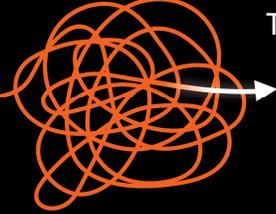




MacEwan UNIVERSITY

Safer Society Foundation
Online Training



Translating Risk, Need,
and Responsivity
(RNR) Principles
into Supervisory and
Clinical Practice

Sandy Jung, PhD, RPsych
Professor and Forensic Psychologist
Edmonton, Alberta, Canada

1



Agenda

8am – 12:30pm PT
11am – 3:30pm ET

8am PT 11am ET	
1. RNR overview	2. Risk principle
9:30 PT 12:30 ET	15-min break
9:45am PT 12:45pm ET	
3. Need principle	4. Responsivity principle
12:30 PT 2:30 ET	15-min break
12:15pm PT 2:15pm ET	
5. Specific responsivity principles	6. Big picture and implementation

Financial Interest Disclosure:
Speaker has a book published related to the workshop topic, for which the speaker receives royalties.

2

2025



ATSA
6th EDITION
**BEST PRACTICE
GUIDELINES
FOR MEN**
Best Practice Guidelines for the Assessment, Treatment,
Risk Management, and Risk Reduction
of Men Who Have Committed Sexually
Abusive Behaviors

EMPIRICAL FRAMEWORK

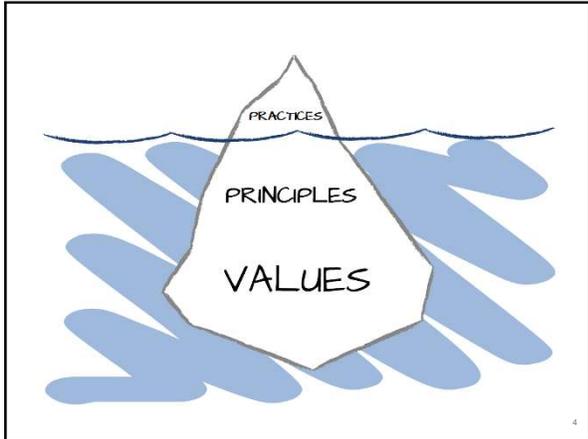
Empirical findings in the research literature have identified that treatment for criminal justice-involved populations is most effective when it is delivered in accordance with the Risk-Need-Responsivity model (RNR). Given the efficacy of this model and its applicability for men who have committed sexually abusive behaviors, the principles of RNR are prevalent in the *Best Practice Guidelines for Men*. Key features of the model are:

Risk Principle — Guides who to target for intervention based on the likelihood of recidivism.

Need Principle — Guides what areas should be identified and targeted for intervention and supervision.

Responsivity Principle — Guides how interventions should be delivered.

3



4



5

Pre-1980s
Growing focus on punishment

Supported by
Martinson's
1974 review

GPCSL theory:
General Personality and
Cognitive Social Learning

Mounting evidence
for treatment
Meta-analyses

RNR

Growth of
measures

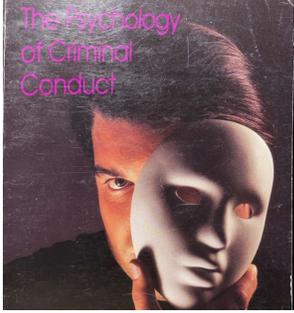
Applying RNR to
individuals who are
sexually violent

Andrew & Bonta (2010a, 2010b)

6

General Personality and Cognitive Social Learning (GPCSL) theory

- 8 major risk/need factors "Central Eight"
- Criminal behavior is learned
- Varies by rewards and costs for criminal and noncriminal behaviors

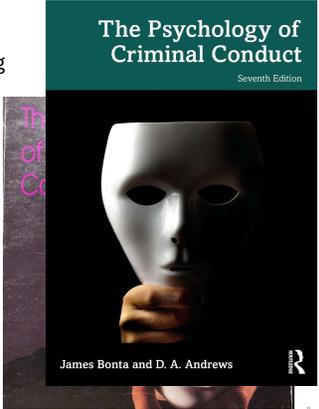


Andrews & Bonta (1994)

7

General Personality and Cognitive Social Learning (GPCSL) theory

- 8 major risk/need factors "Central Eight"
- Criminal behavior is learned
- Varies by rewards and costs for criminal and noncriminal behaviors



