intervention to reduce antisocial behaviours among high-risk youths (see Henggeler, Schoenwald, Borduin, Rowland, & Cunningham, 1998). MST focuses on mobilising positive social influences such as family, school, home and community within the youth's natural environment, in order to affect change. A key feature of MST is to provide assistance to the youth '. . . 24 hours a day and seven days a week . . .' using these change agents (Henggeler et al., 1998, p. 43). The Assertive Community Treatment (ACT) approach for the seriously mentally ill (Marx, Test, & Stein, 1973; Stein & Santos, 1998) shares similarities with MST; both use a team approach and provide services 24 hours per day, and 7 days per week.

The VRP, like MST and ACT, also emphasises the importance of social influences in an offender's treatment environment. All VRP and allied staff (e.g., mental health staff, correctional officers, work supervisors, teachers, probation officers) are potential agents of change. Allied staff often have more day-to-day contact with the offenders than core treatment staff and can model pro-social behaviours and support skill generalisation to everyday situations. The VRP similarly emphasises the importance of all staff working collaboratively 24 hours a day, seven days a week to support VRP objectives.

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Aggression Replacement Training (ART)

Skillstreaming – the learning of new skills through modelling, role-playing, performance feedback and generalisation training (Goldstein, 2004) – is useful for those with particular skill deficits in certain areas such as dealing with stress or group pressures. Similar to ART, VRP also uses modelling, role-playing, performance feedback and generalisation to address deficits linked to violence.

Relapse Prevention (RP)

RP, first applied in substance use and sex offender treatment, is about recognizing and anticipating precursors of problem behaviours so as to better manage lapses (minor infractions) when they invariably occur (Laws, 1998; Marlatt & Gordon, 1985) with the overall goal of preventing relapse (major infractions). In the VRP, behavioural logs and development of the offence cycle are used to identify internal (e.g., negative feelings, stress, etc.) or external (e.g., interpersonal conflicts) precursors of lapses so that an RP plan can be formulated to prevent lapses and relapses. Reducing the frequency and severity of relapses, a harm reduction approach, rather than complete desistance, is also implicit in the RP approach.

The Transtheoretical Model (TM) of change

The TM (Prochaska & DiClemente, 1984; Prochaska, DiClemente, & Norcross, 1992) is a widely used model to conceptualise behaviour change and improvement. The model proposes that in the change process, individuals progress from the less advanced to more advanced stages of change. The VRP also conceptualises changes similar to that of the TM and the VRS is used to operationalize and measure relevant risk reduction-related behavioural changes and progress through the stages as follows based on staff ratings rather than a questionnaire metric: pre-contemplation (denial of problems), contemplation (acknowledgement of problem but no relevant behavioural changes to reduce risk), preparation (inconsistent or very recent relevant behavioural changes), action (consistent demonstration of relevant behavioural changes) and maintenance (maintaining and generalising relevant behavioural changes). As offenders progress through the stages of change, there should be a corresponding reduction in violence risk (see Lewis et al., 2012; Wong & Gordon, 2006).

Motivational Interviewing (MI)

MI approaches are often used by staff to facilitate the engagement of resistant and unmotivated clients by attending to four key principles: expressing empathy, developing discrepancies, rolling with resistance and supporting self-efficacy (Miller & Rollnick, 2002). Many forensic clients, in particular those with personality disorders, are often resistant to treatment and have high dropout rates. The VRP strongly encourages the use of the MI approach to engage and motivate participants throughout the programme; MI is particularly beneficial during the early stages (i.e., Phase 1) of the VRP.

In sum, the VRP draws from all the above approaches to provide an integrated delivery of treatment to address violence-related criminogenic needs. The VRP also

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underscores the importance of maintaining treatment integrity; in essence how to make 'what works' work in the field by doing what we say we do. These issues are discussed in more detail in the following sections.

Target population

The VRP is designed to address the treatment needs of medium- to high-risk non-sexual violent offenders and forensic patients, including those with psychopathic traits or APD and those with mental health needs who are sufficiently stabilised to participate in the programme. With appropriate modifications, using a format more akin to MST but obviously directed towards adult rather than juvenile offenders, the VRP can be applied to offenders and forensic patients recently released to the community. Some sexual offenders with a history of non-sexual violence can also benefit from participating in the VRP.

