

Breaking the Cycle – Tasmanian Corrections Plan (2010-2020)

Background Paper: Pathways to Offending

*“The justice system can rarely do what parents, teachers,
friends, neighbours, and economic opportunity
have failed to do”.*

Elaine Cassel¹

Offenders represent one of the most marginalised groups in society, made up of individuals who have often experienced a lifetime of disadvantage. Nevertheless, it is possible to identify pathways that lead to adult offending and hence opportunities for prevention and early intervention.

Developmental Pathways

Developmental pathways that begin in childhood can lead to the development of antisocial behaviour and offending. These pathways involve the interplay between biological, cognitive and social factors.

Biological influences on the development of criminal behaviour include temperament, neurological disorders caused by neurotransmitter and hormone imbalances, learning disabilities, and cognitive impairments that impact on information processing and behavioural inhibition. The presence of one or more of these risk factors can contribute to poor academic and social functioning which can contribute to the development of antisocial and delinquent behaviour during childhood and adolescences and offending behaviour in adulthood.

Temperament refers to one's innate disposition and is the biological foundation upon which personality is constructed. There are two ways of categorising a child's temperament: i) inhibited vs uninhibited or ii) easy / difficult / slow to warm up. Temperament influences a number of psychological processes associated with offending, such as emotional regulation, sensation seeking, attachment to caregivers, social and moral development. Despite the predetermined nature of temperament, parent-child interactions can have a significant bearing on the expression of certain types of behaviour. Difficult children who tend to resist parents' attempts to comfort them during childhood and develop insecure attachments with care givers are more likely to experience peer conflict and rejection, which can contribute to the development of poor self esteem and subsequent engagement in substance abuse and antisocial behaviour during adolescence unless counteracted by parental influences. Parents can be taught how to increase the chances of developing a secure attachment with their

¹ Cassel, E. & Burnstein, D. (2007). *Criminal Behavior* (2nd ed.). Boston: Allyn & Bacon.

child. Research also suggests that mentoring programs are effective in preventing crime among high-risk children from disadvantaged environments².

Four developmental disorders have been linked to the development of antisocial behaviour and subsequent offending, namely Reactive Attachment Disorder (RAD), Attention Deficit Hyperactivity Disorder (ADHD), Oppositional Defiant Disorder (OOD) and Conduct Disorder (CD).

RAD is characterised by a failure to form normal attachments to primary caregivers in early childhood that leads to a distrust of others or conversely a failure to show any selectivity or discrimination in choice of attachment figures. Such failures can be brought on by severe forms of abuse and neglect, abrupt separation from primary caregivers between the ages of six months and three years, frequent changes in caregivers, and a lack of caregiver responsiveness to a child's efforts to communicate. Such experiences disrupt caregivers' abilities to teach their children through modelling and reinforcement how to regulate and express their emotions and empathise with others, which undermines the development of a conscience and moral reasoning which emerges around two years of age. Children who remain emotionally "undercontrolled" into adolescence and adulthood are more likely to use aggression to get what they want and meet their needs, which places them at increased risk of engaging in antisocial and criminal behaviour.

ADHD is a neurobiological disorder believed to be caused by chemical imbalances in the brain. More specifically, underactivity in the prefrontal cortex which is responsible for thought and impulse control leads to inattentive, and/or hyperactive and impulsive behaviours beyond what would be expected for someone's age. ADHD is five times more common in boys than girls and is estimated to occur in approximately 2.4% of Australian children making it the most common childhood disorder³. Moreover, 56% of children with ADHD have a first degree relative with the disorder. ADHD reduces a child's ability to learn, complete tasks, and get along with others which significantly undermines self confidence. This contributes to the development of learning disabilities, mental health problems such as anxiety and depression, aggression, and poor academic achievement. The majority of children with ADHD continue to have the disorder during adolescence, and as many as 40% continue to meet diagnostic criteria for the disorder as adults. While some of the behavioural problems associated with the disorder, particularly hyperactivity, improve with age, the majority of children with ADHD continue to experience significant impairment in psychosocial functioning across the life course. Poorer outcomes are predicted by low socioeconomic status (SES) of the family, low child IQ, poor peer relationships, high child aggression, and high levels of parental psychopathology (including ADHD and antisocial behaviour). Research suggests that as many as 25% of adult offenders meet diagnostic criteria for ADHD and as many as 80% exhibit symptoms of the disorder⁴. Moreover, 20-30% of children with ADHD develop Antisocial Personality Disorder. Medication together

² Tremblay & Craig, 1995.

