Meeting Justice-Involved People Where They Are:

Considerations in the Reentry of Individuals with Behavioral Health Needs from Penal Settings

A Primer for the Philadelphia Department of Behavioral Health and Intellectual disAbility Services (DBHIDS) Provider Network
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Developed by:
Kelly Porter, BA
Public Health Intern
DBHIDS Policy Unit

Supported by:
Jaymes Fairfax-Columbo, JD, PhD
Behavioral Health and Justice Division
DBHIDS Policy Unit

Adam Stout, MPM
Planning and Innovation Division
DBHIDS Policy Unit

Background

The risk-need-responsivity (RNR) model was developed in the 1980s with the primary intention of reducing recidivism.[i] Recently, the model has been applied to the justice-involved population with a Serious Mental Illness (SMI). The following primer intends to make the RNR model readily understandable for providers treating justice-involved persons with an SMI. It will provide contextual information on SMI in the justice-involved population, provide information on risk factors for recidivism, and provide an overview of the RNR model. Additionally, it will examine how to maximize the chance of success in providing successful risk-reducing interventions through adequately addressing individuals' responsivity needs. The primer will conclude by making recommendations for providers so they can most effectively utilize the model for justice-involved individuals with an SMI.

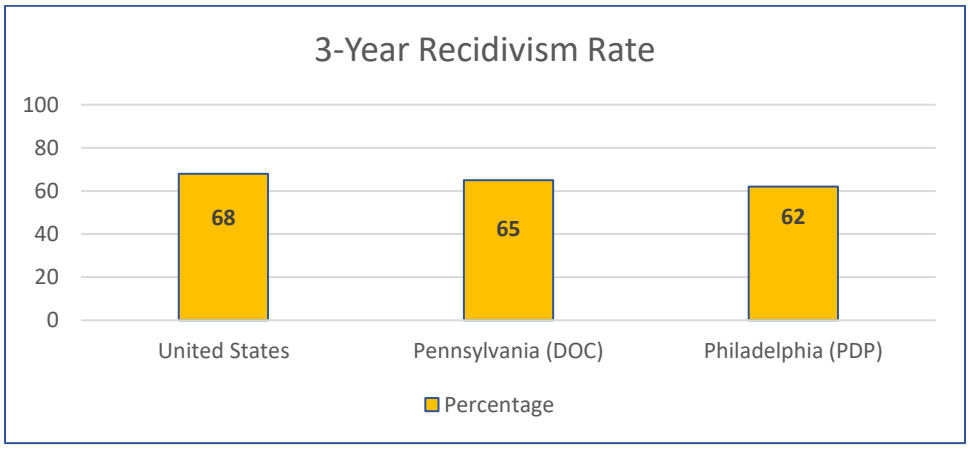
Serious Mental Illness

The U.S. National Institute of Mental Health (NIMH) defines serious mental illness ("SMI") as "a mental, behavioral, or emotional disorder resulting in serious functional impairment, which substantially interferes with or limits one or more major life activities."[ii] The Commonwealth's legal definition of an SMI is consistent with the NIMH definition. Per a bulletin by the Pennsylvania Office of Mental Health and Substance Abuse Services (OMHSAS), adults with an SMI include "persons aged 18 and over, who currently or at any time during the past year, have had a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet diagnostic criteria specified within the Diagnostic and Statistical Manual of Mental Disorders, Third Edition (DSM-III-R) that has resulted in functional impairment, which substantially interferes with or limits one or more major life activities."[iii] Schizophrenia, major depressive disorder, and bipolar disorder are three conditions that are categorized as SMIs.