Andrews & Bonta (1994); Bonta & Andrews (2024)

8

Principles of the Expanded RNR Model

- Overarching Principles**
 1. Respect for the person
 2. Theory
 3. Crime prevention services
- Key Clinical Issues**
 9. Breadth
 10. Strengths
 11. Structured assessment
 12. Professional discretion
- Core RNR Principles**
 4. Human service
 5. Risk
 6. Need
 7. General responsibility
 8. Specific responsibility
- Organizational Principles**
 13. Community-based
 14. GPCSL-based practices
 15. Management

Andrews, Bonta, & Wormith (2011); Bonta & Andrews (2024)

9

Why Should We Implement RNR Principles into Practice

By increasing levels of Risk-Need-Responsivity adherence (meta-analytic examination, $k = 374$):

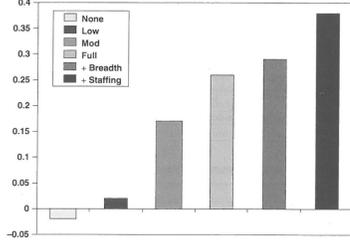
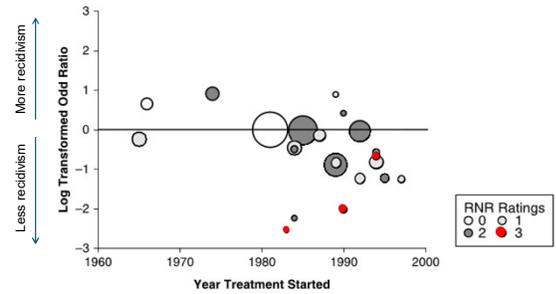


Fig 2.8 (p.76) from Andrews & Bonta (2010a)

13

Why Should We Implement RNR Principles into Practice *with Those Who Sexually Abuse*



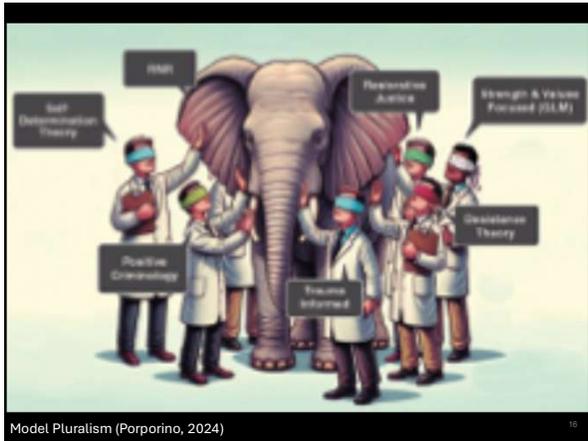
Hanson et al (2009)

14

Arguments Against RNR



15



16

Principles of RNR:

Take home messages

- Adherence with RNR is primary when the goal is to reduce criminal victimization
- With increasing adherence to the 3 principles, there is a corresponding reduction in violent and sexual recidivism



- In light of the constraints in both institutional and community resources, RNR provides best 'bang for your buck'

17

Part B: The Risk Principle



18

RNR Principles: Risk Principle

WHO to treat



- Offender recidivism can be reduced if the level of treatment services provided is proportional to the offender's risk to re-offend

Bonta & Andrews (2024) 19

19

RNR Principles: Risk Principle

WHO to treat



Prediction:
Predict criminal behavior using evidence-based risk tools



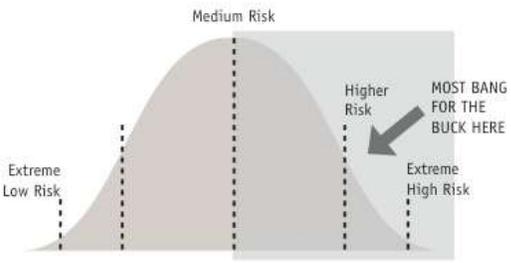
Matching:
Match intensity of service to risk level



Andrews & Bonta (2010a); Andrews et al (2011); Bonta & Andrews (2024) 20

20

Risk Principle: Why is this important?



Extreme Low Risk Medium Risk Higher Risk Extreme High Risk

MOST BANG FOR THE BUCK HERE

Jung (2017) 21

21

Risk Principle:
How are we assessing for risk?

