IMPLEMENTING THE RISK-NEED-RESPONSIVITY MODEL IN VETERAN TREATMENT COURTS

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OBJECTIVES

1. Review risk in forensic mental health terms (static and dynamic factors) and evidence-based principles for effective forensic interventions

2. Introduce the Risk-Need-Responsivity (RNR) model

3. How RNR shapes intervention and/or treatment planning and service delivery at state and local levels

RISK FACTOR: TYPES

(MULVEY ET AL., 2010; LIPSEY & DERZON, 1998)

Static Risk Factors:

- Cannot be changed
- Age at first arrest, number of adjudications, etc.

Dynamic Risk Factors/ "Criminogenic Needs":

- Can be changed/influenced by intervention
- Skills, peer cohort, education, thinking patterns, gang affiliation, etc.

CRIMINOGENIC VERSUS NON-CRIMINOGENIC NEEDS

(ANDREWS & BONTA, 2010)

Table 1
Criminogenic and Noncriminogenic Needs

Criminogenic	Noncriminogenic
Procriminal attitudes (thoughts, values and sentiments supportive of criminal behavior)	Self-esteem
Antisocial personality (low self-control, hostility, adventurous pleasure seeking, disregard for others, callousness)	Vague feelings of emotional discomfort (anxiety, feeling blue and feelings of alienation)
Procriminal associates	Major mental disorder (schizophrenia, depression)
Social achievement (education, employment)	Lack of ambition
Family/marital (marital instability, poor parenting skills, criminality)	History of victimization
Substance abuse	Fear of official punishment
Leisure/recreation (lack of prosocial pursuits)	Lack of physical activity

EIGHT EVIDENCE-BASED PRINCIPLES FOR EFFECTIVE INTERVENTIONS

(NATIONAL INSTITUTE OF CORRECTIONS, COMMUNITY CORRECTIONS DIVISION, U.S. DEPARTMENT OF JUSTICE, 2004)

1. Assess Actuarial Risk/Needs

2. Enhance Intrinsic Motivation (*Motivational Interviewing is a great tool for this*)

3. Target Interventions
    a. *Risk Principle*
    b. *Need Principle*
    c. *Responsivity Principle*
    d. *Dosage*: Structure 40-70% of high-risk offenders; time for 3-9 months
    e. *Treatment*: Integrate treatment into the full sentence/sanction requirements

EIGHT EVIDENCE-BASED PRINCIPLES FOR EFFECTIVE INTERVENTIONS

(NATIONAL INSTITUTE OF CORRECTIONS, COMMUNITY CORRECTIONS DIVISION, U.S. DEPARTMENT OF JUSTICE, 2004)

4. Skill Train with Directed Practice (use Cognitive Behavioral Treatment methods)

5. Increase Positive Reinforcement

6. Engage Ongoing Support in Natural Communities

7. Measure Relevant Processes/Practices

8. Provide Measurement Feedback

RISK PRINCIPLE

(ANDREWS ET AL. 1990; ANDREWS & BONTA, 2010; HOGE & ANDREWS, 2010)

RISK PRINCIPLE:

Direct resources and more intensive services to higher risk individuals and minimize services to lower risk individuals

RISK PRINCIPLE

(ANDREWS ET AL. 1990; ANDREWS & BONTA, 2010; HOGE & ANDREWS, 2010)

Risk Assessment:

- Collection and synthesis of information needed to evaluate likelihood of individual engaging in future criminal/antisocial behavior
- Incorporates static and dynamic risk factors
- Basis of Risk Prediction: Estimate of future risk (Low, Moderate, High)

NEED PRINCIPLE

(ANDREWS ET AL. 1990; ANDREWS & BONTA, 2010; HOGE & ANDREWS, 2010)

NEED PRINCIPLE:

Treatment / Intervention should target criminogenic needs related to risk to reoffend

***Modified*: Treatment /Intervention Plans should target the dynamic risk factors most relevant to most important presenting problem**

THE 8 CRIMINOGENIC NEED AREAS

Criminal History (static factor)

Pro-Criminal Attitudes (dynamic factor)

Antisocial Personality Traits (dynamic factor)

Negative or Deviant Peers (dynamic factor)

Family/Poor Parental Monitoring (dynamic)

Substance Abuse (dynamic factor)

Education/Employment (dynamic factor)

Leisure/Structured Activities (dynamic factor)

NEED PRINCIPLE

(ANDREWS ET AL. 1990; ANDREWS & BONTA, 2010; HOGE & ANDREWS, 2010)

Needs Assessment:

- Basis of Risk Management
- Foundation of Case Management, Intervention Planning, Treatment Planning
- Shapes Referral Plan