³ Gomez, R., Harvey, J., Quick, C., Scharer, I. & Harris, G. (1999). DSM-IV ADHD: Confirmatory factor models, prevalence, and gender and age differences based on parent and teacher ratings of Australian primary school children. *Journal of Child Psychology and Psychiatry and Allied Disciplines*, 40, 265-274.

⁴ Pratt, T. C., Blevins, K. R., Daigle, L. E., Cullen, F. T., & Unnever, J. D. (2002). The relationship of ADHD to crime and delinquency: A meta-analysis. *International Journal of Police Science and Management*, 4, 344-360.

with the use of behaviour moderation strategies on the part of parents and teachers has proven to be the most effective way to treat ADHD during childhood and adolescence.

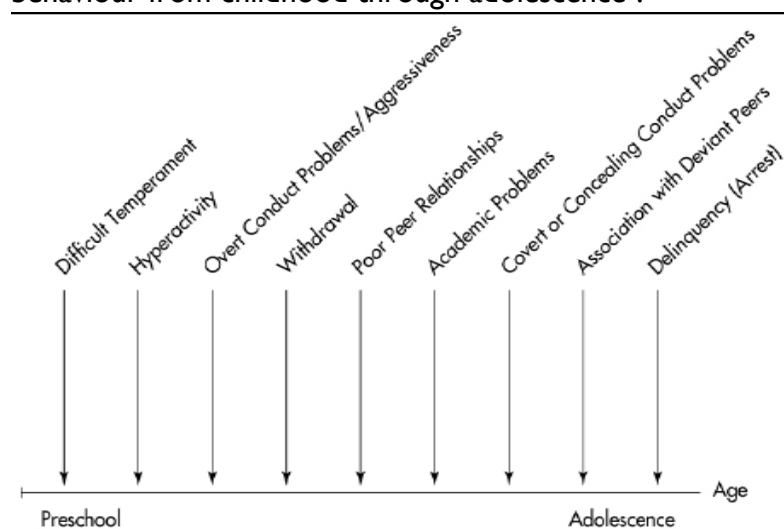
Fifty percent of children with ADHD have at least one other psychiatric condition, 32% have at least two and 11% have at least three. Common comorbid conditions associated with ADHD in adolescents include ODD, CD and substance abuse. It is the presence of comorbid ODD that is associated with most of the conflicts noted in the mother-child interactions of children with ADHD. ODD is characterised by negativistic, hostile and defiant behaviour towards authority figures which manifest as poor emotional regulation, limit testing, argumentativeness, stubbornness, uncooperativeness and a refusal to accept responsibility for one's actions. ODD leads to conflict with parents, teachers and peers, undermines self esteem and is associated with the early onset of substance abuse. A developmental trajectory from difficult temperament to ODD and then CD has been well established. Despite this a number of psychotherapies, including parent and school based training programs are available to treat ODD and CD. Medications are also be used to treat comorbid conditions associated with CD.

CD which is estimated to occur in approximately 3% of Australian children is an extreme form of ODD characterised by a persistent pattern of behaviour in which the rights of others and/or societal norms are violated. It is also a prerequisite for a diagnosis of Antisocial Personality Disorder in adulthood. Children with CD engage in aggression towards people and animals, destruction of property, deceitfulness or theft and serious violation of rules. Such individuals are less likely to respond to parental disapproval or punishment or internalise rules established by authority figures. CD disorder is more common in boys than girls and is associated with poor moral development, lack of empathy, the early onset of sexual behaviour and unplanned pregnancies, low self esteem and suicidal ideation, substance abuse, learning disabilities, underachievement relative to IQ school suspensions and expulsions. Children and adolescents that display CD are more likely to be rejected by well adjusted peers, and suspended or expelled from school. This allows them more time to engage in antisocial behaviour including substance abuse.