Treatment of offenders with psychopathic traits

Many offenders with psychopathic traits are referred for treatment because of their violent behaviours. The Psychopathy Checklist-Revised (PCL-R; Hare, 2003) is the most widely used assessment tool for psychopathy and has two factors and four facets. Factor 1 (F1 and facets 1 and 2) assesses core affective and interpersonal personality traits, such as callousness, shallow affect and manipulativeness, and Factor 2 (F2 and facets 3 and 4) assesses dysfunctional lifestyle and antisocial behaviours such as irresponsibility and criminal versatility. Recent meta-analytic evidence (Yang, Wong, & Coid, 2010) has suggested that F2, the social deviancy factor can significantly predict violence but not so for F1, the affective and interpersonal factor. In reviewing the literature on the causal link between personality disorders and violence, Duggan and Howard (2009) also found no strong evidence to suggest such a link. There are, however, consistent evidence to suggest that F1 characteristics are closely linked to treatment interfering behaviours (e.g. see Wong, Gordon, Gu, Lewis, & Olver, 2012). The evidence suggests that in treating psychopathic offenders to reduce their risk of violence, one should focus on mitigating their violence-linked criminogenic needs as indicated by F2 while carefully managing their treatment interfering behaviours that are linked to F1 characteristics to maintain programme integrity. This conceptualization of the treatment of psychopathy is consistent with what the VRP advocates. For illustration, the criminogenic need profile of a sample of psychopaths was identified using the VRS and compared to that of a representative sample of moderate-to-high-risk male offenders (see Figure 1 and the section on *Treatment targets for violence-prone offenders* for additional discussions of Figure 1).

The VRP recognises the need to make special efforts to engage and motivate offenders with psychopathic traits in treatment as well as to better manage and to reduce treatment interfering behaviours. As discussed earlier, MI approaches ought to be used extensively throughout the programme especially at the early stages of treatment when engagement and the building of working alliances with psychopathic offenders are key and risk of dropout is high (see Wong, forthcoming, for further discussion on these issues).

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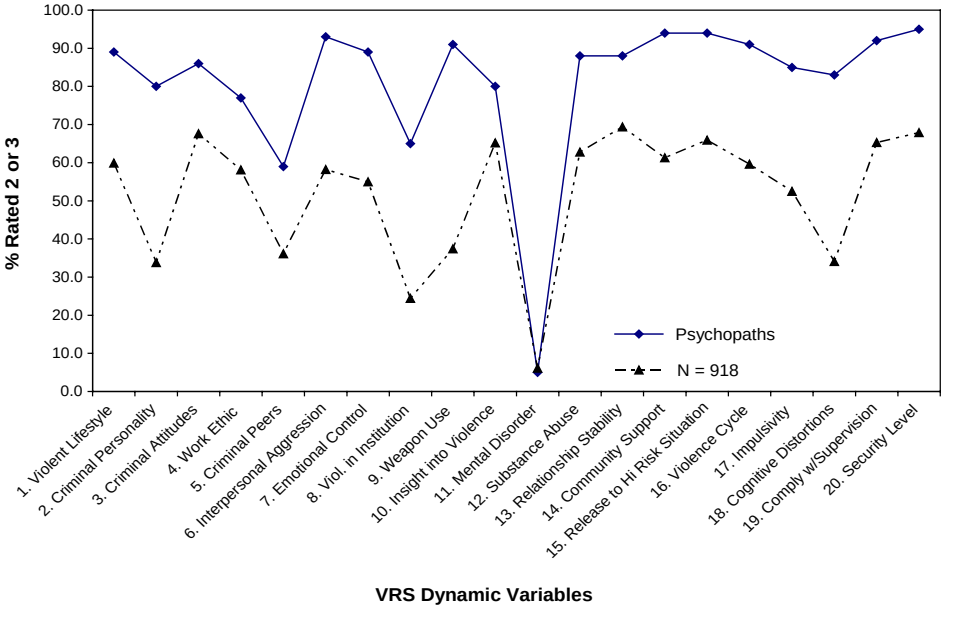

Figure 1. Dynamic risk profile of a general offender and a psychopathic sample assessed using the VRS.
Note: The comparison sample (n = 918) is a sample of federal offenders in Canada. Figure adapted from Wong and Gordon (2006).