Regarding the criminal justice system, SMIs are overrepresented in the Philadelphia Department of Prisons (PDP). In a 2014 *Philadelphia Inquirer* article, the director of medical operations for the Philadelphia jail system described the Philadelphia jail system as "the largest psychiatric hospital in Pennsylvania."[iv] Recent data from the First Judicial District of Pennsylvania Department of Research and Development states that 10.3% of the Philadelphia jail population has an SMI such as schizophrenia or bipolar disorder.[v]

Recidivism

The U.S. National Institute of Justice refers to recidivism as "a person's relapse into criminal behavior, often after the person receives sanctions or undergoes intervention for a previous crime."[vi] The PA Department of Corrections (PA DOC) refers to recidivism specifically as "the first instance of either rearrest or reincarceration to a PA DOC facility after previously being released from PA DOC custody."[vii] Within three years, approximately 68% of individuals released from prison in the U.S. are rearrested, 65% of individuals released from prison in Pennsylvania are rearrested, and 62% of individuals released from the Philadelphia jail system are rearrested.[viii]



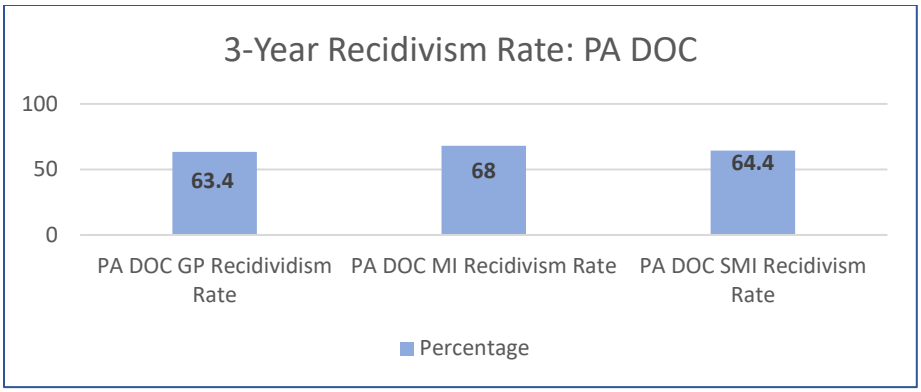
Recidivism has profound impacts on individuals and communities that reinforce the cycle of incarceration. Notably, justice-involved individuals more often experience homelessness, high rates of unemployment, and social stigma. [ix] Stigma may take the form of actual social exclusion or individuals being derogated/disfavored. However, anticipation of stigma can also produce deleterious consequences—like individuals becoming isolative—even if true stigma from others does not actually follow. Further, returning citizens might also engage in self-stigma, due to internalization of the idea that individuals with justice involvement are looked down upon.[x]

Each of these factors is associated with recidivism. Communities, particularly communities of color, may experience pervasive intergenerational poverty, erosion of social relationships, inadequate public safety, and economic instability.[xi] High-reentry communities, so named because they "experience a high degree of churn as individuals cycle back and forth between community and confinement,"[xii] may also experience stigma, economic stagnation, and loss of population. Frankford in Philadelphia has been studied and identified as an example of a high-reentry community.[xiii]

Recidivism and SMI

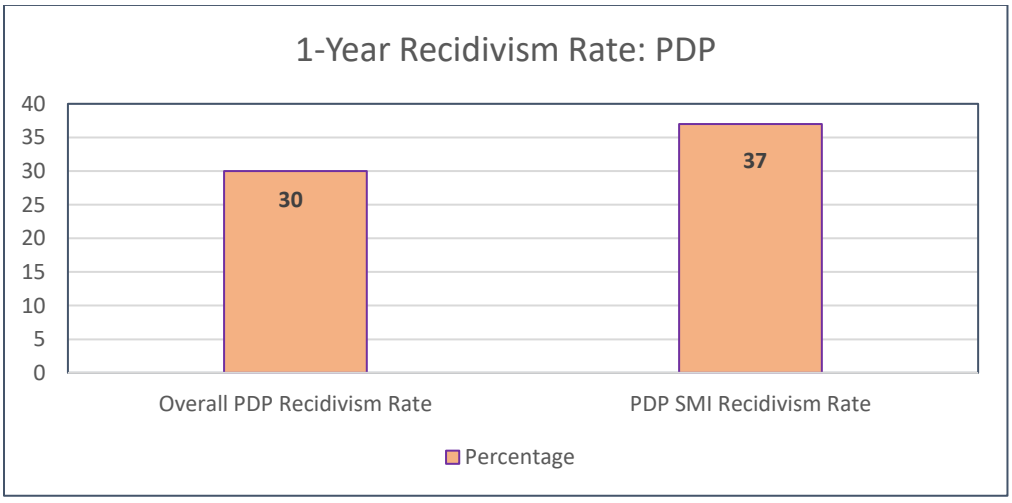
"The typical Philadelphia jail inmate with serious mental illness has already been in and out of the county system seven times before." – Philadelphia Inquirer, 2017[xiv]