The effects of alcohol use are well established and can impact on one's physical, behavioural and cognitive functioning. Some of the cognitive and behavioural difficulties associated with alcohol intoxication include impaired judgement, attention, and problem solving, clumsy, uncoordinated and risk taking behaviour. At significant bloodstream levels alcohol can lead to disorientation, unconsciousness and even death⁵. Chronic alcohol abuse can impair learning and memory, undermine relationships with family and friends, and contribute to the development of delinquent behaviour. Illicit drug use is associated with the commission of more serious juvenile offences. Children with strong family ties, adequate school performance and access to non substance abusing role models are less likely to engage in substance abuse and crime.

⁵ Sadock & Sadock (2007). *Synopsis of psychiatry*. Philadelphia: Wolter Kluwer.

Table I- Approximate ordering of the different forms of disruptive and antisocial behaviour from childhood through adolescence⁶.



In summary, a number of disorders arise during childhood that influence various domains associated with offending. For instance, RAD may contribute to an absence of empathy and concern for others. ADHD can impair social, academic and psychological development. ODD can lead to the development of disrespect for the law and law enforcement officials. CD is a precursor to Antisocial Personality Disorder which is characterised by a disregard for the rights of others, aggression towards others and offending behaviour. A recent study of Australian children and adolescents estimated that approximately 14% of Australian youth have mental health problems, yet only 25% of those with mental health problems seek assistance⁷. This study concluded that individual based treatments were unlikely to reduce the incidence of mental health problems in Australian children and that population based interventions were a more appropriate form of treatment.

School experiences can have a significant bearing on the development or otherwise of antisocial and offending behaviour. For instance, positive school experiences have been demonstrated to buffer adolescents from broken and dysfunctional families against involvement in antisocial behaviour. Conversely, academic failure which can be generated by low IQ, learning disabilities, physical and/or emotional difficulties can engender frustration, peer rejection and diminished self-esteem leading to the development of further psychological and behavioural dysfunction⁸. Chronic absenteeism due to lack of academic achievement, peer conflict, psychological or behavioural problems, and/or low parental support for school attendance places children at increased risk of engagement in substance abuse which is a precursor to greater involvement in antisocial behaviour. Such experiences and behaviours increase the risk of “dropping out” or being expelled from school. This provides further opportunities for disillusioned youth to begin socialising with similarly unsuccessful peers and leads to greater involvement in substance abuse, and antisocial and

⁶ Loeber, R. (1990). Development and Risk Factors of Juvenile Antisocial Behavior and Delinquency. *Clinical Psychology Review*, 10, 1-41.

⁷ Sawyer et al. (2001). The mental health of young people in Australia: key findings from the child and adolescent component of the national survey of mental health and well-being. *Australian and New Zealand Journal of Psychiatry*, 35, 806-814.; Sawyer et al. (2000). The national survey of mental health and wellbeing: the child and adolescent component. *Australian and New Zealand Journal of Psychiatry*, 34, 214-220

⁸ Törestad, B, & Magnusson, D. (1996). Basic skills, early problematic behaviour and social maladjustment. *Educational Studies*.

offending behaviour. An American study estimated the cost of allowing one youth to leave school for a life of drugs and crime at US\$1.7-2.3m in 1998. A study of incarcerated juveniles found that 36% of them had a learning disability and that these individuals were two times more likely to engage in criminal activity than individuals without a learning disability. This risk was even higher if the juvenile also had ADHD or low IQ⁹.

Some have argued that schools actually increase the risk of school failure ostensibly because they are overcrowded, impersonal, and cater for average to good students using redundant curriculum. In addition, they fail to provide adequate support for disadvantaged students to improve their skills and lack the resources to address the physical and psychological needs of students.