Systematic collection of information

Evidence-based
 Review documents
 Comprehensive interview
 Collateral interviews
 Risk prediction and prevention

22

Risk Principle:
Which risk assessment tool?

Use evidence-based practices

The highest form is empirical evidence: research, data, results from controlled studies, etc.
But sometimes it doesn't make us feel good.

The lowest form is anecdotal evidence: stories, opinions, testimonials, case studies, etc.
But it often makes us feel good.

23

Risk Principle:
Which risk assessment tool?

Unstructured Clinical Judgment
 • Purely subjective
 • Not evidence-based

Actuarial Prediction
 • Statistical evidence
 • Outperforms most tools

Structured Professional Judgment
 • Predetermined risk factors
 • Professional judgment

24

**Risk Principle:
Use validated risk tool**

2 Members conduct objective, impartial, and reliable assessments that support well-informed decision making and maintain the credibility and integrity of the profession. In this regard members should:

Estimation of Risk Tools

6.04 Comprehensive assessments should involve the inclusion of tools that estimate a client's level or category of risk for sexual recidivism and may offer probabilities for sexual recidivism over time. Risk may also be assessed for violent non-sexual recidivism and general recidivism. Risk assessments may be conducted and reported as part of a stand-alone risk assessment report that incorporates some, but not necessarily all, components of a comprehensive assessment.

- Use empirically supported instruments and methods (i.e., validated actuarial risk assessment tools and structured, empirically guided risk assessment protocols) rather than unstructured clinical judgment.
- Use the most current and updated form of the risk assessment tools being used.
- Be appropriately trained in scoring, interpreting, effectively and accurately reporting, and applying the findings of the risk assessment instruments and protocols used.

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25

25

**Risk Principle:
Use validated risk tool**



- Actuarial measures [e.g., Static-99R]
- Structured professional judgment [e.g., SVR-20]
- Hybrid tools that measure change [e.g., VRS-SO]

• Using multiple tools:

- Disparity among measures (Barbaree et al., 2006; Jung et al., 2013)
- Use single measure (Kroner et al., 2005; Seto, 2005)
- Averaging between measures (Babchishin et al., 2012)
- Be explicit in what approach was used (Skeem & Monahan, 2011)

26

26

**Risk Principle:
Cautionary Considerations**

We make errors and biases

- Fundamental attribution error
- Illusory correlations
- Self-serving bias
- Representative heuristic
- Confirmation bias
- And the list goes on...

Duwe & Rocque (2018); Hanson & Morton-Bourgon (2009); Harris et al. (2002)

27

27

**Risk Principle:
Cautionary Considerations**

We make errors and biases

- Fundamental attribution error
- Illusory correlations
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- Confirmation bias
- And the list goes on...

Duwe & Rocque (2018); Hanson & Morton-Bourgon (2009); Harris et al. (2002)

Applying clinical override reduces predictive validity

Schmidt et al. (2016); Wormith et al. (2012)

Self-evaluate biases

- Evaluator-specific
- Case-specific
- Context-specific

Miller & Brodsky (2011)

Handout

28

28

**Risk Principle:
Move towards common risk language**

Very low (0-5%)	Category I	Custody counterproductive
Below average (6-13%)	Category II	Case management
Average (14-25%)	Category III	100-200 hours
Above average (26-85%)	Category IV	200-300 hours / 300+ hours
(>86%)	Category V	Non-existent

(see youtube videos by Andrew Brankley)

Hanson et al (2017)

29

Risk Principle

Matching:
Match the level of service to the offender's risk to re-offend

Lower intensity

Higher intensity

<p>Low risk</p> <p>Community program</p> <ul style="list-style-type: none"> - 6 months, 3 hour/wk group - Individual work is available - ~100 hrs total 	<p>High risk</p> <p>Prison program</p> <ul style="list-style-type: none"> - 12-18 months, 15 hour/wk group - Non-sex offender programs available - Individual work is available
---	---

Cortoni & Nunes (2008); Olver et al (2009); Wakeling et al (2012)

30

30

Case example: **Cory, 58**

- No prior record
- Retired
- 2 female victims



31

31

Case example: **Cory, 58**

Stato-2002R Scoring Summary (Actuarial Risk Measure)
(Phenix, Helmus, & Hanson, January 2012)