Recidivism rates are high in both the general population and the population with mental health challenges generally as well as among individuals with SMIs. In Pennsylvania, the PA DOC reports that persons without diagnosed mental health challenges will recidivate at a rate of 63.4%; that a person with a diagnosed mental health issue—but not an SMI—will recidivate at a rate of 68%; and that a person with an SMI will recidivate at a rate of 64.4%.[xv]



Accordingly, the development of effective programs and services is vital for reducing recidivism in the justice-involved population, regardless of mental health status. These programs may be even more vital for individuals with an SMI, however, because the symptoms of their condition can exacerbate the barriers to seeking and maintaining employment and adequate housing that they are already face and that are essential to reducing the risk of reincarceration.[xvi] An individual with an SMI may have additional difficulties in finding and coordinating affordable mental health treatment upon release. Research has found poor coordination of mental health services and treatment to be associated with recidivism.[xvii] Research also suggests that there may be a compounding effect of criminal justice involvement and behavioral health concerns—such as substance use and/or an SMI—on stigma towards returning citizens.[xviii]

From a local perspective, SMI does appear to place individuals at greater risk of recidivism when reintegrating into society after release from PDP, at least in the short-term. Data tracked by the DBHIDS Behavioral Health and Justice Division revealed that as of Quarter 4 of 2022, within one-year of release, individuals with an indicated SMI recidivated at a rate of 37%, seven percentage points higher than the overall PDP recidivism rate of 30%.



Overview of the Risk-Need-Responsivity (RNR) Model Principles[xix]

The primary intention of the risk-need-responsivity (RNR) model is to reduce recidivism. As the name suggests, the model is based on three principles: (1) risk, (2) need, and (3) responsivity.

The Risk Principle: Identifying WHO to Target

The first principle, risk, identifies the likelihood that an individual will commit another crime in the future. It seeks to answer the question, "What is someone's risk level and what intensity of intervention should they receive?"

Risk is often wrongly equated with a likelihood of violence, dangerousness, or other serious criminal offenses. As a result, high-risk offenders are excluded from treatment programs. Psychologist and lawyer Doug Marlowe argues that this is the wrong strategy because high-risk offenders are unlikely to desist from crime without treatment programs, whereas low-risk offenders can stand on their own. Failing to match intensity of services to risk can lead to adverse effects, including increased recidivism.[xx]

Risk factors can be either static risk factors or dynamic risk factors. Static risk factors are factors that cannot be changed, such as past criminal offenses. These factors are immutable to intervention. An example of a static risk factor is one's age of first involvement in the criminal justice system. In contrast, dynamic risk factors are factors that can be changed, such as substance use. Accordingly, these factors should be the primary focus of intervention efforts.

The risk principle is considered well-developed because we have established risk assessment tools that effectively assess and identify higher risk offenders. For example, in Pennsylvania, Lancaster, Lebanon, and Bucks Counties utilize the Level of Service Inventory-Revised (LSI-R) in generating a risk score following a quantitative survey of offender attributes.[xxi] The score can be applied when allocating resources, assigning security level classifications, helping to make probation and placement decisions, and assessing treatment progress. Other examples of risk assessment tools include the Correctional Offender Management Profiling for Alternative Sanction (COMPAS), the Offender Screening Tool (OST), and the Risk and Needs Triage (RANT).

The Need Principle – Identifying WHAT to Target

The need principle answers the question, "What should we target to reduce risk?" The principle is divided into two categories: criminogenic needs and non-criminogenic needs.