Programme design, content and delivery

As described above, the programme uses cognitive-behavioural approaches and social learning principles within a relapse prevention model to assist offenders to make changes. More specifically, the VRP helps offenders identify and modify their cognitions, emotions and behaviours that influence and maintain violence and aggression. Lapses during the programme are used as opportunities to learn to interrupt their dysfunctional cognitive and behavioural patterns linked to violence. Within the VRP, specific cognitive skills (e.g., perception checking, thought stopping and cognitive restructuring), emotional regulation skills (e.g., time outs and stress management skills) and behavioural self-management skills (e.g., de-escalation techniques, effective communication and problem-solving skills) are provided in groups or individually as appropriate. Offenders are then provided with opportunities and strongly encouraged to practice and generalise these skills to their day-to-day functioning and interactions with staff and peers. Where appropriate, interventions that are currently being delivered and are consistent with VRP programme content, such as using Dialectical Behaviour Therapy (Linehan, Armstrong, Suarez, Allmon, & Heard, 1991) to address emotional dis-regulation problems, can be incorporated within the VRP to substitute for or expand on VRP teaching and learning.

Unlike some highly scripted programmes that are quite rigid and inflexible in their delivery, thus assuming that all participants are progressing at about the same rate, progression through the VRP depends on achieving specific goals and objectives, which are assessed based on structured observations using tools provided within the VRP programme manuals. The VRS can be used to assess pre- and post-

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treatment changes in risk level (see next section). The use of a goal-based design of treatment delivery and evaluation provides needed flexibility that is essential when working with a highly heterogeneous group of offenders.

The VRP is delivered in a three-phase format based on an incremental learning approach, that is, learning takes place in small steps and reinforcement of small incremental improvements is key. There are different tasks and objectives for both participants and programme deliverers in each of the three phases. Phase 1 (programme entry) focuses on enhancing the participant's understanding of the origins and maintenance of violence, assessment and identification of behavioural patterns and precursors of violence (i.e., identify treatment targets) and, of key importance, the development of working alliances. MI is particularly important in Phase 1, which may require considerable time investment for more resistant and unmotivated participants. Phase 2 focuses on the acquisition of relevant skills to effectively manage thoughts, feelings and behaviours associated with destructive patterns and cycles linked to violence. During Phase 2, with typically a better established working alliance with staff than in Phase 1, treatment is more closely focused on skills acquisition and the direct addressing of the offender's risk factors linked to violence and aggression, as well as the development of an offence cycle to examine in detail factors linked to criminality and violence. Phase 3 focuses on over-practice of skills learned in Phase 2, formulating a relapse prevention plan, and the generalisation of learned skills across situations to mitigate future risk of violence. Throughout the VRP, naturally occurring or planned activities are used to promote learning, practice and generalisation of all learning to address problems and challenges as they occur in day-to-day living and in future hypothetical high-risk situations: a very important point that will be further elaborated later. Both the *Facilitator's Manual* and the *Participant's Workbook* are organised into Phases 1–3 to provide a shared VRP pathway for both staff and participants. Activities in the three Phases build on one another and can overlap as the individual progresses through the programme.

Ideally, coming to the end of Phase 3 signals the completion of all aspects of the VRP but, in practice, the offender may need to leave the programme earlier because of various programme or non-programme-related reasons. Such arrangements are appropriate if the receiving agencies (such as lower security institutions or community service agencies) can continue with providing necessary services. There can be a myriad of reasons for treatment termination, a very important issue that, unfortunately, cannot be addressed in detail here because of space limitation (but see Beyko & Wong, 2005; Olver & Wong, 2011; Olver, Stockdale, & Wormith, 2011). The VRP can be run as a closed programme with all intakes admitted at about the same time. However, it is sufficiently flexible to accommodate some participants taking short 'breaks' from the programme or being re-admitted for a 'refresher' that can be fast-tracked through the programme or even admission at various points in the programme.

