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### High Risk, Not Hopeless: Correctional Intervention For People At Risk For Violence

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# HIGH RISK, NOT HOPELESS: CORRECTIONAL INTERVENTION FOR PEOPLE AT RISK FOR VIOLENCE

JENNIFER L. SKEEM\* & DEVON L. L. POLASCHEK\*\*

*Across the United States, jurisdictions are working to reduce absurdly high incarceration rates without jeopardizing historically low crime rates. Well-validated risk assessment can identify people at low risk who can be managed safely in the community. But what about high-risk people? In this Article, we synthesize research on effective ways to identify and reduce risk of reoffending among people at high risk of recidivism, including people with psychopathic traits. To maximize the impact of criminal justice reform, we recommend that policymakers prioritize high risk clients for treatment, provide treatments most likely to work with these clients, and reframe incarceration as an opportunity for excellent service provision.*

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## I. INTRODUCTION

This is an exciting period of criminal justice reform in the United States.<sup>1</sup> There has been increased support for alternatives to incarceration, so long as historically low crime rates are not jeopardized. After a distinctly punitive period, policymakers have moderated their approach—becoming more pragmatic and increasingly focused on the mechanisms of crime reduction. This shift has largely been driven by the limited effectiveness and high cost of incarceration; the “fiscal condition of most American jurisdictions is so dire that maintaining what is by international standards an absurdly bloated prison population is simply not a sustainable option.”<sup>2</sup>

Although the shift is driven by fiscal and practical urgency, its form is being shaped by research on the prediction and prevention of criminal behavior. First, structured risk assessment tools that have been shown to predict recidivism are becoming an essential component of sanctioning and corrections. These tools are increasingly being used to identify low risk offenders to release; leaving higher-risk offenders to supervise, treat, or incarcerate.<sup>3</sup> Second, stakeholders have become keenly interested in implementing evidence-based treatment programs, services, and policies that demonstrably improve public safety.<sup>4</sup> At one end of the risk spectrum, then, the focus is on safely diverting low risk people from incarceration and heavy surveillance; at the other, the focus should be on effectively supervising and treating high-risk people to reduce re-offending.

In this Article, we summarize research on effective intervention with individuals at high risk of violence and other criminal behavior—and, therefore, of further involvement in the criminal justice system.<sup>5</sup> Although not featured

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1. The context of criminal justice reform described here parallels and earlier context of juvenile justice reform similarly described by Jennifer L. Skeem, Elizabeth Scott & Edward P. Mulvey, *Justice Policy Reform for High-Risk Juveniles: Using Science to Achieve Large-Scale Crime Reduction*, 10 ANN. REV. CLINICAL PSYCHOL. 709 (2014).

2. *Id.* at 711; John Monahan & Jennifer L. Skeem, *Risk Redux: The Resurgence of Risk Assessment in Criminal Sanctioning*, 26 FED. SENT’G REP. 158, 158 (2014).

3. Monahan & Skeem, *supra* note 2, at 158–62.

4. First Step Act of 2018, 18 U.S.C. §§ 3631–35 (2018); STEPHANIE LEE, STEVE AOS, ELIZABETH DRAKE, ANNIE PENNUCCI, MARNA MILLER, & LAURIE ANDERSON, WASH. ST. INST. FOR PUB. POLICY, RETURN ON INVESTMENT: EVIDENCE-BASED OPTIONS TO IMPROVE STATEWIDE OUTCOMES 1 (2012), [http://www.wsipp.wa.gov/ReportFile/1102/Wsipp\\_Return-on-Investment-Evidence-Based-Options-to-Improve-Statewide-Outcomes-April-2012-Update\\_Full-Report.pdf](http://www.wsipp.wa.gov/ReportFile/1102/Wsipp_Return-on-Investment-Evidence-Based-Options-to-Improve-Statewide-Outcomes-April-2012-Update_Full-Report.pdf) [<https://perma.cc/U2TY-3ZYS>].

5. For more detailed versions of such research, see Devon L. L. Polaschek & Jennifer L. Skeem, *Treatment of Adults and Juveniles with Psychopathy*, in HANDBOOK OF PSYCHOPATHY 710, 712 (C. Patrick ed., 2d ed. 2018); Skeem, Scott, & Mulvey, *supra* note 1.

in current reform discourse, an important component to maximizing public safety is to target and intensively treat the subpopulation where reoffending is most concentrated. A small group of individuals is disproportionately involved in criminal behavior.<sup>6</sup> If science can be applied to effect behavior change for these “high-risk” individuals, many crimes would be prevented.

We define high-risk adults as repeat and serious offenders, given evidence that those who offend frequently, tend to commit a broad range of crimes that include violence.<sup>7</sup> We define “high-risk” as an aggregate phenomenon, reflecting a pattern over time, because criminal behavior is multi-determined by individual and contextual factors,<sup>8</sup> and people with multiple risk factors are at greatest risk of offending.<sup>9</sup> In our view, high-risk people are defined by a greater range of more pronounced risk factors than their lower risk counterparts, more than by a unique causal process.<sup>10</sup> These people differ from others more in degree than in kind.

For the purposes of this Article, our definition of high-risk adults explicitly encompasses, but is not limited to, people with pronounced psychopathic traits. We do not equate the construct of psychopathy itself with criminal deviancy,<sup>11</sup> but instead recognize that psychopathy, *as typically measured* in criminal justice contexts, overlaps heavily with criminality. The leading measure of psychopathy, the Psychopathy Checklist Revised (PCL-R) measures both

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6. See Örjan Falk, Märta Wallinius, Sebastian Lundström, Thomas Frisell, Henrik Anckarsäter, & Nóra Kerekes, *The 1% of the Population Accountable for 63% of all Violent Crime Convictions*, SOC. PSYCHIATRY & PSYCHIATRIC EPIDEMIOLOGY (Oct. 31, 2013) <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3969807/> [<https://perma.cc/Z3AM-5NBD>]; Skeem, Scott, & Mulvey, *supra* note 1, at 711.

7. Deborah M. Capaldi & Gerald R. Patterson, *Can Violent Offenders Be Distinguished From Frequent Offenders: Prediction From Childhood to Adolescence*, 33 J. RES. CRIME & DELINQ. 206, 206 (1996); Paul Nieuwbeerta, Arjan A.J. Blokland, Alex R. Piquero & Gary Sweeten, *A Life-Course Analysis of Offense Specialization Across Age: Introducing a New Method for Studying Individual Specialization Over the Life Course*, 57 CRIME & DELINQ. 3, 4 (2011).

8. See Sara R. Jaffee & Candice L. Odgers, *Conduct Disorder Across the Life Course*, in A LIFE APPROACH TO MENTAL DISORDERS 165, 165, 168–69 (Karestan C. Koenen, Sasha Rudenstine, Ezra Susser, & Sandro Galea eds., 2014).