RESPONSIVITY PRINCIPLE

(ANDREWS ET AL. 1990; ANDREWS & BONTA, 2010; HOGE & ANDREWS, 2010)

RESPONSIVITY PRINCIPLE:

Treatment / Intervention should be provided in a style and mode that is responsive to the individual's learning style and ability

…and culture

RESPONSIVITY PRINCIPLE

(ANDREWS ET AL. 1990; ANDREWS & BONTA, 2010; HOGE & ANDREWS, 2010)

Responsivity:

- Factors that need to be considered in intervention planning
- Can include risk factors specific to individual
- Examples: Language barriers, reading ability, presence of mental illness, etc.
- Can also include circumstantial risk factors such as social supports, family, peer cohort, etc.
- Protective factors can include strengths/protective factors such as employment, positive leisure activities/interests, active and supportive family, faith, etc.

RESPONSIVITY & MOTIVATIONAL INTERVIEWING

(MILLER & ROLLNICK, 2013; ROLLNICK ET AL. 2008; ROSENGREN 2009; PROCHASKA & DICLEMENTE 1984/1998)

Motivational Interviewing:

- Evidence-based, empirically validated technique to foster positive change
- Focus on supporting self-efficacy
- Aims to resolve ambivalence about positive change
- Non-confrontational strategy that utilizes asking the right questions
- Can be used in brief interactions
- Useful tool for ANYONE
- Helps determine how responsive the individual is and where individual is in stage of change

RESPONSIVITY & MOTIVATIONAL INTERVIEWING

(MILLER & ROLLNICK, 2013; ROLLNICK ET AL. 2008; ROSENGREN 2009; PROCHASKA & DICLEMENTE 1984/1998)

Stages of Change: not linear

- Pre-Contemplation:
  - No intention of changing
  - "I don't need to change anything"
- Contemplation:
  - Aware of problem, but not committed to change
  - "Maybe things aren't as good as I thought, but I don't want to change anything"
- Preparation:
  - Aware of problem and intending to make change
  - "I'm gonna fix it"
- Action:
  - Engaging in steps top address and change the problem
  - "I am working on…"
- Maintenance:
  - Sustained change regarding problem
  - "I'm still working on…"
- Relapse:
  - Regressing to prior behaviors, patterns, stages of change
  - "I messed up"

EVIDENCE-BASED PRACTICES & RESEARCH SUPPORTED BEST PRACTICES

Cognitive-Behavioral Therapy (CBT)

Motivational Interviewing (MI)

Cognitive Processing Therapy (CPT)

Eye Movement Desensitization & Reprocessing (EMDR)

Prolonged Exposure (PE)

Peer Model

Columbia Protocol (C-SSRS)

Mental Health First Aid (MHFA)

Counseling on Access to Lethal Means (CALM)

Ask About Suicide to Save a Life (AS+K)

RISK-NEED-RESPONSIVITY: ASKING THE RIGHT QUESTIONS

(ANDREWS ET AL. 1990; ANDREWS & BONTA, 2010; HOGE & ANDREWS, 2010)

Risk/Need focus helps answer:

- "Who needs treatment/intervention?"
- "What type and intensity of treatment/intervention is needed?"

Responsivity focus helps answer:

- "How would this individual benefit from treatment/intervention?"
- "What deficits or circumstances could present barriers to treatment?"
- "What steps can be taken to overcome these barriers?"
- "What individual strengths/protective factors or supports can be incorporated to bolster treatment/intervention?"

CONTEMPORARY RESEARCH FINDINGS

(MULVEY ET AL., 2010; LIPSEY & DERZON, 1998)

Severity of an offense is not a strong indicator of the future pattern of offending

However… tested static and dynamic risk factors for offending are strong indicators of future offending

RISK ASSESSMENT & RISK MANAGEMENT

Resulting identified individualized risks…

- Aid program assignment
- Drive intervention matching
- Shape all Treatment Plans, Case Plans, Reentry Plans, Referral plans
- Serve as anchors for evaluation of progress

RISK MANAGEMENT / TREATMENT PLANNING

Goal of treatment is to stabilize individual and address individual risks/needs while planning for stepping down into less intensive services

Individualized treatment/case plans address dynamic risks (criminogenic needs) as well as influencing factors related to responsivity (i.e., trauma, substance use, mental health diagnoses)

Identified risks/needs serve as basis of matching interventions

LOW RISK INDIVIDUALS

Have few relevant risk factors present

Require minimal or no intervention to decrease likelihood of reoffending

Most low-risk individuals are unlikely to reoffend even if there is no intervention (Lipsey, 2009)…**BUT** mixing them with high-risk individuals can make them worse.

