21C6001: The Foundation and Practical Application of Risk, Need, and Responsivity in the Age of COVID-19 and Justice Reform

Community Supervision Week July 18-24, 2021
July 21, 2021
Before we get started…

1. The broadcast will be recorded and all lines will be muted.
2. Submit questions in the “Chat” to “Everyone” and they will be answered accordingly.
3. Send a message via the “Chat” pane if you have technical issues.
Presenters

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The Foundation of Practical Application of Risk, Need, andResponsivity in the Age of COVID-19 and Justice Reform

Objectives

- Brief overview of the criminal justice system in the era of COVID-19 and justice reform;
- Understand how common fallacies and misunderstandings about risk-need-responsivity (R-N-R) principles have contributed to unwarranted reliance on incarceration and racial and ethnic disparities. Learn how proper use of RNR can reduce unfair disparities, enhance criminal justice outcomes, and lead the way to effective and equitable justice reform;
- Demonstrate a practical application of the principles using reintegrating individuals within Multnomah County; and
- Describe strategies to create and maintain collaborative relationships to achieve effective community supervision.
Risk, Need, Responsivity and Criminal Justice Reform

Douglas B. Marlowe, J.D., Ph.D.

National Association of Drug Court Professionals
Policy Landscape

• End of determinate sentencing; reemergence of rehabilitation
• Smart sentencing (rolling back mandatory minimums)
• Justice reinvestment (reduce prison population drivers)
• Justice realignment (county ownership) \((e.g., \text{CA AB109})\)
• Decriminalization \((e.g., \text{OR Measure 110})\) and defelonization \((e.g., \text{CA Prop 47})\)
• Increased recognition of implicit racial & ethnic bias and systemic injustices
• COVID-19 (jail impacts and health disparities)
• Caps on community supervision terms \((e.g., \text{CA AB1950})\)
• “Defund the Police”; “Shrink Community Corrections”
Upshot of These Developments . . .

- Community corrections must be faster, more efficient and more effective.
- Must do our jobs with fewer resources.
- Have considerably less leverage at our disposal.
- Must continually ensure racial, ethnic, and cultural equity.
- Must deliver more services remotely.
- Must prove our efficacy to a skeptical public and policymakers.
- Must defend evidence-based practices against assertions from both ends of the political spectrum.
• “Evidence-based” depends on when, how, and to whom services are delivered
• Match supervision intensity to risk, and treatment intensity to need
• Specific Responsivity: order and timing of services is critical:
  1. Responsivity needs -- interfere with rehabilitation (e.g., mental illness)
  2. Criminogenic needs -- cause or exacerbate crime (e.g., antisocial peers)
  3. Maintenance needs -- undermine treatment gains (e.g., illiteracy)
  4. Restorative justice needs -- enhance reintegration (e.g., victim restitution)
• Certainty and celerity (immediacy) of responses
• Adjusted magnitude: proximal vs. distal vs. mastered behavioral goals
• Phase specificity: what was distal becomes proximal and is eventually mastered
We Must Quickly and Efficiently . . .

- Assign supervision and treatment models based on risk and need
- Develop case plans ensuring service delivery in the proper sequence
- Move participants through phases based on mastery, not time
- Match response magnitude to the proximal, distal or mastered nature of behaviors
- Determine when distal goals have become proximal or mastered and alter responses
- Deliver frequent remote reminders, social messaging, and incentives & sanctions
- Capture key performance indicators (KPIs) (e.g., service matches; certainty, celerity and magnitude of responses) for continuous quality improvement (CQI)
What Do We Need?

- We cannot become more effective or efficient by shrinking.
- We must automate our procedures and operations pursuant to RNR principles and specific responsivity case-planning.
- We must make greater use of remote technologies for check-ins, delivery of incentives and sanctions, performance feedback, surveillance and CQI.
- We must work together with the treatment and social service systems to coordinate services for high risk and high need persons.
- All KPI’s must be examined continuously by race, ethnicity, gender and other cultural factors to assess equity and inclusion -- and reported publicly.
Practical Application of Risk Need Responsivity in Multnomah County

Erika Preuitt, Director of Community Supervision

Multnomah County, Oregon
DCJ’s journey as a learning organization is rooted in a strong foundation based on:

- Equity, data science, system partnership, and community engagement.

We believe in taking the time to understand an issue, and working with impacted individuals and communities to design sustainable solutions.

**Risk assessments**
- Level of Service / Case Management Inventory (LS/CMI)
- Public Safety Checklist (PSC)
- Risk Assessment Instrument (RAI)
- Women’s Risk Needs Assessment (WRNA)

**Case management**
- Effective Practices in Community Supervision (EPICS)
- Functional Family Probation (FFP)
- African-American Program (AAP)
- Community Healing Initiative (CHI)
- Specialty units

**Leading with race**
- Examining our operations with the specific lens of “what hinders/helps” BIPOC, and adjusting as needed.
- Diane Wade House
- Habilitation, Empowerment, Accountability, Treatment (HEAT)
- Smart Supervision Project
Community Safety through **Positive Change**

We believe people (*and systems*) can change.