Assessment of pre-treatment risk, identification of treatment targets and post-treatment changes in risk

The VRS, a valid and reliable dynamic risk assessment tool (VRS; Wong & Gordon, 1999–2003, 2006), is an integral part of the VRP. The VRS, which has 6 static and 20 dynamic risk predictors, is used to assess the risk of violence (risk principle), treatment targets (need principle), treatment readiness (responsivity principle) and to

measure risk change; recognising risk is dynamic. Staff ratings of the dynamic predictors (0, 1, 2, 3) indicate the relative strength of association between the predictor (e.g., as criminal attitudes) and violence with ratings of 2 and 3 indicating a moderate or strong association, respectively, and therefore, relevant treatment targets. The individual's readiness for treatment for each treatment target is then assessed by staff using a modified version of the Stage of Change Model (Prochaska et al., 1992) to establish a pre-treatment baseline measure (e.g., at the contemplation stage pre-treatment). At the conclusion of treatment, the Stage of Change for each treatment target is re-assessed (e.g., now at the action stage post-treatment). Risk reduction is indicated by progression through the stages of change (e.g., from contemplation to action) and is translated into a quantitative reduction in violence risk. The pre-treatment stage of change can be used to guide the selection of appropriate intervention strategies matched to the individual's ability and the level of treatment readiness: the post-treatment risk level and the stage of change can also be used to guide post-treatment risk management (Wong & Gordon, 2004).

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Treatment targets for violence-prone offenders

The profiles of treatment targets of 918 medium- to high-risk non-sexual Canadian federal offenders[3] and 65 psychopaths (PCL-R > 25) assessed using VRS dynamic predictors (shown on the *x*-axis) are presented in Figure 1. The two profiles show the percentages of offenders in the two samples with each of the treatment targets (dynamic predictors rated 2 or 3) in question. Other than the mental disorder predictor,[4] in the general offender sample, there is a 30–65% prevalence of the treatment targets identified by the VRS. As expected, the psychopathic sample has a much higher prevalence of the same treatment targets. Obviously, not all potential treatment targets can be identified by the VRS; additional clinical investigations should be undertaken as required.

Case formulation

The main objective of case formulation is to abstract key features of a case to guide the selection of the most effective treatment for each individual (Haynes & O'Brien, 2000; Sturmey, 2010). However, research on forensic case formulation is very limited and reliability studies of non-forensic case formulation are also inconsistent (Sturmey, 2010). Until forensic case formulations are better researched, dynamic risk assessment tools such as the VRS can be used as an aid to systematically identify treatment targets. For offenders with complex or highly unusual problems, that is, the outliers of the general offender population, general clinical case formulation guided by a dynamic risk assessment tool may assist in identifying treatment needs.

From talking the talk to walking the walk

The breaking of behavioural patterns associated with aggression and violence are highlighted and addressed throughout the programme. The incremental learning principle of strengthening small improvements must take place both inside and outside the formal treatment sessions. In essence, a central VRP principle is that ideally, treatment should take place 24 hours a day and 7 days a week and not just

within formal treatment groups or individual therapy sessions. Observations of the behaviours of offenders in informal day-to-day contacts and interactions with all staff and peers are crucial in assessing the veracity of apparent behavioural changes as allied staff often have more opportunities to observe offenders relative to core treatment staff. As such, the VRP recognises the important roles of both the clinical/treatment and the allied staff in monitoring and addressing the offender's negative behaviours and in facilitating and rewarding positive behaviours. It is recognised that staff have their prescribed roles and are different in their training and experience. Nonetheless, all staff should work as a coherent team towards a common goal of violence reduction rather than in silos, as the latter can lead to giving offenders contradictory messages, staff splitting, or worse, undermining one another's efforts.