Early Onset vs Late Onset Antisocial Behaviour

While parental influences are present from the start, teachers begin to play an integral role in shaping children's behaviour from the age of three years. Parents and teachers teach children socially appropriate ways to express themselves and control their behaviour through modelling and behavioural reinforcement. Such abilities are important for the development of pro-social behaviour. Although most 2 years olds display aggressive and oppositional behaviour the majority outgrow this behaviour with the assistance of their parents and teachers. Some however continue to display aggressive behaviour throughout childhood, develop violent and anti-social behaviour during adolescents and some of these adolescents become serious adult offenders.

Official statistics and self report measures alike attest to the fact that antisocial behaviour becomes the norm rather than the rule during adolescence. Studies that have considered the continuity and change in antisocial behaviour throughout adolescence have demonstrated that antisocial behaviour peaks in mid adolescence (around 15 years) and declines steadily thereafter. However, a small number of individuals continue to display high rates of antisocial behaviour into adulthood (Smart et al, 2004). Moreover, official statistics (Australian Institute of Criminology, 2008) demonstrate that year on year adolescents aged between 15 and 19 years are more likely than any other age group to be charged with a crime and that they offend at more than three times the rate of adults (e.g. 5,918 versus 1,581 per 100,000 respectively in 2005-06). Although juvenile crime declined across Australia in the 11 year period 1995 to 2006, the proportion of female offenders increased from 21 to 24 percent. Nevertheless, males are more likely to engage in aggressive forms of antisocial behaviour than females.

A developmental taxonomy has been proposed to reconcile the apparent contradictory observation that adolescent antisocial behaviour is both persistent and transient¹⁰. Moffitt and others suggest that antisocial behaviour is committed by two types of individuals during

⁹ Brier, N. (1989). The Relationship Between Learning Disability and Delinquency A Review and Reappraisal *Journal of Learning Disabilities*, 22, 546-553

¹⁰ Moffitt, T.E. (1993). Adolescence-limited and life-course-persistent antisocial behavior: A developmental taxonomy. *Psychological Review*, 100, 674-701.

Patterson, G. R. (2002). Etiology and treatment of child and adolescent antisocial behavior. *The Behavior Analyst Today*, 3(2), 133-144.

adolescence, each with distinctly different developmental pathways and causal factors. A small group display life-course-persistent antisocial behaviour. These individuals are characterised by mild neuropsychological deficits of the nervous system such as ADHD which affect verbal and executive functions and are often found in criminogenic environments. As indicated above these individuals initially display conduct disorder in childhood which manifest as antisocial behaviour in adolescence. Moffitt (1993) suggests that the antisocial behaviour displayed by such individuals is maintained by a lack of prosocial alternatives and ever reducing openings for change. Moreover, it is suggested that this type of behaviour pattern is solidified before 18 years of age (given its lack of treatability) but established after childhood (given its lack of predictability). Hence, adolescence is identified as a crucial developmental period in the formation of life-course-persistent antisocial behaviour.

Support for Moffitt's (1993) taxonomy can be found in a growing number of longitudinal studies that have demonstrated that the prevalence of antisocial behaviour changes across the life span, and that different risk and resilience factors are associated with its early versus late onset. The most notable Australian study is the Australian Temperament Project undertaken in Victoria over the past 20 years (Smart et al., 2004). This study followed the development of a representative community sample of 2443 Victorian children from infancy to early adulthood. They found that early onset antisocial behaviour was associated with familial and social risk factors, whereas late onset antisocial behaviour was temporary in nature, somewhat of a rite of passage, that did not necessarily result in life time consequences, and occurred in well adjusted adolescents with few risk factors (Smart et al., 2004). While a small number of adult offenders with no prior history of antisocial or delinquent behaviour engage in crime, they have much in common with individuals that limit their antisocial behaviour to adolescence, i.e. relatively few family, school, or mental health problems. While offending tends to decrease with age some offenders continue offending into old age. For instance, a longitudinal study that followed adolescent offenders found that 12% of them were still offending at age 60. An estimated 3-5% of individuals who demonstrate antisocial behaviour during childhood become adult offenders, while the number is even smaller for those who began engaging in antisocial behaviour during adolescence. Although life-course persistent offenders are estimated to comprise just 5-10% of delinquents, they commit the majority of crime. Hence, the age at which one begins to engage in antisocial behaviour is a good predictor of the persistence and seriousness of subsequent offending. Nevertheless, a lifetime of offending and disadvantage can be averted by timely and effective intervention.