- Do not assume your staff understand RNR - train and coach them regularly.
- Adopt an actuarial assessment tool, regularly engaging in interrater reliability.
- Use a consistent case plan format – coach regularly.
- Engage in cognitive behavioral case management model - establish coaches and regular booster sessions.
- Understand the intersection of trauma and brain science, and how they impact individuals on supervision - train and coach regularly.
- Invest in resources to help individuals stabilize.
- Celebrate success and provide incentives to clients and staff.
- Ensure managers are skilled coaches, modeling these skills to their staff.
- Integrate foundational implicit bias and equity lens training to all levels of employees - we need to give ourselves the oxygen mask before we can help others.
Organizational components

Diversity and Equity Steering Committee (DESC)
This department-wide group supports continuing education to increase understanding on issues of diversity, equity and race.

Workforce Equity Strategic Plan (WESP)
Multnomah County’s response to longstanding inequities in the organization’s recruiting, hiring, professional development, promotion and retention practices.

➢ DCJ is actively improving hiring practices with these goals in mind: creating a workforce that reflects the communities we serve, hiring returning citizens, increasing our employee retention rates.

Peer and Trauma Support Team (PTST)
Our volunteers provide timely and confidential assistance, support and referrals to fellow DCJ employees during challenging life events.

Core Competencies
In 2018, Multnomah County introduced a Core Competency Model. The 10 Core Competencies describe how we behave, our values as an organization and how we do things here. They are not technical skills specific to a role or department. Instead, living the Core Competencies is an expectation of every County employee, regardless of role or department. Think of them as our shared language and North Star.

DCJ Programming*
➢ African-American Program (AAP)
➢ Community Healing Initiative (CHI)
➢ Community Partners Reinvestment (CPR)
➢ Diane Wade House
➢ Habilitation Empowerment Accountability Treatment (HEAT)
➢ Hands of Wonder / Culinary Arts
➢ Justice Involved Women and Families
➢ Juvenile Detention Alternatives Initiative (JDAI)
➢ Smart Supervision Project
➢ Specialty Units

*DCJ’s programming typically involves collaboration with one or more system/community partner
Use the science

We know more today than ever before, and we continue to learn. Equity, trauma-informed practices, and brain science show us the way to better results and desperately needed reform.

Community engagement

The community, most importantly individuals we supervise, are the experts in their experience and they know what their needs are. It’s our job to listen and respond.

System partnerships

In Multnomah County, we have a spirit of collaboration and partnership within the justice system. Collectively, we come to various decision-making tables together and work hard to understand each other’s perspective.

Don’t be afraid to open the door

This is a marathon, not a sprint. Try not to get caught up on what’s been done, focus on where you’d like to be as an organization. Keep assessing and examining your practices, ask for help.
Next Steps

Engage staff in future of work planning.
Examine efficacy of tools used during the pandemic to reach and work with clients.
Run toward the data to analyze disparities and reverse them where possible.
Engage in Workforce Equity Strategic Plan to strengthen hiring, retention, recruiting and professional development.
Focus on community partnerships and build culturally responsive programming to inclusively lead with race.
Refine case management practices to ensure effectiveness and minimize supervision lengths.
Applying Risk, Need, Responsivity in a Criminal Justice/Behavioral Health Collaboration

Mack Jenkins, M.S., Chief Probation Officer (ret)

Member-California Council on Criminal Justice and Behavioral Health (CCJBH)
It is Not Criminal Justice “Reform”

• Reform is the wrong word.
• CJ system is *evolving* through the incorporation of knowledge gathered through research, and the application of science based principles of behavior change.
• Now have knowledge regarding interventions that address behavioral health issues found in a justice involved population.
• Employing those interventions requires a partnership between supervision and treatment.
It is Not Criminal Justice “Reform”

• The issue is not accountability or treatment, the focus must be both.

• Collaboratively applying RNR is of a part of the evolution of the criminal justice system.
Three Core Principles of RNR

**Risk Principle**: Match the level of service to the individual's risk to re-offend.

**Need Principle**: Assess criminogenic needs and target them in treatment.

**Responsivity Principle**: How treatment should be provided. Maximize the individual’s ability to learn by providing cognitive behavioral treatment and tailoring the intervention to his/he’s learning style, motivation and strengths.
Supervision Model in RNR Collaboration

- Identifies the “who” (i.e., high risk) and screens for the “what” (criminogenic needs) through criminal risk/need assessment.
- Addresses the “how” through cognitive based interventions.
- Provides supervision beyond a surveillance and compliance focus.
- Utilizes the “Balanced Approach” model of supervision/engagement
  - Applies both accountability and social work roles
  - Social work role includes the “coach” model of supervision
  - Facilitates behavior change
- Utilizes Core Correctional Practices
  - Delivered through an application of case management practices
- Communicates/coordinates with Behavioral Health (Treatment)
Behavioral Health Role in RNR Collaboration

• Identifies the “clinical what” aka clinical needs/diagnosis, through clinical assessment.