Criminogenic needs are dynamic risk factors for criminal behavior and recidivism with the potential to be changed or treated. Canadian psychologists Donald A. Andrews and James Bonta identified eight major criminogenic needs, known as the "Big 8," to be assessed and targeted in interventions. The figure below shows the eight criminogenic needs and their indicators. The first four criminogenic needs (shaded in yellow) are often

referred to as the “Big 4” and are the most relevant needs in combatting recidivism. The remaining four (shaded in blue) are referred to as the “Lesser 4.” Though still important to target, addressing them has a lesser impact on reducing recidivism.[xxii] Typically, criminogenic needs should be treated before non-criminogenic needs.

Criminogenic Need	Indicators
Antisocial behavior	Early onset and continued involvement in antisocial activities
Antisocial personality pattern	Impulsivity, adventurousness, pleasure-seeking, restless aggression, and irritability
Antisocial peers	Association preferences with procriminal peers
Procriminal attitudes	Rationalizations for crime; negative attitudes towards the law
Family	Inappropriate parental monitoring and disciplining, poor family relationships
School and/or work	Poor performance and limited engagement with school and work
Leisure/recreation	Limited involvement in anti-criminal leisure activities
Substance use	Use of alcohol and/or drugs

*Early onset of justice system involvement is the only domain of the “Big 8” where criminal justice interventions will not work because it is historical in nature. However, continued involvement can be targeted.

Non-criminogenic needs are typically challenges or disorders that actively interfere with or undermine rehabilitation. Per Marlowe, they are “often a result rather than the cause of crime.”[xxiii] They can be further divided into responsivity (or stabilization) needs and maintenance needs.

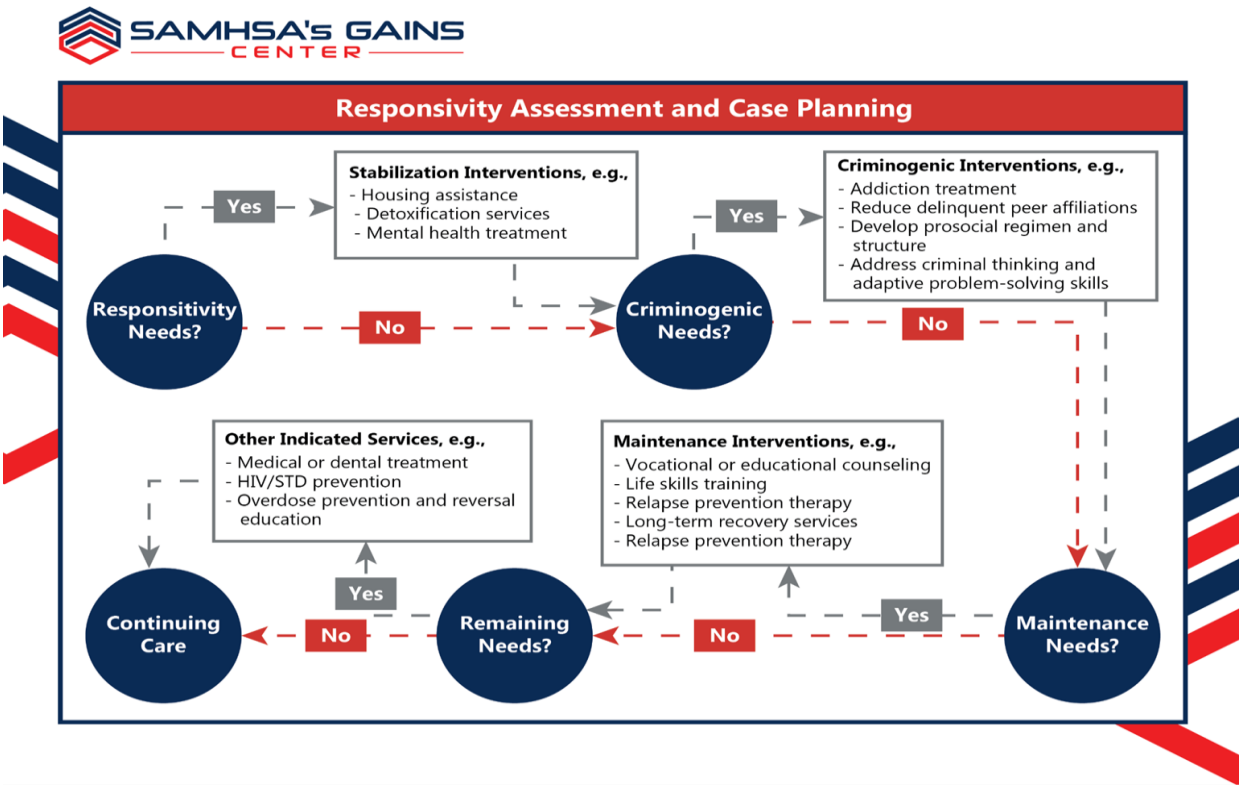
- **Responsivity needs** (also known as stabilization needs) are needs that are not independently related to crime, but that are related to recidivism reduction in that they *actively interfere with rehabilitation efforts for criminogenic needs*. These can include clinical syndromes (e.g., psychotic disorders, bipolar disorders, trauma symptoms, brain injuries) or social service needs (e.g., homelessness, lack of childcare). *Responsivity/stabilization needs are the exception to the rule that criminogenic needs should be treated first. Providers should treat responsivity needs first so they do not hinder/undermine treatment progress.*
- **Maintenance needs** are needs that are not directly related to crime and do not interfere with risk reducing intervention, but, if unaddressed, can diminish rehabilitation gains over time. Such needs might include low literacy skills, poverty, chronic medical needs, or deficient job skills.