9. Todd I. Herrenkohl, Eugene Maguin, Karl G. Hill, J. David Hawkins, Robert D. Abbott, & Richard F. Catalano, *Developmental Risk Factors for Youth Violence*, 26 J. ADOLESCENT HEALTH 176, 182 (2000); Robert J. Sampson & John H. Laub, *Life Course Desisters? Trajectories of Crime Among Delinquent Boys Followed to Age 70*, 41 CRIMINOLOGY 555, 571–75 (2003).

10. For a review of taxonic studies suggesting there is no natural class of psychopathic, life course persistent, or other high risk offender, see Skeem, Scott, & Mulvey, *supra* note 1, at 719–23.

11. See Jennifer L. Skeem & David J. Cooke, *Is Criminal Behavior a Central Component of Psychopathy? Conceptual Directions for Resolving the Debate*, 22 PSYCHOL. ASSESSMENT 433 (2010).

general antisocial traits and behavior (Factor 2) and interpersonal and affective features of emotional detachment that are more specific to psychopathy (Factor 1).<sup>12</sup> As explained later,<sup>13</sup> scores on the PCL-R are strongly associated with scores on purpose-built risk assessment tools, and tend to predict violent recidivism about as strongly as these purpose-built tools.

In today's rapidly changing policy context, high-risk offenders present a conundrum. On the one hand, research indicates that these are precisely the individuals to treat intensively, to maximize crime reduction.<sup>14</sup> Correctional treatment yields the largest reductions in criminal behavior when it is provided to the highest risk offenders.<sup>15</sup> On the other hand, there are real and imagined barriers to providing high-risk people with intensive intervention. These people are often assumed to be the most hardened and least likely to respond to treatment.<sup>16</sup> This is particularly true of people with psychopathic traits. Hervey Cleckley, the progenitor of modern conceptions of psychopathy, noted "we do not at present have any kind of psychotherapy that can be relied upon to change the psychopath fundamentally."<sup>17</sup> Assumptions aside, high-risk individuals often commit serious crimes deemed worthy of serious punishment, and they are relatively likely to re-offend. For these reasons, they are often sentenced to prisons where evidence-based treatment is nonexistent or, at best, in very short supply.<sup>18</sup> These practices may effectively exclude high-risk people from

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12. ROBERT D. HARE, THE HARE PSYCHOPATHY CHECKLIST-REVISED TECHNICAL MANUAL (2d ed. 2003).

13. *Infra* Part III.

14. See Devon L. L. Polaschek, Julia A. Yesberg, Rebecca K. Bell, Allannah R. Casey, & Sophie R. Dickson, *Intensive Psychological Treatment of High-Risk Violent Offenders: Outcomes and Pre-Release Mechanisms*, 22 PSYCHOL. CRIME & L. 344, 348, 353, 359 (2016).

15. D.A. Andrews, James Bonta, & R.D. Hoge, *Classification for Effective Rehabilitation: Rediscovering Psychology*, 17 CRIM. JUST. & BEHAV. 19, 30 (1990); Mark W. Lipsey, *The Primary Factors that Characterize Effective Interventions with Juvenile Offenders: A Meta-Analytic Overview*, 4 VICTIMS & OFFENDERS 124, 126, 138 (2009).

16. See Mark W. Lipsey, David B. Wilson, & Lynn Cothorn, *Effective Intervention for Serious Juvenile Offenders*, JUV. JUST. BULL. 6 (Apr. 2000), <https://www.ncjrs.gov/pdffiles1/ojdp/181201.pdf> [<https://perma.cc/R8ZW-74XG>].

17. HERVEY CLECKLEY, THE MASK OF SANITY 439 (5th ed. 1976).

18. The following show evidence that correctional program integrity is often limited and that the treatment needs of people in the system often go unmet. See, e.g., GRANT DUWE, U.S. DEP'T OF JUSTICE, THE USE AND IMPACT OF CORRECTIONAL PROGRAMMING FOR INMATES ON PRE- AND POST-RELEASE OUTCOMES 1, 4 (2017), <https://www.ncjrs.gov/pdffiles1/nij/250476.pdf>. [<https://perma.cc/YE2G-BP2W>]; Christopher T. Lowencamp, Edward J. Latessa, & Paula Smith, *Does Correctional Program Quality Really Matter? The Impact of Adhering to the Principles of Effective Intervention*, 5 CRIMINOLOGY & PUB. POL'Y 575, 576-77, 588, 590 (2006); Robert Weisberg & Joan

intensive treatment that would more effectively protect public safety. Such practices are concerning, given that virtually all prisoners are released into the community eventually.<sup>19</sup>

In this Article, we attempt to make progress toward resolving this conundrum by examining how research can inform intervention for high-risk adults—particularly those with psychopathic traits. We begin by describing treatment principles and programs that reduce recidivism for high-risk offenders in general in Part II, before shifting to evidence on the treatability of high-risk offenders with psychopathic traits specifically in Part III. These two populations overlap heavily, given that people who obtain high scores on general risk assessment tools typically obtain high scores on the leading measure of psychopathy, as well.<sup>20</sup> We then address difficulties in the *process* of treating high risk and psychopathic individuals, which has been a formidable barrier to treatment that must be addressed in Part IV. We conclude by highlighting how intervention and policy for this group can be informed by science in Part IV. Our thesis is that high-risk and psychopathic individuals should be deliberately engaged in structured and well-implemented treatment programs that model anticriminal attitudes and cognition, improve emotion and behavior regulation, and instill problem solving skills to reduce recidivism. These programs should feature prominently in incarceration and re-entry services for this group.

## II. EFFECTIVE TREATMENT OF HIGH-RISK OFFENDERS

Prior to the late 1980s, the dominant view about treatment was that “nothing worked” to reduce recidivism among people convicted of crimes.<sup>21</sup> Over the past quarter-century, over fifty meta-analyses of hundreds of controlled intervention studies with offenders have identified elements of treatment that reduce recidivism.<sup>22</sup> Based on findings from these studies, offenders in general have begun to be regarded as treatable, with a steady growth of

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Petersilia, *The Dangers of Pyrrhic Victories Against Mass Incarceration*, 139 *DAEDELUS* 124, 125, 129–31 (2010).

19. TIMOTHY A. HUGHES, DORIS JAMES WILSON, & ALLEN J. BECK, BUREAU OF JUSTICE STATISTICS, U.S. DEPT OF JUSTICE, *TRENDS IN STATE PAROLE, 1990–2000*, at 4 (2001), <https://www.bjs.gov/content/pub/pdf/tsp00.pdf> [<https://perma.cc/Y44N-9NR9>].