HIGH RISK INDIVIDUALS

Higher likelihood of engaging in continued offending or violence

Have multiple risk factors present

Require more intensive intervention to decrease risk

TEXAS VETERANS COMMISSION

- VA CLAIMS & VCSOs
- EDUCATION
- EMPLOYMENT
- ENTREPRENEURSHIP
- HEALTHCARE ADVOCACY
- WOMEN VETERAN PROGRAM
- FUND FOR VETERANS' ASSISTANCE GRANTS
- VETERAN CITIZENSHIP & NATURALIZATION
- VETERAN MENTAL HEALTH DEPARTMENT

WE ARE NOT THE VA!!!….but they are our friends ☺

VETERANS MENTAL HEALTH DEPARTMENT

Across all programming, VMHD has the broadest definition of veteran. Regardless of:

- Discharge status
- Branch of service
- Length of service
- Active-duty status

The same broad definition applies to veteran family.

All services provided across VMHD programming are offered freely.

VETERANS MENTAL HEALTH DEPARTMENT

- Training
- Technical Assistance / Direct Outreach
- Resource Connection
- Coordination w/ State Legislature & Veteran Serving Agencies
- Veteran Advocacy

VETERANS MENTAL HEALTH DEPARTMENT (VMHD)

- RURAL COMMUNITY & FAITH-BASED PROGRAM
- HOMELESS VETERAN INITIATIVE
- JUSTICE INVOLVED VETERAN PROGRAM
- MILITARY VETERAN PEER NETWORK
- VETERAN PROVIDER TRAINING PROGRAM
- VETERAN SUICIDE PREVENTION

JUSTICE INVOLVED VETERAN PROGRAM

Risk/Need

- Continued involvement in CJ system
- Access to veteran services at each SIM intercept
- Reentry planning

Responsivity

- Training for law enforcement to intervene & divert
- JIV info cards (“jailcards”)
- TA to Veteran Treatment Courts
- Statewide Partnerships
- Leveraging local resources (e.g., MVPN)

HOMELESS VETERAN PROGRAM

Risk / Need

- Higher rates of trauma, mental health issues, justice involvement
- Hierarchy of needs
- Accessibility
- Gaps in the continuum of care

Responsivity

- Definitions of “veteran” and “homeless”
- Coordinate across programs
- Services are identified at all levels: local, state, federal
- Provide trainings to direct service staff
- Strong interagency collaboration

MILITARY VETERAN PEER NETWORK

Risk / Need

- Isolation and lack of connectivity / support
- Stigma
- Accessibility / waitlists
- Family engagement

Responsivity

- Statewide peer-to-peer network
- Trained peer volunteers
- Direct peer-to-peer support
- Suicide Prevention training to community stakeholders
- Warm-handoffs to local resources and VA

VETERAN PROVIDER TRAINING PROGRAM

Risk / Need

- **Trauma** is a pervasive problem among veterans
  - Posttraumatic Stress Disorder (PTSD)
  - Moral Injury
  - Military Sexual Trauma
  - Traumatic Brain injury
- Competent and Responsive Workforce

Responsivity

- Military Cultural Competency
- Military Informed Care
- Trauma-informed training & technical assistance
- Veteran Counselor Pilot Program
- Evidence-Based Practices

COMMUNITY & FAITH-BASED PARTNERSHIPS

Risk / Need

- Access to services (distance, finances, etc.)
- Workforce Shortage
- Social Isolation
- Life Purpose

Responsivity

- Faith / Spirituality linked to resiliency
- Identification of veteran status
- Faith & Allegiance Initiative
- Initial touchpoint / bridge to mental health services
- Leveraging community partners
- Especially rural and underserved areas

VETERAN SUICIDE PREVENTION PROGRAM

- Gatekeeping: AS+K
- Lethal Means Restriction: CALM
- Mental Health First Aid
- Buddy Check Day: 11th of every month
- Texas Suicide Prevention Collaborative (TXSPC)
- Statewide Behavioral Health Coordinating Council (SBHCC)
- SBHCC Suicide Prevention Subcommittee
- Texas Coordinating Council for Veteran Services (TCCVS)

- 988 Crisis Line Planning
- Collaboration with VA, SAMHSA, and national efforts
- State Partnerships with HHSC, TDHCA, TDCJ, TWC, TCJS, LMHAs, TX and more
- Statewide Planning Participation (State Plan, Long-Term Action Plan, Local Coalitions, etc.)
- Central Texas Challenge
- **VMHD Suicide Prevention Program**

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