- No prior record
- Retired
- 2 female victims



Risk Factor	Scores	Converted Subscore
1. Age at release [40 to 59.9 = 0]		
<i>Age</i>		
2. Prior sentencing occasions for sexual offending [none]		
3. Juvenile arrest / adult conviction for sexual offending [none]		
4. Rate of sexual offending [none]		
<i>Persistence of Sexual Offending</i>		
5. Any sentencing for non-contact sexual offending [none]		
6. Any male victim [none]		
7. Young, unrelated victims [yes, has two or more <12 years victims, unrelated]		
<i>Deviant Sexual Interests</i>		
8. Any unrelated victim [yes]		
9. Any stranger victim [none]		
<i>Relationship to Victim</i>		
10. Prior criminal justice system [none]		
11. Prior sentencing [none]		
12. Community supervision violation [none]		
13. Years free prior to index sexual offending [none]		
14. Prior non-sexual violence sentencing [none]		
<i>General Criminality</i>		
TOTAL SCORE:		

32

32

Case example: **Cory, 58**

Stato-2002R Scoring Summary (Actuarial Risk Measure)
(Phenix, Helmus, & Hanson, January 2012)

- No prior record
- Retired
- 2 female victims



Risk Factor	Scores	Converted Subscore
1. Age at release [40 to 59.9 = 0]	0	0
<i>Age</i>		
2. Prior sentencing occasions for sexual offending [none]	0	0
3. Juvenile arrest / adult conviction for sexual offending [none]	0	0
4. Rate of sexual offending [none]	0	0
<i>Persistence of Sexual Offending</i>		
5. Any sentencing for non-contact sexual offending [none]	0	0
6. Any male victim [none]	0	0
7. Young, unrelated victims [yes, has two or more <12 years victims, unrelated]	1	1
<i>Deviant Sexual Interests</i>		
8. Any unrelated victim [yes]	1	1
9. Any stranger victim [none]	0	0
<i>Relationship to Victim</i>		
10. Prior criminal justice system [none]	0	0
11. Prior sentencing [none]	0	0
12. Community supervision violation [none]	0	0
13. Years free prior to index sexual offending [none]	0	0
14. Prior non-sexual violence sentencing [none]	0	0
<i>General Criminality</i>		
TOTAL SCORE:	2	2
(5-yr, 2.1% using routine sample as comparison)		

33

33

Case example
Cory, 58

• What would be your next step?

Lower intensity Higher intensity



Community program
- 6 months, 3 hour/wk group
- Individual work is available

Prison program
- 12-18 months, 15 hour/wk group
- Non-sex offender programs available
- Individual work is available

34

34

Risk Principle:
Take home messages

- Sound RNR assessment
- Evidence-based practice / assessment instrument
- Self-check on subjectivity creeping in
- Suit the treatment intensity to the assessment, regardless of which evidence-supported measure is used
- Need to consider decision-making within the real constraints of what programs exist (or what is possible to develop)



35

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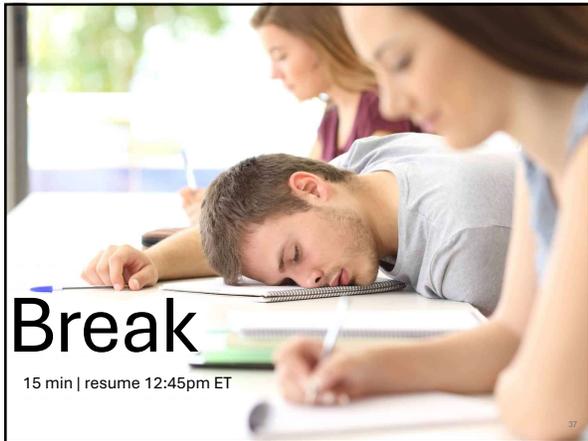
Risk Principle:
Take home message about low risk offenders

1. Treatment services provided to low risk offenders should be kept to a minimum.
2. If treated, low risk offenders should be separated as much as possible.
3. Often, most or all of the low risk offenders' needs are noncriminogenic needs (e.g., anxiety, depression and general feelings of distress).