20. See *infra* note 37 and accompanying text.

21. D. A. ANDREWS & JAMES BONTA, *THE PSYCHOLOGY OF CRIMINAL CONDUCT* 351–56 (Ellen S. Boyne ed., 5th ed. 2010).

22. See Clive R. Hollin, *What is Cognitive Behavioral Therapy (CBT) With Offenders?*, in *THE WILEY INTERNATIONAL HANDBOOK OF CORRECTIONAL PSYCHOLOGY* 627 (Devon L. L. Polaschek, Andrew Day, & Clive R. Hollin eds., 2019).

methodologically sound evaluation research demonstrating that criminal risk can be reduced with effective treatments.

In recent years, this literature has been dominated by offending-focused cognitive-behavioral group-based interventions or “CBT.” CBT explicitly targets strong risk factors like criminal attitudes, or distorted evaluative beliefs and biased thinking patterns that contribute to criminal behavior, such as misperceiving benign situations as threats.<sup>23</sup> CBT provides opportunities for acquiring and practicing pro-social skills for interpersonal interaction, self-management, and problem-solving.<sup>24</sup> It is structured, applicable in groups, and can be monitored for implementation fidelity.<sup>25</sup>

In high-quality meta-analyses that focus on mixed samples of offenders—not necessarily high-risk offenders—CBT programs achieve the largest and most consistent effect sizes, reducing recidivism by 25% (on average) to 50% (in well-implemented configurations).<sup>26</sup> Concretely, a 50% reduction in recidivism translates to recidivism rates of 40% in control conditions versus 19% in well-implemented CBT conditions.<sup>27</sup> No meaningful differences in effectiveness have been found among various brands of CBT (generic, specific proprietary brands, etc.).<sup>28</sup> Across brands of CBT, the most effective versions target multiple risk factors for recidivism and do so in a multimodal format. For example, these versions are aimed at changing people’s cognitive (e.g., moral values), emotional (e.g., anger control), and behavioral (e.g., interpersonal skill streaming) patterns in a prosocial direction.<sup>29</sup> To be effective, CBT programs must be implemented with high levels of treatment integrity—meaning they are delivered by trained staff and are monitored for their fidelity to program manuals over time.<sup>30</sup> It does not take a brand name program to reduce recidivism, but rather a program that is “well-made” (with a theory of change, multiple specific targets, etc.) and well-implemented.

But what is the relevance of these findings to high-risk offenders? Meta-analytic findings on what works extend beyond CBT programs—and specify principles that characterize a broader array of effective correctional treatment

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23. *Id.* at 624–25.

24. *Id.* at 626.

25. *Id.* at 627.

26. Mark W. Lipsey, Nana A. Landenberger, & Sandra J. Wilson, *Effects of Cognitive-Behavioral Programs for Criminal Offenders*, 3 *CAMPBELL SYSTEMATIC REVIEWS* 1, 21 (2007).

27. *Id.* at 20.

28. *Id.* at 18.

29. CLIVE R. HOLLIN, *What is Cognitive Behavioral Therapy (CBT) With Offenders?*, in *THE WILEY INTERNATIONAL HANDBOOK OF CORRECTIONAL PSYCHOLOGY*, *supra* note 22, at 626.

30. Lipsey, Landenberger, & Wilson, *supra* note 26, at 22.

services. Bonta and Andrews have packed these principles into what is now known as the RNR (risk-need-responsivity) model of offender treatment.<sup>31</sup> Put simply, treatment programs for offenders yield the largest reductions in criminal behavior when they (a) target relatively intensive services toward higher risk offenders (the *Risk* principle), leaving lower risk offenders with little or no therapeutic attention; (b) focus treatment services on changing empirically documented risk factors for crime (e.g., criminal attitudes, substance abuse, impulsivity), termed “criminogenic needs” (the *Need* principle); and (c) deliver interventions in a manner that maximizes offenders’ engagement in the treatment process and ability to use the treatment services to make changes (the *Responsivity* principle).<sup>32</sup>

According to empirical evidence underpinning the RNR model, warm, enthusiastic, respectful, well-trained, and well-supervised therapists spend considerable time using the most effective cognitive and behavioral techniques to work with higher-risk offenders to change criminal risk factors.<sup>33</sup> When clients demonstrate characteristics that challenge engagement and change—and if higher-risk clients have been chosen, they usually will—these therapists endeavor to work *with* the difficult characteristics (e.g., hostility, poor motivation, poor learning), rather than taking them as indicators that the client is not suitable for treatment.<sup>34</sup> This attitude about “difficult clients” is important because a number of these same characteristics that disrupt the process of treatment also contribute to offense risk, making the characteristics more prominent in the very clients who are the highest priority for treatment.<sup>35</sup>

In general, the more that programs—including CBT programs—adhere to the principles of risk, need, and responsivity, the larger the reductions overall in reconviction risk.<sup>36</sup> The impact on crime for those adhering to all three principles is modest but important, with reported effect sizes ranging from 0.15 to 0.34.<sup>37</sup> An effect size of even 0.15 is notable. For example, if 50% of untreated offenders had been reconvicted at follow-up, the corresponding rate for treated offenders given a 0.15 effect would be 35%—a relative reduction of more than 30%.

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31. ANDREWS & BONTA, *supra* note 21, at 47.

32. *Id.* at 47–50; Andrews, Bonta, & Hoge, *supra* note 15 at 23–24, 31–32, 35.

33. ANDREWS & BONTA, *supra* note 21, at 47–50.

34. *Id.* at 55.

35. *Id.*

36. Lipsey, *supra* note 15, at 126.

37. ANDREWS & BONTA, *supra* note 21, at 395–96.



## III. EFFECTIVE TREATMENT OF PSYCHOPATHIC OFFENDERS

The findings described in the previous Section are relevant not only to high risk individuals, but also to those with high scores on the measure of psychopathy that is most often used in criminal justice settings.<sup>38</sup> As suggested earlier,<sup>39</sup> PCL-R scores are broadly indicative of the level of criminal risk the offender poses.<sup>40</sup> Although designed to measure and diagnose psychopathy, the PCL-R's popularity with adult offenders is especially due to its utility in assessing risk of violent and other criminal behavior.<sup>41</sup> The accuracy of PCL-R scores in predicting recidivism is equal to, or slightly lower than, that of purpose-built risk assessment inventories that do not index psychopathy at all.<sup>42</sup> So, in accordance with the risk principle,<sup>43</sup> high-PCL-scoring clients are high-risk offenders, and should be among those most highly prioritized for intensive intervention, rather than being considered ineligible for intervention because they are difficult to treat.<sup>44</sup>

Interventions most likely to be effective for psychopathic offenders include CBT and other services that target the individuals' variable risk factors for recidivism, ideally following broader principles in the RNR model. Evidence for this proposition is mostly indirect, however, because few studies have directly examined the impact of CBT or other evidence-based programs on recidivism for individuals with psychopathy.