Family Related Pathways

Family exerts the greatest influence on a child's development including the formulation of values, attitudes and beliefs up until the age of 10 years, when the family's role in shaping behaviour begins to be equalled and even surpassed by peers and non-family members. Even children that grow up in functional families are at risk of involvement in antisocial and offending behaviour during adolescence if positive family influences are outweighed by the influence of peers who are involved in antisocial or criminal activity.

Family risk factors associated with later offending include:

- Dysfunctional family structure and communication

- Maladaptive parenting styles and practices
- Family history of criminal activity, mental illness, substance abuse, teen pregnancy, school drop out and interpersonal conflict
- Parental attitudes that are tolerant or supportive of child's problem behaviours
- Childhood abuse or neglect
- Family violence
- Frequent changes in custody

Research indicates that although factors such as parent criminality, social and economic disadvantage, child temperament, and marital discord systematically affect the development of antisocial behaviour, their influence is mediated by the extent to which they disrupt day-to-day parenting practices. Irritable, ineffective discipline, and poor parental monitoring have been demonstrated to be the most proximal determinants of the development and maintenance of antisocial behaviour¹¹. Parenting practices typically fall into one of three categories: authoritarian, permissive or authoritative. Authoritarian parents are cold, distant and disapproving towards their children and enforce harsh physical punishment rigidly and without explanation. Such parenting creates moody and apprehensive children who alternate between aggressive and withdrawn behaviour. Permissive parents fail to set and enforce clear rules and boundaries and are easily coerced and manipulated by their children. Such parenting creates resistant, non-compliant children who are prone to poor self-esteem, aggressive and impulsive behaviour. Authoritative parents provide clear rationales for their rules and expectations and enforce them in a fair and consistent manner. They express disapproval over misbehaviour and provide encouragement and rewards for good behaviour. Such parenting encourages children to take responsibility for their own behaviour and appreciate the positive and negative consequences that stem from it. When done well this type of parenting is said to create co-operative children with high levels of self control and esteem, who do well in school and get along with others. Hence, parenting practices combined with developmental risk factors have the potential to either move children away or towards offending behaviour.

A 30 year follow up study of 1500 children undertaken in 2000 found that childhood abuse and neglect increased the likelihood of involvement in delinquent and adult offending by 29%. Physically abused and neglected as opposed to sexually abused children were more likely to be arrested. Maltreated children also began offending at younger ages, committed twice as many offences, and were arrested more often than non-abused children. Contrary to earlier studies, abused females were at increased risk of arrest for violent crimes. Furthermore, children whose parent(s) had been arrested were 2-3 times more likely to engage in antisocial behaviour as adults after controlling for the effects of abuse and neglect than children whose parent(s) had not been arrested¹².

¹¹ Reid, J. B., Patterson, G.R. (1989). The development of antisocial behaviour patterns in childhood and adolescence. *European Journal of Personality*, 3, 107-119.

¹² Widom, C.S., & Maxfield, M.G. (2000). An update on the cycle of violence. National Institute of Justice: Research in Brief, 2001. Retrieved from <http://www.ncjrs.gov/pdffiles1/nij/184894.pdf> on 15 September 2009.