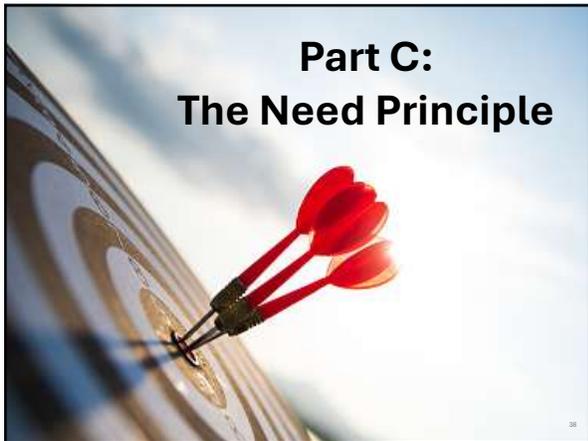
Andrews & Bonta (2010a); Bonta (2009); Wakeling et al (2012)

36

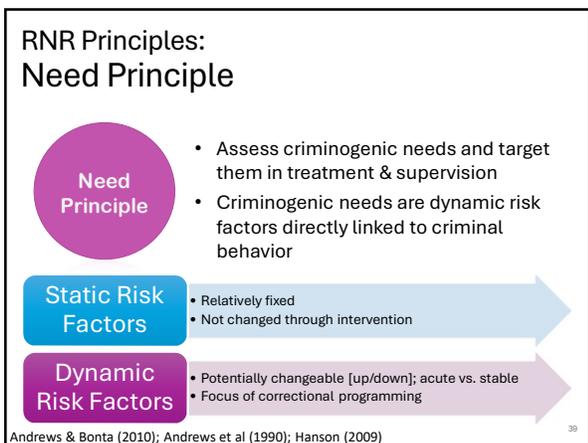
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37



38



39

**Need Principle:
Central 8**

The Big Four

- 1. History of antisocial behavior [static]
- 2. Antisocial personality pattern
- 3. Antisocial cognition
- 4. Antisocial associates

The Moderate Four

- 5. Family/marital circumstances
- 6. School/work
- 7. Leisure/recreation
- 8. Substance abuse

Andrews & Bonta (2010a); Andrews et al (2004)

40

**Need Principle:
Relevant Treatment Targets**

Dynamic Risk Factors
(criminogenic needs of those who sexually abuse)

- Sexual preoccupation
- Paraphilic interests
- Offense-supportive attitudes
- Emotional intimacy deficits
- Impulsivity & poor problem solving
- Resistance to rules/supervision
- Negative social influences

Mann et al (2010)

41

**Need Principle:
Promising Dynamic Factors**

Hostile beliefs about women

Machiavellianism (view others as weak, easily manipulated)

Lack of concern for others/callousness

Dysfunctional coping

Mann et al (2010)

42

**Need Principle:
Unsupported Needs**

Potential risk factors	Not risk factors
<ul style="list-style-type: none"> • Denial • Low self-esteem • Major mental illness • Loneliness 	<ul style="list-style-type: none"> • Depression • Social skills deficits • Poor victim empathy • Poor motivation for treatment

Differentiate between criminogenic needs and clinical needs

Mann et al (2010) 43

43

**Need Principle:
Empirically-Supported Tools**
(not an exhaustive list)

- Stable-2007 / Acute-2007
 - SAARNA: <https://saarna.org>
- SVR-20 / RSVP
 - Protect International: <https://protect-international.com>
- VRS-SO
 - Psynergy Consulting: <http://www.psynergy.ca/>
- ARMADILLO (for developmentally delayed SOs)
 - <http://www.armidilo.net>
- SOTIPS
 - <http://robertmcgrath.us>

Also, other risk tools (e.g., VRAG, LS/CMJ)



44

**Need Principle:
Intimate partner sexual violence**

Choose based on what you want to predict

<p>Intimate partner violence</p>	<ul style="list-style-type: none"> • ODARA: Ontario Domestic Assault Risk Assessment (13) • SARA: Spousal Assault Risk Assessment (20) • B-SAFER: Brief Spousal Assault Form for the Evaluation of Risk (15) • Danger Assessment (20)
<p>Sexual violence</p>	<ul style="list-style-type: none"> • Static-99/R (10) • Static-2002/R (14) • Stable-2007 / Acute-2007 • SVR-20: Sexual Violence Risk-20 / RSVP: Risk for Sexual Violence Protocol • VRS-20: Violence Risk Scale for Sex Offenders