In fact, only four studies of adult offenders have examined directly whether treatment reduces violent and other criminal behavior by psychopathic

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38. The leading measure of psychopathy is PCL-R. See HARE, *supra* note 12.

39. *Infra* Part III; see *supra* note 12 and accompanying text.

40. Kevin S. Douglas, Gina M. Vincent, & John F. Edens, *Risk for Criminal Recidivism: The Role of Psychopathy*, in HANDBOOK OF PSYCHOTHERAPY 682 (Christopher J. Patrick ed. 2018).

41. Jennifer L. Skeem, Devon L. L. Polaschek, Christopher J. Patrick, & Scott O. Lilienfeld, *Psychopathic Personality: Bridging the Gap Between Scientific Evidence and Public Policy*, 12 PSYCHOL. SCI. PUB. INT. 95, 97, 127 (2011).

42. See Jay P. Singh, Martin Grann, & Seena Fazel, *A Comparative Study of Violence Risk Assessment Tools: A Systematic Review and Metaregression Analysis of 68 Studies Involving 25,980 Participants*, 31 CLINICAL PSYCHOL. REV. 499, 509 (2010); Min Yang & Stephen C. P. Wong, *The Efficacy of Violence Prediction: A Meta-Analytic Comparison of Nine Risk Assessment Tools*, 136 PSYCHOL. BULL. 740, 740, 757 (2010).

43. ANDREWS & BONTA, *supra* note 21, at 47–48.

44. Jennifer L. Skeem, Devon L. L. Polaschek & Sarah Manchak, *Appropriate Treatment Works, but How?: Rehabilitating General, Psychopathic, and High-Risk Offenders*, in PSYCHOLOGICAL SCIENCE IN THE COURTROOM 358, 363 (Jennifer L. Skeem, Kevin S. Douglas, & Scott O. Littlefield eds., 2009).

individuals.<sup>45</sup> The results of three are positive.<sup>46</sup> In a study unique for being conducted outside of the criminal justice system, intensive treatment of civil psychiatric patients reduced violence regardless of PCL-R score (i.e. psychopathy did not moderate the effect of treatment).<sup>47</sup> High-PCL scoring individuals who had completed fewer than six treatment sessions in the previous ten weeks were 2.5 times more likely to be violent in the next ten weeks than those who attended more sessions (even after controlling for the treatment assignment process).<sup>48</sup> Treatment in this study was “psychiatric treatment as usual.”<sup>49</sup> The modal intervention was psychotherapy combined with psychotropic medication; the extent to which services could be characterized by RNR principles is unclear.

In the first of two correctional studies, graduates of an intensive RNR-based program for high-risk, violent adult prisoners (with elevated PCL scores) showed reductions in general and violent offending compared to matched untreated controls.<sup>50</sup> And as in the Skeem, Scott, and Mulvey study, scores on the PCL were unrelated to violent reconviction ( $r = .05$ ).<sup>51</sup>

A second criminal justice study compared outcomes for two groups: (1) offenders with PCL-R scores above 25 ( $n = 32$ ) who completed the Correctional Service of Canada’s Aggressive Behavior Control program, and (2) offenders matched for PCL-R Factor 1 and Factor 2 scores along with race and age at first conviction ( $n = 32$ ) who received services as usual.<sup>52</sup> Both samples had a very high base rate of subsequent convictions, and no significant differences were found on measures of recidivism per se (e.g., any reconviction, time to first reconviction).<sup>53</sup> Given the small sample size, and the high rate of

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45. Skeem, Polaschek, Patrick & Lilienfeld, *supra* note 41, at 131.

46. *Id.*

47. *Id.* (citing Jennifer L. Skeem, John Monahan, & Edward P. Mulvey, *Psychopathy Treatment Involvement, and Subsequent Violence Among Civil Psychiatric Patients*, 26 L. & HUM. BEHAV. 577, 583 (2002).

48. *Id.*

49. Skeem, Monahan & Mulvey, *supra* note 47.

50. Devon L. L. Polaschek, *High-Intensity Rehabilitation for Violent Offenders in New Zealand: Recidivism Outcomes for High- and Medium-Risk Prisoners*, 26 J. INTERPERSONAL VIOLENCE 664, 670, 674 (2011); Skeem, Polaschek, Patrick, & Lilienfeld, *supra* note 41, at 132.

51. Devon L. L. Polaschek & Rebecca K. Bell, PCL:SV Backfill Project: Retrospective Scoring of PCL:SVs from Files for VPU Retrospective Evaluation Sample 4 (2008) (unpublished report prepared for New Zealand Dep’t of Corr.) (on file with author).

52. Steven C.P. Wong, Audrey Gordon, Deqiang Gu, Kathy Lewis & Mark E. Olver, *The Effectiveness of Violence Reduction Treatment for Psychopathic Offenders: Empirical Evidence and a Treatment Model*, 11 INT’L J. FORENSIC MENTAL HEALTH 336, 342 (2012).

53. *Id.* at 345.

re-offending—an expected and common problem with high-risk offender outcome studies—sentencing indices were also examined as a proxy for new offence seriousness.<sup>54</sup> On average, men who completed the Aggressive Behavior Control program received less severe sentences according to all indices, with group differences significant for the three most serious indices—longest sentence length, longest aggregate sentence, and aggregated sentence length.<sup>55</sup> Thus, the two groups did not differ significantly on most outcome indices, but the most severe outcomes showed an effect in favor of treatment, especially when aggregated.<sup>56</sup>

The results of these studies stand in contrast to those obtained in an evaluation of an experimental treatment program conducted in the 1960s. In this study, psychopathic offenders who received treatment while hospitalized at the Oak Ridge unit in Penetanguishene, Canada ( $n = 46$ ) showed higher rates of violent (but not general) recidivism following release than a sample of untreated high-psychopathy prisoners matched on criminal history variables but not specifically on PCL-R scores.<sup>57</sup> However, the treatment to which offender patients were subjected in this study was highly unconventional and ethically unacceptable by today's standards (e.g., limited staff oversight of patients who were forced to spend days together naked in “encounter bubbles” with wall-mounted feeding tubes, having been administered various psychoactive substances including alcohol, methedrine, and LSD to “help break through psychic defenses”).<sup>58</sup>

Certain aspects of the “treatment” procedure evaluated in this study could well have contributed to the adverse outcomes reported. One source of harm may have been the punitive and non-voluntary elements of the regime. Patients were punished for not complying with program requirements, but could not leave the program of their own accord. As evidence for this argument, time spent being punished for “noncompliant behavior” in treatment was correlated with later convictions for violent crimes, regardless of whether patients were

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54. *Id.* at 342, 347.

55. *Id.* at 344.

