Applying Risk-Need-Responsivity (RNR) Principles to the Treatment and Management of Sexual Offenders

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Substance abuse
High Risk Offenders
RNR
Motivational Interviewing
What works
SOT
Psychopathy
FIT
Compassion

Ernie Marshall

Objectives

- Participants will be able to summarize the three principles of the Risk Needs Responsivity Model.
- Participants will be able to describe the application RNR principles to the evaluation, management, and treatment of sexual offenders.
- Participants will be able list several evidence based practices that support the application of RNR in the treatment and management of sexual offenders.

Risk-Need-Responsivity

- Developed in the early 1990s by by Canadian researchers James Bonta, Don Andrews, and Paul Gendreau.
- The Psychology of Criminal Conduct (1994)
  - Bonta and Andrews

Risk-Need-Responsivity

- RISK-How likely a person is to engage in criminal behaviors
- NEED-Changeable areas in a person's life should be targeted for intervention / supervision in order to decrease their likelihood of future criminal behavior
- Responsivity- What personal strengths and/or specific individual factors might influence the effectiveness of treatment services

Risk Principle

- Match level of services to level of risk
- Prioritize supervision and treatment resources for higher risk clients
- Higher risk clients need more intensive services
- Low risk clients require little to no intervention

Patterns in Risk Level & Tx Intensity

Offender RISK LEVEL	% Recidivism: Tx BY RISK LEVEL		Impact on RECIDIVISM	Authors of Study
	Minimum	Intensive		
Low Risk	16%	22%	(↑ 6%)	O'Donnell et al., 1971
High Risk	78%	56%	(↓ 22%)	
Low Risk	3%	10%	(↑ 7%)	Baird et al., 1979
High Risk	37%	18%	(↓ 19%)	
Low Risk	12%	17%	(↑ 5%)	Andrews & Kiessling, 1980
High Risk	58%	31%	(↓ 27%)	
Low Risk	12%	29%	(↑ 17%)	Andrews & Friesen, 1987
High Risk	92%	25%	(↓ 67%)	

•*Some studies combined intensive Tx with supervision or other services*

Compiled from: Andrews, D.A., Bonta, J., Hoge, R.D. (1990). Classification for Effective Rehabilitation: Rediscovering Psychology. *Criminal Justice and Behavior, 17*: 19.

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Need Principle

- Assess criminogenic needs and target those needs with treatment and interventions

Criminogenic Needs

- Dynamic or "changeable" risk factors that contribute to the likelihood that someone will commit a crime.

Criminogenic Needs

- Dynamic or "changeable" risk factors that contribute to the likelihood that someone will commit a crime.
- Changes in these needs / risk factors are associated with changes in recidivism.

Dynamic Risk Instruments

- SVR-20
- Stable-2007 / Acute-2007
- VRS-SO
- ARMADILO (for developmentally delayed SOs)
- SRA-FV

Dynamic Risks for Sexual Offenders

- Sexual preoccupation (abnormally intense interest in sex)
- Deviant Sexual interest
- Offense-supportive attitudes
- Emotional congruence with children
- Lack of emotional intimacy with adults
- Lifestyle impulsiveness (e.g., unstable lifestyle)
- Poor problem solving
- Resistance to rules/supervision (oppose external control)
- Negative social influences
  - Mann, Hanson & Thornton (2010)

Potential

- Hostile beliefs about women
- Machiavellianism
- Callousness
- Dysfunctional coping

- Mann, Hanson & Thornton

Non-Criminogenic Needs

- Self-esteem
- Anxiety
- Medical needs
- Victimization issues
- Learning disability

Although NOT criminogenic risk factors, they are important to include in an effective RNR assessment.

WHY?

Protective Factors

- Criticism of RNR – focus on avoidance vs approach
- Emerging focus on protective factors
- SAPROF
- IORNS

Dynamic Protective Factors

Response to Challenges and Temptations	1) Coping with Stress 2) Self-Control 3) Empathic Behavior 4) Cognitive Functioning
Social Protective Factors	1) Work 2) Organized Leisure Activities 3) Sufficient Financial Resources 4) Healthy Romantic Relationships 5) Social Network 6) Life Goals
Openness to External Protection	1) Attitude Toward Authority 2) Motivation for Treatment 3) Response to Medication
External Protective Factors	1) Living Circumstances 2) Professional Care 3) External Control

Responsivity Principle

- General Responsivity:
  - The strategy and the alliance
    - Use evidence based interventions
      - CBT, Common Factors
- Specific Responsivity:
  - Provide the treatment in a style and mode that is responsive to the offender's learning style and ability