The need principle is considered well-developed because criminogenic needs have been well-established by empirical literature.[xxiv]

The Responsivity Principle – Identifying HOW to Target

The third principle, responsivity, is "matching an offender's personality and learning style with appropriate program settings and approaches."[xxv] The responsivity principle seeks to answer the question, "How should we intervene?"

Responsivity encompasses general responsivity and specific responsivity. General responsivity calls for using evidence-based interventions and techniques to address criminogenic needs. Specific responsivity is "a 'fine tuning' of evidence-based interventions to consider an individual's strengths, learning abilities/style, treatment motivation, personality traits, cultural differences, demographic concerns, and trauma history, among other unique characteristics. In short, general responsivity encourages use of interventions that have been proven effective for broad groups of people with justice involvement, while specific responsivity concerns how to tailor those interventions to appeal to the specific individual in front of the provider.



Marlowe purports that the responsivity principle is comparable to general treatment planning and case management in other areas of behavioral health, yet with a specific emphasis on recidivism reduction.[xxvi] In the above graphic, the proper order for responsivity and case planning is outlined. The first stage requires identifying and stabilizing those needs that actively interfere with rehabilitation (responsivity/stabilization needs, referenced above), such as an SMI, when appropriate. The second stage is when case management would focus on criminogenic needs through interventions like substance use disorder (SUD) treatment, addressing destructive thinking styles, the

development of a prosocial regimen, and the development of non-delinquent peer affiliations. The third stage involves addressing maintenance needs and/or any remaining needs, such as medical or dental treatment.

The principle of general responsivity is considered well-developed because evidence-based interventions to address criminogenic needs exist. In contrast, the principle of specific responsivity is not considered well-developed. Little research has been done on how to adapt evidence-based risk reduction interventions for specialized populations, or how to take an individualized approach to employing risk reduction interventions.

Strengths and Weaknesses of the RNR Model[xxvii]

Over the years, commentators have identified several strengths of the RNR model. Among them is unifying power and external consistency—existing psychological theories and research data informed the development of the RNR model, so it can be used with almost any broadly-utilized psychological theory or orientation. The RNR model also has empirical validity in that any new data corroborates existing data. The model has practical utility in that it can be effectively utilized in a wide range of innovative programs.

Nevertheless, the model has drawn criticism. For one, the model is not necessarily accessible and does not translate to clinicians very well. This is because information on the model is only found by reading the *Psychology of Criminal Conduct* by Andrews and Bonta or reading an explanation of the model directly from the authors. Moreover, the model has been criticized for focusing too much on criminogenic needs over non-criminogenic needs.[xxviii] This focus could be because the principle of specific responsivity is not as developed as the other principles.