56. *Id.*

57. Grant Harris, Marnie Rice, & Catherine Cormier, *Psychopaths: Is the Therapeutic Community Therapeutic?*, 15 THERAPEUTIC COMMUNITIES 283, 284, 290–92 (1994).

58. Devon L. L. Polaschek, *Adult Criminals with Psychopathy: Common Beliefs About Treatability and Change Have Little Empirical Support*, 23 CURRENT DIRECTIONS PSYCHOL. SCI. 296, 299 (2014).

psychopathic.<sup>59</sup> Psychopathic patients were more “difficult” and were therefore punished more often, locked in solitary cells longer, and given more potentially harmful drugs.<sup>60</sup> These experiences probably provoked anger and hostility—which, in turn, are risk factors for new violence.<sup>61</sup> Thus, although the Rice study provides corroborating evidence that psychopathy is associated with more challenges to the treatment process (e.g., non-compliance), and that programs can *increase* the risk of recidivism, at least in some clientele, it is silent on the issue of whether treatments that are generally effective in reducing violence are also effective for individuals with psychopathy.<sup>62</sup> The treatment program examined was far from an “evidence-based” one.

Another challenge to the limited treatability literature reviewed above is that none of the three studies was a randomized controlled trial.<sup>63</sup> No study of this type investigating psychopathic offenders’ responses to empirically validated treatment has yet been published. Some reviewers have concluded that in the absence of randomized controlled trials, there remains no convincing evidence that psychopathic offenders can benefit from treatment.<sup>64</sup> We consider this stance to be unduly conservative. Several meta-analyses of intervention protocols for high-risk offenders have found little or no difference in effect sizes for randomized versus high quality quasi-experimental designs.<sup>65</sup> The studies reviewed *are* high-quality, quasi-experimental designs that apply several credible methods for scaffolding causal inference. In our view, these studies are rigorous enough to challenge lingering beliefs that psychopathic offenders are impervious to intervention.

Still, outcome studies are rare at this point, and those that are available do not shed light on why or how treatment completion leads to reduced recidivism.<sup>66</sup> It is important to show that treatment targets can be changed among psychopathic offenders, and that these changes relate to improved long-

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59. *Id.* at 299–300; Marnie R. Rice, Grant T. Harris, & Catherine A. Cormier, *An Evaluation of a Maximum Security Therapeutic Community for Psychopaths and Other Mentally Disordered Offenders*, 16 L. & HUM. BEHAV. 399, 407 (1992).

60. Polaschek, *supra* note 58, at 300.

61. *Id.*; Skeem, Polaschek, & Manchak, *supra* note 44, at 365, 368.

62. Polaschek, *supra* note 58, at 300.

63. Skeem, Polaschek, Patrick, & Lilienfeld, *supra* note 41, at 132.

64. Grant Harris & Marie E. Rice, *Treatment of Psychopathy: A Review of Empirical Findings*, in HANDBOOK OF PSYCHOPATHY 555, 562–63 (Christopher J. Patrick ed., 2006).

65. Clive R. Hollin, *Evaluating Offending Behaviour Programmes: Does Only Randomization Glister?*, 8 CRIMINOLOGY & CRIM. JUST. 89, 100, 102 (2008).

66. Darryl G. Kroner & Annie K. Yessine, *Changing Risk Factors That Impact Recidivism: In Search of Mechanisms of Change*, 37 L. & HUM. BEHAV. 321, 323 (2013).

term outcomes. We review evidence on this topic next. Here, we refer to treatment targets as *variable risk factors*,<sup>67</sup> in the language of the RNR model, they are *criminogenic needs* or *dynamic risk factors*.<sup>68</sup>

Studies that assess relations between change in variable risk factors (e.g., before versus after treatment) with the subsequent recidivism of psychopathic offenders are few. Instead, most studies simply assess whether PCL scores predict a treatment “success” variable measured at one time point during treatment (e.g., homework completion, therapists’ ratings of treatment improvement).<sup>69</sup> Given the strong correlation between PCL scores and general risk scores, one would expect PCL scores to be associated with poorer treatment success variables. Unless, and until, investigators measure *change* in treatment success variables over time, these studies do not answer the much more important question about whether and how much people with high PCL scores benefit from intervention.

Two studies to date have successfully used a purpose-designed offender change measure to demonstrate that change in individuals with psychopathy is greater among those who do not recidivate after treatment. In both studies, trained raters retrospectively scored a version of the Violence Risk Scale (VRS)<sup>70</sup> and Sex Offender Version (VRS-SO),<sup>71</sup> after extracting relevant information from file records at two time-points (beginning and end of

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67. Monahan & Skeem, *supra* note 2, at 160 (defining “variable risk factors”).

68. ANDREWS & BONTA, *supra* note 21, at 48–49.

69. See Calvin M. Langton, Howard E. Barbaree, Leigh Harkins, & Edward J. Peacock, *Sex Offenders’ Response to Treatment and Its Association With Recidivism as a Function of Psychopathy*, 18 SEXUAL ABUSE 99, 105–07 (2006); Jan Looman, Jeffrey Abracen, Ralph Serin, & Peter Marquis, *Psychopathy, Treatment Change, and Recidivism in High-Risk, High-Need Sexual Offenders*, 20 J. INTERPERSONAL VIOLENCE 549, 557–59 (2005); Michael C. Seto & Howard E. Barbaree, *Psychopathy, Treatment Behavior, and Sex Offender Recidivism*, 14 J. INTERPERSONAL VIOLENCE 1235, 1238–40 (1999).

70. Stephen C. P. Wong & Audrey Gordon, *The Validity and Reliability of the Violence Risk Scale: A Treatment-Friendly Violence Risk Assessment Tool*, 12 PSYCHOL. PUB. POL’Y & L. 279, 281–82, 286 (2006).

71. Stephen C.P. Wong, Mark E. Olver, Terry Nicholaichuk, & Audrey Gordon, *The Validity and Reliability of the Violence Risk Scale-Sexual Offender Version: Assessing Sex Offender Risk and Evaluating Therapeutic Change*, 19 PSYCHOL. ASSESSMENT 318 (2007).

intervention).<sup>72</sup> Raters were blind to recidivism outcomes.<sup>73</sup> Olver and Wong found that psychopathic men in an intensive high-risk sex offender program were judged over the course of treatment to have made measurable progress on the VRS-SO's risk-related treatment targets.<sup>74</sup> Most compellingly, the more these offenders changed, the less likely they were to be reconvicted of sexual and violent offenses.<sup>75</sup> A second study from this research group focused on serious high-risk violent offenders (PCL-R  $M = 26$ ).<sup>76</sup> Paralleling results from the earlier study of sex offenders, the more that these high psychopathy offenders reduced VRS risk factors over treatment, the less likely they were to be reconvicted for violent offenses.<sup>77</sup>

These two studies, then, document change in PCL-psychopathic offenders during treatment, and then statistically link that improvement to reduced recidivism. One obvious limitation of these studies is that there is no untreated comparison group; thus, we cannot be certain the change is a consequence of program participation. However, as independent evidence that the program produced change, recidivism rates for both programs determined from outcome evaluations showed that attendance was associated with reduced recidivism relative to an untreated comparison group.<sup>78</sup> Although untreated comparison subjects were not assessed for change in VRS risk factors,<sup>79</sup> the comparative reduction in recidivism for treated individuals is indicative of program impact.