 ODARA 101 website for more resources and training info

45

Need Principle:
Intimate partner sexual violence

1. Relationship conflict
2. Social supports
3. Antisocial behavior / personality pattern
4. Antisocial cognitions
5. Substance abuse
6. Lethality-relevant factors (imminence):
 - Depression
 - Desperation
 - Hopelessness
 - Stress from School/Work

Andrews & Bonta (2010a); Capaldi et al (2012); Hilton & Ennis (2020)

46

Need Principle:
Intimate partner sexual violence

What else should I look for?

- violent fantasies (recurrent and/or fixations)**
 - about an individual
 - escalate in seriousness
- grandiose delusions**
- narcissism**
- leakage**
 - subtle threats (or suggestive indications of violence)
 - recurring themes (violence, hopelessness, despair, hatred, isolation, loneliness, pessimism or "end of the world" philosophy)
- weapon possession**
- coercively controlling behaviors**

47

Need Principle:
Matching treatment and/or supervision with criminogenic needs

- Sexual preoccupation
- Paraphilic interests
- Offense-supportive attitudes
- Emotional intimacy deficits
- Impulsivity & poor problem solving
- Resistance to rules / supervision
- Negative social influences

Handout

48

Need Principle: Implementation at a micro-level

How can we target criminogenic needs?

- Mainstream correctional programs that meet the risk, need, and responsivity principles
 - Sexual self-regulation skills training
 - Behavioral conditioning of deviant sexual arousal
 - Sexual preoccupation (medication)
 - Substance use
 - Problem-solving skills
- Creating modules and/or finding existing community programs
- Restrictions on whom they associate with
 - Restrictions on contacts with children or vulnerable adults when supervised in the community

49

49

Need Principle: Take home messages

- Criminogenic needs can come and go, unlike static risk factors that can only change in one direction (increase risk) and are immutable to treatment intervention
- Offenders have many needs deserving of treatment, but not all these needs are associated with their criminal behavior
- Sound individualized assessment of empirically supported needs



50

50

Case example: Daniel

- Abusive childhood
- Age 21, abused niece



- Age 33-36, 5 victims



51

51

Case example: **Daniel**

Static-99R Score Summary

Risk Factor	Yes = 1, No = 0	Under 60 Release Score
1	Age at Release? (Score range is -3 to 1)	-1
2	Ever lived with lover \geq 2 years?	0
3	Index non-sexual violence, any conviction?	1
4	Prior non-sexual violence, any convictions?	0
5	Prior sex offenses? (Score range is 0-3)	3
6	Prior sentencing dates (excluding index)?	0
7	Convictions for non-contact sex offenses?	0
8	Any unrelated victims?	1
9	Any stranger victims?	1
10	Any male victims?	1
Total Score =		6

- Abusive childhood
- Age 21, abused niece
- Age 33-36, 5 victims




52

Case example: **Daniel**

Static-99R Score Summary

Risk Factor	Yes = 1, No = 0	Under 60 Release Score
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4	Prior non-sexual violence, any convictions?	0
5	Prior sex offenses? (Score range is 0-3)	3
6	Prior sentencing dates (excluding index)?	0
7	Convictions for non-contact sex offenses?	0
8	Any unrelated victims?	1
9	Any stranger victims?	1
10	Any male victims?	1
Total Score =		6

- Abusive childhood
- Age 21, abused niece
- Age 33-36, 5 victims




• 90-95th percentile range (high risk)
• 2.9x higher than typical Cdn SO

53

Case example: **Daniel**

Matching Treatment and/or Supervisory Criminogenic Needs

Sexual violence relevant	Central 8
<input type="checkbox"/> Sexual preoccupation	<input type="checkbox"/> History of antisocial behavior
<input type="checkbox"/> Paraphilic interests	<input type="checkbox"/> Antisocial personality pattern
<input type="checkbox"/> Offense-supportive attitudes	<input type="checkbox"/> Antisocial cognition
<input type="checkbox"/> Emotional intimacy deficits	<input type="checkbox"/> Antisocial associates
<input type="checkbox"/> Impulsivity & poor problem solving	<input type="checkbox"/> Family/marital circumstances
<input type="checkbox"/> Resistance to rules / supervision	<input type="checkbox"/> School/work
<input type="checkbox"/> Negative social influences	<input type="checkbox"/> Leisure/recreation
	<input type="checkbox"/> Substance abuse