The Impact of Adequately Addressing Responsivity Needs

The use of the RNR model in risk reduction treatment can significantly improve recidivism rates and produce additional benefits. Andrews and Bonta determined that utilizing the RNR model can reduce recidivism by as much as 35%, and additional meta-analytic studies have found that using the RNR model can result in a reduction in sexual, violent, and general recidivism.[xxix] Additionally, the Washington State Institute of Public Policy found that supervision using the RNR principles resulted in a 31% reduction in recidivism and net savings of $20,660 per participant.[xxx]

In “meeting the justice-involved person where they are,” a more trusting and collaborative relationship may develop as the individual may feel that their provider is respecting them in aligning with their schedule and needs. Ultimately, adequately addressing responsivity needs may improve adherence and retention in treatment programs[xxxi], and retention can yield recidivism reduction.

Recommendations For Providers

The RNR model is not one-size-fits-all because individuals have different responsivity needs, including SMIs. The following recommendations may be helpful to providers who work with individuals with justice system involvement, and particularly with individuals with justice system involvement and an SMI:

- Providers should work towards a greater focus on specific responsivity in addition to general responsivity. In focusing on specific responsivity, providers should identify and build upon potential protective factors, such as computer skills and strong familial relationships.
- Providers should tailor treatment to individuals' non-criminogenic needs in order to help reduce any barriers to risk reduction treatment. For example, if an individual is illiterate, the provider should deliver treatment information orally rather than providing the person with a written pamphlet. Providers should also help connect justice-involved individuals to appropriate community resources based on criminogenic and non-criminogenic needs.
- When appropriate, providers should address an individual's responsivity/stabilization needs before their criminogenic needs. This is the one exception to the general principle that criminogenic needs should be targeted before non-criminogenic needs. Most importantly, providers should recognize that SMIs are not generally a cause of crime, though they can affect progress and increase the likelihood of recidivism if they are not treated and stabilized. For example, in cases where the justice-involved individual has pro-criminal attitudes and active symptoms of schizophrenia, the provider should seek to treat and stabilize the individual's psychotic symptoms before addressing the individual's pro-criminal attitudes. Addressing stabilization needs first gives other criminogenic interventions their best chance at success.
- To comport with the principle of general responsivity, providers should familiarize themselves with evidence-based treatments. DBHIDS supports training in numerous evidence-based treatments. More information can be found via DBHIDS' Evidence-Based Practice and Innovation Center.
- As the justice-involved population is more likely to experience trauma, providers should support staff being trained in trauma-informed care. Additionally, providers should encourage staff to become trained in empowerment interventions and techniques, to support justice-involved individuals who may feel powerless and/or stigmatized.
- Given the overrepresentation of individuals with an SMI in the justice system, providers should support staff becoming trained in recovery-oriented interventions. Cognitive Therapy for Recovery (CT-R) is one such intervention.
- Providers should be motivational and proactive in their outreach. For instance, an individual with major depressive disorder may struggle with scheduling appointments over the phone, which can be a demanding task. The provider could routinely check-in on the person via text message or email instead as

these are modes of communication that are less demanding. Providers might also seek to deliver low-barrier interventions including flexible scheduling of appointments, minimized associated paperwork, long-acting medications, and mobile treatment.

- Providers should be familiar with and utilize reentry checklists, such as the Housing Screening Questionnaire, the Council of State Governments (CSG) Reentry Checklist, and the GAINS (Gather, Assess, Integrate, Network, and Stimulate) Jail Reentry Checklist. These checklists can inform the provider on how to best address the individual's responsivity needs.
- Addressing non-criminogenic needs requires an enhanced focus on the social determinants of health (SDOH). For example, individuals without insurance should be connected to Medicaid if possible. Providers might also seek to connect individuals to case management or low barrier treatment options as appropriate. Further, providers might help individuals to access reliable and safe public transportation for traveling to and from appointments.

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