In conjunction with the recidivism results described earlier,<sup>80</sup> these studies of treatment-related change suggest that PCL-psychopathic offenders can indeed be effectively treated through intensive services and that effective

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72. Mark E. Olver & Stephen C. P. Wong, *Therapeutic Responses of Psychopathic Sexual Offenders: Treatment Attrition, Therapeutic Change, and Long-Term Recidivism*, 77 J. CONSULTING & CLINICAL PSYCHOL. 328, 329–32, 334–35 (2009); Kathy Lewis, Mark E. Olver, & Stephen C. P. Wong, *The Violence Risk Scale: Predictive Validity and Linking Changes in Risk With Violent Recidivism in a Sample of High-Risk Offenders With Psychopathic Traits*, 20 ASSESSMENT 150, 152–53 (2012).

73. Olver & Wong, *supra* note 72, at 329–32, 334–35; Lewis, Olver, & Wong, *supra* note 72, at 152–53.

74. Olver & Wong, *supra* note 72, at 334–35.

75. *Id.* at 334–35.

76. Lewis, Olver, & Wong, *supra* note 72, at 152–53.

77. *Id.* at 156, 161.

78. Mark E. Olver & Stephen C.P. Wong, *A Description and Research Review of the Clearwater Sex Offender Treatment Programme*, 19 PSYCHOL. CRIME & L. 477, 484 (2013); Wong, Gordon, Gu, Lewis & Olver, *supra* note 52, at 336–37.

79. Wong, Gordon, Gu, Lewis, & Olver, *supra* note 52, at 337.

80. *See supra* Part II.

treatment can reduce risk. Although the pool of relevant research is small, the messages appear clear.

#### IV. DIFFICULTIES IN PROVIDING TREATMENT TO HIGH RISK OFFENDERS

The research in the previous Section indicates that people with high levels of psychopathic traits, just like other high-risk offenders, benefit from treatment shown to be effective in modifying variable risk factors. In fact, the evidence base supports the argument that high-risk individuals—difficult, high-need, complex cases as they are—should be prioritized for such treatment to maximize recidivism reduction.<sup>81</sup>

The problem is that these individuals are rarely prioritized for intervention, and even more rarely complete treatment programs. First, in studies that have examined correctional programs' adherence to the risk principle, investigators consistently find that the vast majority of programs (66–97%) do not match service intensity and duration to offenders' risk of recidivism.<sup>82</sup> Second, a meta-analysis of 114 studies of offender treatment attrition, found that “[t]he clients who stand to benefit most from treatment (i.e. high-risk, high-needs) are the least likely to complete it.”<sup>83</sup> Non-completion of treatment often takes the form of expulsion from services based on difficult behavior or client-initiated dropout from services.<sup>84</sup> Both problems—lack of prioritization and dropout—pave the way toward failure in treating high-risk clients. Violence prevention programs will have little value if most of the target clients are not provided the opportunity to attend, or start but then fail to complete the process.

The selective attrition of people who most need services is often cast as a problem of “treatment-resistant clients” but may also be viewed as a problem of “client-resistant services.” An extensive research base identifies characteristics of offenders that emerge with increasing levels of criminal risk. As risk increases, the overall picture is one of mounting treatment-impeding behavior, with risk factors manifesting themselves in the treatment process itself. High-risk offenders are often angry and irritable, prone to feeling

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81. D. A. Andrews & Craig Dowden, *Risk Principle of Case Classification in Correctional Treatment: A Meta-Analytic Investigation*, 50 INT'L J. OFFENDER THERAPY & COMP. CRIMINOLOGY 88, 89, 93, 96 (2006).

82. For a review, see Scott W. VanBenschoten, John Bentley, Nancy Beatty Gregoire, & Christopher T. Lowenkamp, *The Real-World Application of the Risk Principle: Is It Possible in the Field of Probation*, 80 FED. PROB. 3, 3 (2016).

83. Mark E. Olver, Keira C. Stockdale, & J. Stephen Wormith, *A Meta-Analysis of Predictors of Offender Treatment Attrition and Its Relationship to Recidivism*, 79 J. CONSULTING & CLINICAL PSYCHOL. 6, 6, 9 (2011).

84. *Id.* at 6–7.

victimized, suspicious of others' motives, antagonistic, aggressive, untrustworthy, egocentric, non-compliant, and uncommitted to change.<sup>85</sup> Crime-reducing therapies are centrally concerned with helping offenders learn new skills, but higher-risk offenders can make poor "students." They tend not to persist with treatment when they find tasks hard.<sup>86</sup> They often lack self-reflection and self-control.<sup>87</sup> To make matters worse, high-risk offenders are known to exhibit high rates of verbal ability deficits, along with neuropsychological impairments, a history of school failure, and negative attitudes toward new learning.<sup>88</sup> In short, characteristics that contribute to high risk peoples' offending (e.g., hostility, noncompliance, negative attitudes, disruptive behavior, learning problems)—and therefore need to change—can also make them difficult clients. Given these characteristics, it is understandable that clinicians, probation officers, and other professionals generally prefer to avoid high-risk cases—spending their time instead with cooperative, motivated, low risk cases, who have little need for their services.<sup>89</sup>

#### V. ALIGNING CORRECTIONAL POLICY AND PRACTICE WITH RESEARCH ON HIGH-RISK PEOPLE

In this Section, we highlight three ways in which correctional policy and practice with high-risk people can be better aligned with what we know, based on the research reviewed in previous Sections. In making these three recommendations, we assume that high-risk people are being systematically identified in a correctional system—that is, that well-trained staff are

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85. Terrie E. Moffitt, *Life-Course-Persistent and Adolescence-Limited Antisocial Behavior: A 10-Year Research Review and a Research Agenda*, in CAUSES OF CONDUCT DISORDER AND JUVENILE DELINQUENCY 49, 61–62 (Benjamin B. Lahey, Terrie E. Moffitt, & Avshalom Caspi eds., 2003); Ronald Blackburn, *Personality Assessment in Violent Offenders: The Development of the Antisocial Personality Questionnaire*, 39 PSYCHOLOGICA BELGICA 87 (1999); Christopher T. Lowenkamp & Edward J. Latessa, *Increasing the Effectiveness of Correctional Programming Through the Risk Principle: Identifying Offenders for Residential Placement*, 4 CRIMINOLOGY & PUB. POL'Y 263, 263–64 (2005); Robert R. Ross, Elizabeth A. Fabiano, & Crystal D. Ewles, *Reasoning & Rehabilitation*, 32 INT'L J. OFFENDER THERAPY & COMP. CRIMINOLOGY 29, 30 (1988).