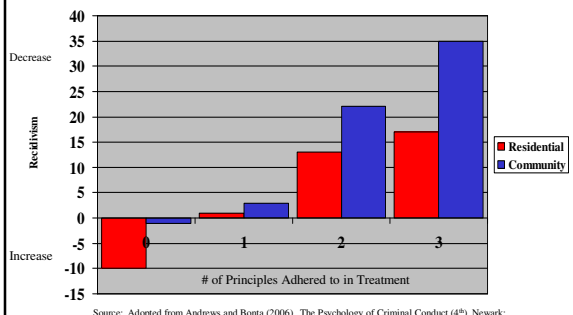
Responsivity Principle

- Individual factors that might influence the effectiveness of treatment services
  - Anxiety
  - ADHD
  - Motivation Level
  - Reading Level / ESL
  - Language
  - Personality characteristics

Responsivity

- The attitude and style of the officer/counselor have an enormous effect on responsivity.
- Why?

Adherence to Risk, Need, General Responsivity by Setting: Community Based versus Residential Programs



Source: Adopted from Andrews and Bonta (2006). The Psychology of Criminal Conduct (4th). Newark: LexisNexis.

Desistance

- Desistance is generally defined as the cessation of offending or other antisocial behavior.
- The definition of desistance is not clearly operationalized
- A process vs an event

Desistance Factors

- Ageing
- Life stability
- Narrative Script
- Social Identity
- Personal Agency (Locus of Control)
- Educational Attainment

RNR Summary

- Risk- who to target
- Need-what to target
- Responsivity-how to target it

Medical metaphor

- Risk- triage the most critical person, prioritize treatment of this case
- Need- target symptoms/causes of the critical illness
- Responsivity-Use the best medication for this person at this time

RNR concerns

- It is difficult to motivate offenders by focusing primarily on risk reduction
- The RNR model does not pay enough attention to the role of personal or narrative identity and agency (Desistance factors)
- RNR pays insufficient attention to the therapeutic alliance
- Noncriminogenic needs such as personal distress and low self-esteem that are important with respect to offender responsivity.

Ward, Melsor, &Yates, 2007

Expanded RNR

- Overarching Principles
  - 1. Respect for the person
  - 2. Theory
  - 3. Human service
  - 4. Crime prevention
- RNR
  - 5. Risk
  - 6. Need
  - 7. Responsivity (general + specific)
  - Andrews, Bonta, & Wormith (2011)

Expanded RNR

- Structured Assessment
  - 8. Assess RNR
  - 9. Strengths
  - 10. Breadth
  - 11. Professional discretion
- Program Delivery
  - 12. Dosage

– Andrews, Bonta, & Wormith (2011)

Expanded RNR

- Staff Practices
  - 13. Relationship skills
  - 14. Structuring skills
- Organizational
  - 15. Community-based
  - 16. Continuity of service
  - 17. Agency management
  - 18. Community linkages

Evidence Based Practices

- Motivational Interviewing
- Cognitive Behavioral Therapy/Treatment
- Trauma Informed Approach
- Common Factors

- What is Evidence Based Practice?

"Evidence-based practice in psychology (EBPP) is the integration of the best available research with clinical expertise in the context of patient characteristics, culture, and preferences"

WHAT IS MOTIVATIONAL INTERVIEWING?

- **Motivational interviewing is a form of collaborative conversation for strengthening a person's own motivation and commitment to change.**
- ***It is a person-centered counseling style for addressing the common problem of ambivalence about change by paying particular attention to the language of change.***
- **It is designed to strengthen an individual's motivation for and movement toward a specific goal by eliciting and exploring the person's own reasons for change within an atmosphere of acceptance and compassion**

WHAT IS MOTIVATIONAL INTERVIEWING?

- A way of being with another person that creates a platform for change

WHY MOTIVATIONAL INTERVIEWING?

- **Relatively brief.**
- **Generalizes across problem areas.**
- **Goes well with other treatment methods.**
- **Verifiable – Is it being delivered properly?**
- **Can be delivered by non-specialist.**

TWO COMPONENTS OF MOTIVATIONAL INTERVIEWING

- The "Spirit of MI". Establishing an effective, collaborative working/helping alliance to increase motivation to change.
- Facilitating Change. Reinforcing change talk, developing a change plan, strengthening commitment to change.