Longitudinal studies conducted in Cambridge and Pittsburgh, since 1996 and 1987 respectively, highlight the fact that criminal activity tends to be concentrated in a small number of individuals and families. The intergenerational nature of offending however does not imply a genetic transmission of criminality. In fact, there is no evidence to support the notion that criminality is inherited. For instance, a separate study of 8000 male delinquents found that environmental factors explained 6 times more variance in anti-social behaviour during adolescence than heredity¹³, further highlighting the importance of the interaction between individual and environmental factors in the determination of involvement in criminal activity. Nevertheless, both the Pittsburgh and Cambridge studies found that having an immediate family member, especially a father arrested or convicted of a crime predicted offending in male offspring, even though there was no evidence to suggest that parents actively encouraged or taught their children to engage in crime. This reinforces that fact that children learn through imitation and behavioural reinforcement. Hence, parental attitudes and behaviours have the capacity to significantly influence their children's behaviour. For instance, children whose parents supplied them with alcohol or cigarettes are more likely to engage in substance abuse during adolescence, which is a major risk factor for further involvement in criminal behaviour.

The long term sequelae of childhood exposure to family violence are well established. These include the development of aggressive and antisocial behaviour as well as anxiety and depression during childhood, the onset of delinquency and substance abuse during adolescence and the perpetration of crime including family violence and child abuse in later life^{14 15 16 17 18}. The latter two appear to be related to the fact that exposure to family violence as a child leads to the development of beliefs about violence and aggression as an appropriate and/or effective means to solve problems and get one's way. There is also some evidence to suggest that children exposed to family violence have difficulty taking on other people's perspectives and empathising with them¹⁹, possibly because of the disruption family violence causes to the victimised parent's ability to cater for the psychological needs of their children²⁰.

Research conducted during the 1970s into the concentration of offending in multi-problem families in Tasmania found that 50% of the individuals from the second generation of the 16 families investigated (73% of the males, 17% of the females) had a police record, 34% had been to prison (51% of the males, 9% of the females). The average age of their first appearance in the Children's Court was 12.3 years. Taken together family members had spent a total of 201 years in prison in the preceding 15 years, which was 250 times more

¹³ Lyons, M.J., True, W.R., Eisen, S.A., Goldberg, J. (1995) - Differential heritability of adult and juvenile antisocial traits. *Archives of General Psychiatry*, 52, 906-915.

¹⁴ Dube, Felitti, Dong, Chapman, Giles & Anda (2003). Childhood abuse, neglect, and household dysfunction and the risk of illicit drug use: The adverse childhood experiences study. *Pediatrics*, 111 (3), 564-572.

¹⁵ Sturge, C. & Glaser, D. (2000). Contact and domestic violence – The experts' court report. *Family Law*, 615-629.

¹⁶ Fantuzzo, J.W., DePaola, L.M., Lambert, L., Martino, T., Anderson, G. & Sutton, S. (1991). Effects of interparental violence on the psychological adjustment and competencies of young children. *Journal of Consulting and Clinical Psychology*, 59, 258-265.

¹⁷ Holden, G. W., & Ritchie, K. L. (1991). Linking extreme marital discord, child rearing, and child behaviour problems: Evidence from battered women. *Child Development*, 62, 311-327.

¹⁸ Hughes, H. M. (1988). Psychological and behavioural correlates of family violence in child witness and victims. *American Journal of Orthopsychiatry*, 58, 77-90.

¹⁹ Hinchey, F.S. & Gavelek, J.R. (1982). Empathic responding in children of battered women. *Child Abuse and Neglect*, 6, 395-401.

²⁰ Sturge, C. & Glaser, D. (2000). Contact and domestic violence – The experts' court report. *Family Law*, 615-629.

than the average Tasmanian family²¹. The study also considered the extent to which family members had required assistance from social welfare and mental health services. They found that 38% of family members had been wards of the State, 12% had attempted suicide, 10% were intellectually disabled and 10% have received psychiatric treatment. The direct cost of the 16 families' involvement in crime, welfare and psychiatric services was estimated to be \$1.5m, while the indirect costs were estimated to add another \$1.25m. More recently, the Tasmania Department of Police and Emergency Management sought to replicate and extend the work undertaken by Davies and Dax in 1974. Preliminary findings based on one of six multi-problem families studied indicated that 61% of the 84 known family members had at least one conviction and 30% had served at least one custodial sentence. While family members had committed an average of 18 offences each, 12 family members accounted for 59% of the total number of recorded offences. The study also found that family members tended to commit crimes together and recruited other children and young people into criminal activity. Positive school experiences and/or securing employment, moving away from family members and finding a supportive non-offending partner assisted some family members to avoid becoming involved in or desist from crime.