• Addresses the “how” through both clinical and cognitive behavioral interventions targeting clinical and as necessary, criminogenic needs.

• Reducing recidivism and criminal justice involvement become part of treatment and recovery goals.

• Communicates/coordinates with supervision.
Defining the CJ/BH Collaboration

The partners: probation/parole, county/state agencies, private providers, and community based organizations.

- Establish common priorities between criminal justice and behavioral health systems for individuals who are likely to commit future crimes and have treatment needs;
- Share information across systems;
- Utilize interdisciplinary trainings to promote and sustain the collaborative interplay between supervision and treatment; and
- Create a common starting point and facilitate support for cross system support for polices, practices and decision making.
Collaborative Case Management in the CJ/BH Collaboration

“Professional Case Management” = Collaborative Case Management is the core of the collaboration…

• Collaborative case management is the process through which supervision and treatment join in the effort to provide intervention services through the term of supervision;

• Translate clinical and criminal assessment information into a unified set of goals to address prioritized needs.

• The practices of assessment, planning, treatment engagement, monitoring and advocacy are coordinated; and

• The elements of multiple case plans (supervision, treatment providers) are shared, client activities/expectations are coordinated and collaboratively monitored.
Collaborative Approach to Responsivity

Remember Dr Marlowe’s point on Specific Responsivity:

“Specific Responsivity: order and timing of services is critical:

1. Responsivity needs -- interfere with rehabilitation (e.g., mental illness)
2. Criminogenic needs -- cause or exacerbate crime (e.g., antisocial peers)
3. Maintenance needs -- undermine treatment gains (e.g., illiteracy)
4. Restorative justice needs -- enhance reintegration (e.g., victim restitution)"

The application of this principle should involve collaboration and coordination between:

• Supervision agencies
• Behavioral health providers
• Community providers
Checklist for Criminal Justice/Behavioral Health Collaboration-Decision Makers

✓ Does a formal relationship exist between the supervision agency and behavioral providers?
  • Is there an expectation of working together? MOUs, contracts?

✓ Is information sharing sufficient for collaborative case management between supervision and providers?
  • Risk/Need info, MH/SA screening info, case plan goals, progress, etc.

✓ Are sufficient interdisciplinary trainings in place to promote and sustain collaborative relationship between supervision officers and providers?
Checklist for Criminal Justice/Behavioral Health Collaboration—Decision Makers

Does the criminal case process continuum (arrest through sentencing) include:

✓ Criminal risk assessment?
✓ MH and substance use screening?
✓ Clinical assessment and coordinated (if not integrated) case planning?
Checklist for Criminal Justice/Behavioral Health Collaboration - Line level officers

✓ Do you have a seamless relationship with the behavioral health providers in your jurisdiction?
✓ Do you refer treatment to treatment or do you work with treatment?
✓ Do you complete a risk and need assessment and share that information with providers delivering services to individuals on your caseload?
✓ Do you develop case plans that identify and target criminogenic needs?
✓ Do you share your case plan goals with providers and do they share treatment goals and priorities with you?
✓ How do you and providers address general and specific responsivity?
Checklist for Criminal Justice/Behavioral Health Collaboration - Clinicians/Treatment Providers

✓ Do you have a seamless relationship with community supervision in your jurisdiction?
✓ Do you complete a clinical assessment and share that information with your community supervision partners?
✓ Do your treatment plans address both clinical and criminogenic needs?
✓ Do you share your treatment plans shared with your community supervision partners?
✓ Do your plans address both general and specific responsivity?
✓ Between you and your community supervision partners are there multiple plans and are they integrated and compatible?
The CJ system is no longer simply about, arrest, adjudication, disposition/punishment,
It's not “reforming”, it is evolving through research and application of science.
RNR part of the science.
The effective application of RNR requires a collaboration between criminal justice and behavioral health;
Collaborative case management is the key to that relationship;
The effective collaboration requires specific steps for decision-makers, and line-level probation officers, and clinicians.
Questions from the Field?

What questions do you have?

*Chat* them now!
Key Resources for COVID-19

Centers for Disease Control and Prevention
https://www.cdc.gov/

Coronavirus (COVID-19)
https://www.coronavirus.gov/

Government Response to Coronavirus (COVID-19)
https://www.usa.gov/coronavirus

National Center for State Courts
https://www.ncsc.org/

U.S. Department of Veterans Affairs, Veterans Justice Outreach
https://www.va.gov/HOMELESS/VJO.asp

U.S Department of Veterans Affairs [See Coronavirus FAQ’s on homepage]
https://www.va.gov

National Institute of Corrections
https://nicic.gov/coronavirus

National Association of Drug Court Professionals
https://www.nadcp.org/covid-19-resources/
Thank you for participating!

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