Offence Analogue Behaviours (OABs) are defined as offenders' negative offence-linked behaviours such as aggression and intimidation, while Offence Replacement Behaviours (ORBs) are the positive, violence-reducing behaviours such as assertiveness and conflict resolution skills (see Gordon & Wong, 2010). An OAB and ORB Guide has been developed to assist staff in monitoring and addressing these behaviours. The Guide helps staff identify, address and document the offender's everyday OABs that are linked to criminogenic factors identified by the VRS. Similarly, ORBs are identified, reinforced and documented. The gradual replacement of the 'bad' by the 'good' behaviours should be a valid and objective indication of violence reduction related treatment improvements.

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Delivery format

The VRP is primarily designed for delivery in a group format supplemented by individual work when necessary. However, the VRP can also be delivered in a one-on-one format to participants who are not yet amenable to group programming, such as those who are behaviourally unstable, rejected by the group, held in isolation, have intermittent acute mental health problems or are cognitively compromised: all of which are specific responsivity issues. In line with the responsivity principle, the VRP is flexible enough to accommodate these issues as it is organised in a goal oriented rather than a session-oriented format: in short, many roads can lead to Rome.

In sum, the VRP is designed to meet the treatment needs of a heterogeneous group of violence-prone forensic clients and can be implemented in a variety of mental health and prison settings. Individual or group delivery length is based on client responsivity. For example, individuals with attentional or cognitive deficits may require shorter but higher frequency sessions.

Staff training

A treatment programme is only as good as the programme staff! Both initial and in-service staff training is vital to implement and sustain the VRP. The VRP was developed based on psychological principles, thus, to maintain programme integrity, that is, doing what we say we do, it is best led and supervised by an appropriately trained and experienced mental health professional, such as a psychologist. It is desirable to have programme staff who are human service oriented and informed about clinical or psychological principles. Multidisciplinary treatment teams that can work collaboratively towards VRP objectives can greatly enrich the programme.

Careful staff selection based on local needs and availability is key; these issues are discussed in more details in the VRP *Programme Management Manual*. Where feasible, a 24-hour-a-day and 7-days-a-week treatment approach is highly desirable. VRP staff training entails training both core clinical/treatment staff as well as allied staff (as much as possible), who will likely have significant meaningful contacts with the treatment participants. The type of training is contingent on the role and type of contacts staff are expected to have with programme participants, ranging from brief VRP awareness training to more intensive facilitator training. Other than programme content-specific training, the use of social learning approaches such as the modelling of pro-social behaviours, the use of reward and punishment contingencies and MI approaches are important. Further realignment of the VRP to local needs, resources and organisational structures, is best accomplished through additional consultation and staff training undertakings prior to the formal implementation of the programme. As the saying goes: prepare, prepare, prepare!

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VRP implementation

The VRP is designed such that the programme can be implemented in a variety of settings. Effective implementation depends on a thorough appraisal of the treatment environment, target population, resources, staffing, existing treatment interventions and so forth that may be unique to the setting. A *VRP Implementation Checklist* has been developed to guide implementation, along with a series of *Programme manuals and materials*; see Appendix 1. For example, programme duration and the amount of group vs. individual work would vary with staffing levels. The overall goal is to ensure core programme integrity is maintained (see Livesley, 2007; Wong, forthcoming).

Length of programme

The VRP is not organised in a highly scripted format with a defined number of 'lessons' to be covered within a fixed time period because of participants' responsivity issues. It is also recognised that different organisations may have different treatment objectives that may require varying comprehensiveness or intensity of treatment. Programme length is also contingent on staffing levels, operational or security issues that may limit access to the programme, as well as the need to attend to certain specific programme objectives such as facilitating community release or reduced security. These are participant and site-specific variables that are best dealt with on a case-by-case basis. Thus, it is difficult to specify a priori the programme length. Past research has shown that significant reductions in violent reoffending and institutional misconduct can be demonstrated after participating in a programme of about eight months in duration (see section on VRP outcome evaluations).