Together these family risk factors shape personality including attitudes, values and beliefs and the ability to regulate emotions and behaviour. Emotional regulation skills and self control are vital for getting along with others and succeeding in life. Children who fail to learn these skills are at risk of using instrumental aggression to get what they want and hostile aggression to dominate other children and seek revenge. Hostile aggression is at the root of antisocial behaviour and initially develops at home in accordance with parental influences.

The most effective means of reducing chronic juvenile offending are holistic family based intervention programs delivered to high risk juvenile offenders in their own homes such as Multisystemic therapy (MST). MST is an intensive family based treatment program designed to address those aspects of a child's family, school, peer and social environment that are contributing to their antisocial behaviour. A MST based program introduced to Western Australia in 2004 demonstrated substantial reductions in the quantity, frequency and severity of offending six months after participants completed the program. Until such programs are widely implemented however, chronic criminal activity will continue to be displayed by a small number of children and adolescents who tend to be concentrated in a small number of families.

Based on the information presented above, it is possible to identify a number of factors that contribute to criminal behaviour during adulthood. Generally speaking, the majority of adult offenders are young males, who exhibited antisocial behavior from a very young age. They are likely to have emanated from single parent families of lower socio-economic status and were exposed to family violence, physical and/or sexual abuse, parental substance abuse and criminality during their formative years. They exhibit hyperactive traits, which undermine their emotional regulation, impulse control and problem solving skills. They are likely to have learning disabilities, experienced early academic failure, difficulty securing and/or maintaining employment and long standing substance abuse and mental health problems.

²¹ Davies, L., & Dax, E.X. (1974). The criminal and social aspects of families with a multiplicity of problems, *Australian and New Zealand Journal of Criminology*, 7, 197-213.

Numerous studies have demonstrated that female offenders, especially incarcerated female offenders have experienced significantly higher rates of physical, sexual and psychological abuse compared to male offenders (Shearer, 2003). They also display more mental health problems including personality disorders, psychosis, mood disorders, and deliberate self harm (Hollin & Palmer, 2006).

Adult Offenders and Social Exclusion

Although there is some disagreement about the exact meaning of the term and Australia has been slow to adopt policies based on its principles in comparison to other countries, social exclusion can be most aptly defined as:

“a complex and multi-dimensional process [that] involves the lack or denial of resources, rights, goods and services, and the inability to participate in the normal relationships and activities, available to the majority of people in a society, whether in economic, social, cultural or political arenas. It affects both the quality of life of individuals and the equity and cohesion of society as a whole²².”

Hence, social exclusion incorporates more than just income poverty, and can happen when people or areas experience a combination of linked problems such as unemployment, lack of knowledge and skills, low incomes, poor housing, and family breakdown. Whilst the combination of problems may vary, they are typically long standing - beginning in childhood, mutually reinforcing and unlikely to be resolved by services working in isolation.

Although offenders form a distinct subset of the socially excluded they also share much in common with the chronically excluded. These include:

- Behaviour and impulse control difficulties
- Difficulty forming and sustaining relationships
- Skills deficits
- History of institutionalization and abuse
- Poor housing/homelessness
- Poor physical and mental health
- Limited economic and employment prospects.

Current efforts in offender rehabilitation tend to focus on offending behavior with little attention given to an offender's social or personal circumstances. Generally speaking such programs have proven to reduce re-offending by approximately 14%. Hence, it is possible to improve this figure further by providing more holistic intervention strategies and

²² Levitas et al. (2006)

reintegration services post release. This may require not only system change but practical assistance for offenders as they navigate their way through and out of the system. Effective offender rehabilitation and reintegration calls for social inclusion strategies based on joined up service delivery systems across a number of government departments.