Motivational Interviewing

- Operationalizes the common factors of psychotherapy
  - The alliance
  - Mutually agreed upon goals
  - Intrinsic vs extrinsic motivation

Common Factors

Common Factors

- 11.5% of variance in therapy outcome was due to the common factor of goal consensus/collaboration,
- 9% was due to empathy,
- 7.5% was due to therapeutic alliance,
- 6.3% was due to positive regard/affirmation,
- 5.7% was due to congruence/genuineness
- 5% was due to therapist factors
- 1% of outcome variance, in contrast, treatment method accounted for roughly
  - Laska, Gurman & Wampold 2014, p. 472

Common Factors

- Therapist/Staff issues
  - Judgment
  - Belief in change
  - Countertransference
    - Defensiveness
    - Concern about being duped

System Factors

- Adversarial Environment
  - Milieu matters
- Familiarity/Overfamiliarity
  - Perception
- Kindness is not weakness

Cognitive Behavioral Therapy

- Multiple models/programs with similar efficacy
- How you deliver may be more important than what you deliver
- CBT for offenders focuses on challenging criminal thinking errors/distorted beliefs

Cognitive Behavioral Therapy

- It is the general CBT approach that is responsible for the overall positive effects on recidivism
- There were no significant differences between the various CBT programs.
- The effect size of CBT were greater for higher risk offenders offenders with higher risk of
- recidivism than those with lower risk
- What matters is :
  - quality implementation producing low treatment dropouts, monitoring of the
  - quality and fidelity of the treatment program and training for the
  - providers.

Trauma Informed Approach

- Trauma-informed care: TIC is a strengths-based service delivery approach that is grounded in an understanding of and responsiveness to the impact of trauma, that emphasizes physical, psychological, and emotional safety for both providers and survivors, and that creates opportunities for survivors to rebuild a sense of control and empowerment.

Trauma Informed Approach

- Realize the prevalence of trauma.
- Recognize how trauma affects all individuals involved with the program, organization, or system, including its own workforce.
- Respond by putting this knowledge into practice.
- Resist retraumatization

Trauma Informed Approach

- Safety
- Trustworthiness
- Choice
- Collaboration
- Empowerment

Trauma Informed Approach

- Triggers for retraumatization
  - Feeling a lack of control
  - Experiencing unexpected change
  - Feeling threatened or attacked
  - Feeling vulnerable or frightened
  - Feeling shame

Trauma Informed Approach

- Trauma-specific treatment services: These services are evidence-based and promising practices that facilitate recovery from trauma. The term "trauma-specific services" refers to prevention, intervention, or treatment services that address traumatic stress as well as any co-occurring disorders (including substance use and mental disorders) that developed during or after trauma.
- +

SRSTC treatment program

- Primary goal is to reduce risk of re-offense
  - Learn to live a fulfilling life
- Target known dynamic risk and responsivity issues.
- Personality characteristics that are treatment interfering are also relationship interfering

SRSTC treatment program

- Education, work program, and recreational programming are key components;
  - Protective and desistance factors
  - Opportunities to practice and display pro-social behavior

Therapist expectations

- Why you are doing what you're doing
- Knowledge of RNR and Common Factors literature
- Measurably competent at Motivational Interviewing

Phase One Goals

- Orientation to treatment programming
- The promotion of meaningful treatment engagement
  - Identifying their personal strengths and values, and beginning to develop a pro-social self-identity.
  - Developing an understanding of treatment interfering factors, and which ones apply to them.
- Demonstrate general self-management, which could include the management of the willful choice to engage in anti-social acts or developing strategies to overcome the inability to regulate themselves.

Phase One Goals

- Prior to advancing to Phase Two, it is important that patients have a clear understanding of the objectives and tasks associated with Phase Two, and have expressed a readiness and willingness to take on these tasks and objectives.

Phase Two Goals

- Identify the dynamic risk factors and protective factors associated with their offending (historically and currently)
- Demonstrate motivation for managing these risk factors.
- To assist with this process, patients undergo various polygraph examinations and assessments of their sexual functioning.
- Additionally, patients will continue to develop a pro-social self-identify and maintain the gains earned in Phase One.

Phase Three Goals

- In Phase Three, patients will develop and practice strategies for reliably and consistently managing the dynamic risk factors associated with their offending, as well as enhancing protective factors, and develop specific plans for continued management upon their release from SRSTC.

Ongoing Challenges

- How to measure change?
- Prioritizing needs at the individual level?
- Are some dynamic risks really dynamic?
- Differences in expression of long term vulnerabilities in current functioning

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