A synopsis of outcome evaluations of VRP

Most outcome research was carried out based on the ABC programme because of its more extensive history but should be generalizable to the VRP given the overall similarity of the two programmes and target population. A sample of 31 offenders who were residing in a super-maximum security prison because they had committed very serious violent offences such as murders and hostage taking during their

incarceration were admitted to the ABC Programme for treatment, with the aim of reintegrating them to a regular lower security prison post-treatment. Over 80% of the offenders were reintegrated successfully into a low security facility without returning to the super-maximum institutions within a follow-up period of over 20 months. They also have lower institutional offence rates post-reintegration compared to pre-reintegration (Wong et al., 2005).

A number of officially identified gang members who had committed serious offences were treated in the ABC programme. A case matched control design was used to compare recidivism in the community of a treated gang group and matched controls with little or no treatment after about 24 months follow-up. Members of both groups ($n = 40$, respectively) were about 24 years of age, with about 20 criminal convictions pre-treatment, of comparable recidivism risk (assessed with General Statistical Information on Recidivism tool; Bonta, Harman, Han, & Cormier, 1996) and were serving, on average, six-year sentences. After being in treatment for about eight months, the treated gang group had significantly lower incidence of court adjudicated violent and non-violent recidivism, significantly fewer major institutional misconducts and, if they had recidivated violently, committed significantly less serious violent offences than the matched controls (Di Placido, Simon, Witte, Gu, & Wong, 2006).

A follow-up study extended the above findings by assessing the impact of treatment on institutional security placements, segregation time and institutional misconduct of gang-affiliated offenders. Gang members ($n = 68$) who completed treatment were compared to a matched group ($n = 56$) with the same demographic and criminological characteristics but had received significantly less treatment. Members of both groups had extensive criminal, violent and incarceration histories with no significant difference between groups. Almost 90% of both groups were also diagnosed with substance use disorder and similarly about 75% with APD. While there were minimal differences in their security placement in the three years pre-treatment, in the three years post-treatment, treatment completers were housed in lower security levels, received less segregation time and had less serious institutional offences than non-completers (Brulotte, Di Placido, Gu, Witte, & Wong, in preparation).

In another treatment outcome study (Wong et al., 2012), 34 treated psychopaths were matched with 34 untreated controls (mean PCL-R ratings of 28.6 and 28.0, respectively). The two groups were matched on race, age, PCL-R, F1 and F2 scores and followed up in the community (both for a mean of 7.4 years). All were high-risk violence-prone offenders with significant psychopathic traits. On follow-up, the treated and matched group were equivalent in the number of violent, and non-violent re-convictions and sentencing dates, as well as time to first re-conviction: although the trends were in the expected direction, that is, better performance for the treated compared to the match group. However, compared to the untreated group, the treated group had a significantly less serious re-offences as indicated by the significantly shorter aggregated sentences they received (27.7 vs. 56.4 months, respectively, $p < .05$). Sentence length has been shown to be a reasonable proxy for the level of violence or severity of offending (see Di Placido et al., 2006). Treatment appeared to reduce the degree of violence or severity of reoffending: a harm reduction effect for these high risk psychopathic offenders. For the highly psychopathic offenders, eight months of treatment is probably not long enough to produce the optimal outcome. Despite the less than optimal treatment 'dosage', the results support the contention that risk reduction programmes such as the VRP can

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reduce violent recidivism, even among particularly high-risk individuals and that treatment definitely did not make them worse (see Rice, Harris, & Comier, 1992).

A sample of 150 male mostly high-risk violent offenders with significant psychopathic traits (mean VRS score = 60; about 1 *sd* above the normative sample mean; mean PCL-R = 26, 64% > 25) was treated in the ABC programme for about eight months. They were released and followed up for approximately five years in the community to determine if risk reductions observed in the treatment programme were linked to reduction in violent recidivism. The amount of treatment improvement as indicated by risk reduction assessed with the VRS were linked to the amount of reduction in violence recidivism in the community (Lewis et al., 2012; Olver, Lewis, & Wong, 2012). Such changes were still evident after controlling for psychopathy and recidivism risk.