86. Ellison M. Cale, *A Quantitative Review of the Relations Between the "Big 3" Higher Order Personality Dimensions and Antisocial Behavior*, 40 J. RES. PERSONALITY 250, 252, 253 (2006).

87. *Id.* at 257, 268.

88. Charles J. Golden, Michele L. Jackson, Angela Peterson-Rohne, & Samuel T. Gontkovsky, *Neuropsychological Correlates of Violence and Aggression: A Review of the Clinical Literature*, 1 AGGRESSION & VIOLENT BEHAV. 3, 4, 11–13 (1996); Terrie E. Moffitt, Donald R. Lynam, & Phil A. Silva, *Neuropsychological Tests Predicting Persistent Male Delinquency*, 32 CRIMINOLOGY 277, 280 (1994).

89. Andrews & Dowden, *supra* note 81, at 89.



implementing a well-validated risk assessment tool that accurately classifies people as at low, moderate, or high risk for recidivism.<sup>90</sup> We begin with the most basic problem: that high-risk clients rarely receive risk-reducing treatment.

*A. Prioritizing High-Risk Clients and Engaging Them in Treatment*

At least three approaches can be leveraged to address the problem of “treatment-resistant clients” and “client-resistant services.” First, policies that prioritize high-risk cases for more intensive supervision and services—like guidelines that specify the expected range of contacts, service types, and service dosages for low-, moderate-, and high-risk cases—can be essential in shifting practice. For example, VanBenschoten, Bentley, Gregoire, and Lowenkamp described a concerted effort in the federal probation system to align policy with the risk principle—including implementation of a new risk assessment instrument, provision of training, and expansion of the pool of low-risk people eligible for less intensive supervision.<sup>91</sup> Over time, this policy appeared to change officers’ behavior, as was apparent in more supervision time and greater treatment resources being spent on higher risk offenders.<sup>92</sup> Notably, these authors have also articulated a supervision matrix specifically designed to reduce violent recidivism through prioritization of existing resources (rather than greater expenditures).<sup>93</sup> Redistributing resources based on people’s risk of recidivism—with low-, moderate-, and high-risk people receiving services proportionate to their needs and potential to benefit—is an efficient and evidence-informed method for rationalizing service provision to maximize both clients’ therapeutic gain and public safety.

Second, policies that incentivize high-risk people to participate in evidence-based treatment to earn privileges or “good time” credit toward early release can be helpful. For example, the First Step Act (2018), a federal criminal justice reform bill, prioritizes evidence-based recidivism reduction programs for medium-to-high-risk inmates and requires the use of incentives and rewards for inmates to participate in such programs—ranging from additional phone and visitation time to earned time credits for early release from prison.<sup>94</sup>

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90. For guidance and references on successful implementation of risk assessment, see Erin Harbinson, *Risk Assessment and Implementation*, U. MINN., ROBINA INST. CRIM. L. & CRIM. JUST. (Aug. 13, 2018), <https://robinainstitute.umn.edu/news-views/risk-assessment-and-implementation> [<https://perma.cc/JS6V-MEM2>].

91. VanBenschoten, Bentley, Gregoire, & Lowenkamp, *supra* note 82, at 3–4.

92. *Id.* at 4.

93. *See id.* at 4–5.

94. First Step Act of 2018, 18 U.S.C. §§ 362(a), (d) (2018).

Finally, and perhaps most importantly, practitioners need to be trained to skillfully, assertively, and persistently engage higher-risk people in services. Although a review is beyond the scope of the present Article, promising approaches include conducting brief interventions like motivational interviewing to increase clients' readiness to change and self-efficacy, "engaging clients in preparatory work aimed at increasing their understanding of the aims of treatment" and evidence behind it, and setting treatment goals in a person-centered and collaborative manner—ideally, within the context of a firm, fair, and caring relationship.<sup>95</sup>

### B. *Providing Appropriate, Evidence-Informed Treatment*

There is a dearth—or absence—of experiments that test the effect of well-implemented, multi-modal CBT programs in reducing recidivism risk for people with high scores on measures of violence risk, psychopathy, or both. The absence of such randomized controlled trials may reflect mistaken assumptions that these high-risk clients cannot be effectively treated, more than (typical) reluctance to randomly assign clients to usual treatment versus evidence-based treatment. If the absence of rigorous research reflects myths that high risk people cannot be effectively treated—it should be remedied. As reviewed earlier, indirect evidence strongly suggests that those at high risk are precisely the right people to target with evidence-based treatment programs.<sup>96</sup>

This indirect evidence justifies ongoing scholarly investment in systematic research investigating the malleability of robust risk factors for recidivism—including psychopathic traits—and the violent behavior that can emanate from them. We believe the current state of evidence suggests that—rather than being *excluded* from evidence-based treatment—high-risk people should be *prioritized* for broad band CBT programs that show the greatest promise for reducing their myriad risk factors for recidivism and translating to prevention of violence and other criminal behavior. Indeed, other countries have successfully treated high-risk people to reduce violence, using the RNR model.<sup>97</sup>

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95. Craig Dowden & D. A. Andrews, *The Importance of Staff Practice in Delivering Effective Correctional Treatment: A Meta-Analytic Review of Core Correctional Practice*, 48 INT'L J. OFFENDER THERAPY & COMP. CRIMINOLOGY 203, 208 (2004); Danielle Sturgess, Jessica Woodhams, & Matthew Tonkin, *Treatment Engagement From the Perspective of the Offender: Reasons for Noncompletion and Completion of Treatment—A Systematic Review*, 60 INT'L J. OFFENDER & COMP. CRIMINOLOGY 1873, 1881, 1891 (2016); Skeem, Polaschek, & Manchak, *supra* note 44, at 378.

96. *Supra* Part II.

97. See Polaschek, Yesberg, Bell, Casey, & Dickson, *supra* note 14, at 345–46.

Also, in theory, providing high-risk people with services and supervision that specifically target each person's most prominent risk factors also shows promise. In our experience working with correctional systems, however, it is more difficult to implement policies and practices that tailor risk reduction strategies to each high-risk individual<sup>98</sup> than to implement a single well-aimed, well-implemented, multimodal CBT program that is likely to reduce risk in different ways, for different people. Indeed, in the hands of skilled facilitators, such CBT programs can be applied in a manner that targets each person's individual needs, despite the group format. At worst, correctional services are infamous for "correctional quackery"—that is, a failure to use research in designing programs rather than "common sense" and trends.<sup>99</sup> At best, correctional services often fail to provide the most basic services that are appropriate for an individuals' needs.<sup>100</sup> Given such entrenched problems, it seems wise to keep goals simple and attainable. To us, this means that systems prioritize high quality implementation of a single, multi-modal CBT program for people at relatively high risk of recidivism. This includes monitoring CBT facilitators over time to ensure that their facilitation continues to demonstrate high fidelity to the treatment model.

When systems are prioritizing higher risk clients for more intensive services (our first recommendation) and are providing well-made and well-implemented CBT programs (our current recommendation), they are following key tenets of the Risk-Need-Responsivity model (RNR).<sup>101</sup> However, the RNR model is considerably broader than these key tenets. A tool is available to assess the extent to which a given program adheres to broader RNR principles of effective intervention: the Correctional Program Assessment Inventory (CPAI).<sup>102</sup> Based on a study of thirty-eight adult residential programs, a program's CPAI score moderately predicted offenders' new offenses ( $r = 0.35$ ) and return to prison ( $r = 0.42$ ).<sup>103</sup> Programs with greater fidelity to principles measured by

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98. See Jill Viglione, Danielle S. Rudes, & Faye S. Taxman, *Misalignment in Supervision: Implementing Risk/Needs Assessment Instruments in Probation*, 42 CRIM. JUST. & BEHAV. 263, 277, 279–80 (2015); Gina M. Vincent, Laura S. Guy, Rachael T. Pernault, & Bernice Gershenson, *Risk Assessment Matters, But Only When Implemented Well: A Multisite Study in Juvenile Probation*, 40 L. & HUM. BEHAV. 683, 684 (2016).

99. See e.g., Edward J. Latessa, Francis T. Cullen, & Paul Gendreau, *Beyond Correctional Quackery—Professionalism and the Possibility of Effective Treatment*, 66 FED. PROB. 43, 43 (2002).

100. Lowencamp, Latessa, & Smith, *supra* note 18, at 587; Weisberg & Petersilia, *supra* note 18, at 130.

101. BONTA & ANDREWS, *supra* note 21.

102. PAUL GENDREAU & DON A. ANDREWS, CORRECTIONAL PROGRAM ASSESSMENT INVENTORY (CPAI) (6th ed. 1996).

103. Lowencamp, Latessa, & Smith, *supra* note 18, at 582, 584.

CPAI were more effective.<sup>104</sup> Administrators may find the CPAI a useful supplement to CBT fidelity tools, in their efforts to improve the implementation and effectiveness of their programs.

### C. Using Incarceration as a Service Provision Site

People at high risk for violence are relatively likely to be confined as part of their criminal sentences. Compared to community-based programs, services in institutions tend to be more oriented toward harsh punishment, which tends to have an adverse effect on recidivism.<sup>105</sup>

This need not be the case. First, CBT programs that implement evidence-based principles can be—and sometimes are—offered in jails and prisons.<sup>106</sup> This is particularly true in other countries.<sup>107</sup> Second, RNR programs and principles are applicable to high-risk people in custodial settings.<sup>108</sup> Third, many of the promising programs reviewed earlier for people with psychopathic traits were provided in institutions.<sup>109</sup> Finally, meta-analyses illustrate that effective principles of correctional intervention can be applied in custodial settings—even if they often are not.<sup>110</sup> After controlling for participant and intervention characteristics, the supervision setting (institution vs. community) did not moderate the effect of CBT on recidivism.<sup>111</sup> As Lipsey and his colleagues concluded, good programs “can be effective within institutional environments where there is more potential for adverse effects.”<sup>112</sup>

When high-risk people are serving long sentences, institutional settings arguably provide an opportunity to deliver intensive doses of good treatment, and ideally follow up this investment with careful release planning. As explained earlier, treatment dose matters—as the number of sessions completed increases, so does the effect of treatment on recidivism.<sup>113</sup>

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104. *Id.* at 588.

105. Lipsey, *supra* note 15, at 125, 134, 137–39.

106. Nana A. Landenberger & Mark W. Lipsey, *The Positive Effects of Cognitive—Behavioral Programs for Offenders: A Meta-Analysis of Factors Associated With Effective Treatment*, 1 J. EXPERIMENTAL CRIMINOLOGY 451, 453–54 (2005).

107. *See e.g.*, Polaschek, Yesberg, Bell, Casey & Dickson, *supra* note 14, at 346–47.

108. BONTA & ANDREWS, *supra* note 21.

109. Landenberger & Lipsey, *supra* note 106, at 453–54, 458.

110. *Id.* at 452–53, 458; Lipsey, *supra* note 15, at 124–25, 138, 143.

111. Landenberger & Lipsey, *supra* note 106, at 463, 465–66, 471.

112. Lipsey, *supra* note 15, at 143.

113. *See e.g.*, Landenberger & Lipsey, *supra* note 106, at 453, 463–65.

## VI. CONCLUSION

In this Article, we have outlined ongoing research that can guide effective justice policy and practice for high-risk people. Overall, our review indicates that there is hope for intervention—that appropriate treatment can promote both positive life changes and public safety. These outcomes can be achieved if we focus on malleable aspects of psychological functioning related to continued criminal involvement and if we do so in a disciplined way.

Two major premises underpin this basic conclusion. First, people at risk for violence—including those with psychopathic traits—are not so different from other offenders as to warrant the presumption that they need to be identified and quarantined because we have no methods for promoting positive change or keeping their dangerous behavior in check. We assert that the difference between high-risk offenders and other offenders is largely a difference of degree, not kind. As a result, intervening broadly and intensively in community and institutional settings—using evidence-informed programs and principles—makes much more sense than thinking in terms of how to treat some hypothesized underlying, pervasive characterological deficit.

Second, current justice reform efforts need to accommodate this perspective of high-risk people as one that can promote both client welfare and public safety. Dealing effectively with high-risk people is one of the most important goals of the justice system. These people represent more than a serious threat to the social order that must be contained—they also present important opportunities for correctional systems to maximize risk reduction by re-allocating resources to evidence-informed programs tailored to address their wide-ranging needs. Limited perspectives on what community and institutional services can provide to these people have historically been barriers to this approach. But, as we suggested earlier, lawmakers have become more receptive to programs with crime-reduction potential. What is needed is recognition that this pragmatic approach is particularly effective with high-risk people.

In summary, this Article proposes that correctional policies and practices pertaining to high-risk people need to be rethought in light of research on services for this population. This is an opportunity to take innovative steps that could help these people and protect the community, while maximizing the impact of scarce services. The challenge is formidable, but also achievable, and well worth the effort.