The VRP has been implemented in a number of prison and forensic mental health hospitals in the UK. An independent evaluation of the efficacy of a small pilot VRP ($n = 4$) conducted at a super-maximum prison was commissioned and reported (see Fylan & Clarke, 2006). All four prisoners who participated in the VRP were extremely difficult to manage offenders who had to be kept in isolation as they had committed very violent acts while incarcerated, such as homicide involving prison officers or fellow inmates. The small sample size precluded quantitative analyses of the data. However, the authors of the report did note prisoners' behaviour showed marked improvement based on staff observations – violent behaviour had decreased and inter-personal skills had improved – and noted that such observations appeared to have been maintained in less supportive and non-treatment oriented environments. Obviously, this can only be deemed a pilot programme with such a small sample size.

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Summary

The VRP is designed to provide treatment to forensic service users to reduce the risk of violent recidivism and institutional misconduct. The VRP was designed by integrating a number of different theoretically derived and evidence-based approaches in offender rehabilitation, together with the lessons learnt by the authors in its development and implementation, into a (hopefully) coherent and understandable whole. Outcome evaluations indicate that treatment participants show reductions in violent recidivism and institutional misconduct even when offenders have significant psychopathic personality traits. By helping these violence-prone individuals manage their lives better, there should be a corresponding improvement in their general well-being and in their impact on people they come into contact with, not to mention significant savings in management and incarceration costs. It is our hope that treatment programmes such as the VRP can be accepted and implemented by correctional authorities as being just as essential for good correctional practice as is good security.

Future directions

A randomised controlled trial of the VRP is highly desirable but, understandably, difficult and costly to conduct. A second line of inquiry is to identify the necessary and sufficient components of the VRP for the different client groups with a view to delivering only what is necessary to effect positive change and violence reduction. Under development is a short version of the VRP (the VRP-SV) appropriate for

moderate risk offenders. It is less intensive and requires less time to complete, and is therefore likely applicable to a wider range of offenders than the VRP full version.

Research since the 1970s has provided a reasonably good empirical understanding of the risk and need domains of the RNR. No doubt more research is required but, at least, there is more clarity as to what and where to look. The responsivity prong of the triad with respect to offenders and staff and the many obstacles in maintaining programme integrity are, to us, the main challenges for the future. More qualitative and quantitative research is needed to unravel these issues.

Notes

1. The term offender is used generically to indicate individuals held under the criminal justice or forensic mental health jurisdictions.
2. Seriously mentally disordered or learning disabled offenders, rather than personality disorder offenders, have been given priority to treatment at the Regional Psychiatric Centre.
3. They have a mean 2.58 violent and 15.59 non-violent convictions over a 10-year criminal career.
4. This sample consisted of very few offenders with major mental illnesses that are associated with violence and thus the low endorsement of the Mental Disorder item.

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Appendix 1
Programme manuals and materials

The following programme materials have been developed for the VRP:

VRP Implementation Checklist is a self-assessment tool used to assess the organisation's readiness for programme implementation and delivery such as considerations regarding human resource, the physical environment, staff training and data collection procedures etc.

Programme Management Manual (Wong, 1999) provides the rationale and theoretical bases of the programme, describes the programme design and addresses the management issues in the programme implementation, such as staff and resource considerations.

Facilitator's Manual (Gordon & Wong, 1999–2009) guides the programme facilitator(s) on the delivery of the intervention by specifying the rationale, objectives of the interventions, group work and assignments for each of the VRP modules etc. Also included in the manual are handouts to illustrate and supplement the session content as well as session and Phase evaluation forms.

Supplementary Facilitator's Manual (Gordon, 2009) provides additional materials, activities and handouts to extend and supplement the Facilitator's Manual.

Participant's Workbook (Wong, 1999) which parallels the *Facilitator's Manual* in topics covered and is written in a simple, user-friendly language (suitable for those with only five to six years of schooling) to facilitate participants' comprehension of the programme material.

Offence Analogue Behaviour (OAB) and Offence Replacement Behaviour (ORB) Rating Guide (Gordon & Wong, 2011) was developed to assist staff in identifying, monitoring and documenting OABs and ORBs.

Violence Risk Scale (Wong & Gordon, 1999–2003, 2006) is an integral part of the VRP and is used as described above.

VRsoft©: an Access® based software programme has been developed for the collection of VRS and VRP related data.