54

Case example: **Daniel**

Matching Treatment and/or Supervisory Criminogenic Needs

Sexual violence relevant	Central 8
<input checked="" type="checkbox"/> Sexual preoccupation	<input checked="" type="checkbox"/> History of antisocial behavior
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<input type="checkbox"/> Negative social influences	<input type="checkbox"/> Leisure/recreation
	<input type="checkbox"/> Substance abuse

55

55

Case example: **Cory**

Areas of criminogenic need?



- Sexual preoccupation
- Paraphilic interests
- Offense-supportive attitudes
- Emotional intimacy deficits
- Impulsivity & poor problem solving
- Resistance to rules / supervision
- Negative social influences

56

56

Case example: **Cory**

Areas of criminogenic need?

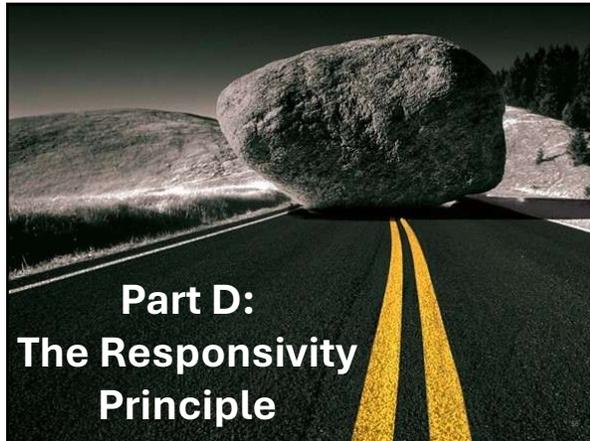


- Sexual preoccupation
- Paraphilic interests
- Offense-supportive attitudes
- Emotional intimacy deficits
- Impulsivity & poor problem solving
- Resistance to rules / supervision
- Negative social influences

Employment
 Leisure

57

57



58

RNR Principles:
Responsivity Principle

- Use the most effective approaches to facilitate change in attitudes and behaviors of offenders
- Treatment can be enhanced if the intervention pays attention to personal factors that can facilitate learning
- These interventions should match the general learning styles, motivations, and abilities of the offender, as well as offender's personality, gender, and ethnicity

Andrews & Bonta (2010); Looman et al (2005)

59

Responsivity Principle:
Two Components

- **General responsibility**
 - Influence strategies
 - Structured
 - Cognitive-behavioral
 - Therapeutic alliance
- **Specific responsibility**
 - Matching treatment to client characteristics

Maximize benefits of treatment

Bonta & Andrews (2024)

60

**Responsivity Principle:
General Responsivity**

Treatment programs should include these:

- Cognitive-behavioural in orientation
- Manual based
- Delivered in the manner intended by program developers
- Highly structured, specify aims/tasks
- Personnel who are committed to ideals of rehabilitation
- Trained, qualified, appropriately supervised staff

Andrews & Bonta (2010a) 61

61

**Responsivity Principle:
General Responsivity**

Treatment programs should include these:

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62

62

**Responsivity Principle:
General Responsivity**

Treatment programs should include these:

- Cognitive-behavioural in orientation

Effective cognitive social learning strategies adhere to 2 principles:

The **RELATIONSHIP** principle

- Establish a warm, respectful and collaborative working relationship with offender

The **STRUCTURING** principle

- Influence the direction of change towards the prosocial through appropriate modeling, reinforcement, problem-solving, etc

Active listening skills

Develop common goals

Nonjudgmental feedback

63

**Responsivity Principle:
General Responsivity**

Treatment programs should include these:

- Cognitive-behavioural in orientation
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- Delivered in the manner intended by program developers**
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64

64

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General Responsivity**

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- Manual based
- Delivered in the manner intended by program developers
- Highly structured, specify aims/tasks
- Personnel who are committed to ideals of rehabilitation**
- Trained, qualified, appropriately supervised staff**

65

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**Responsivity Principle:
General Responsivity**

Therapist's attitude

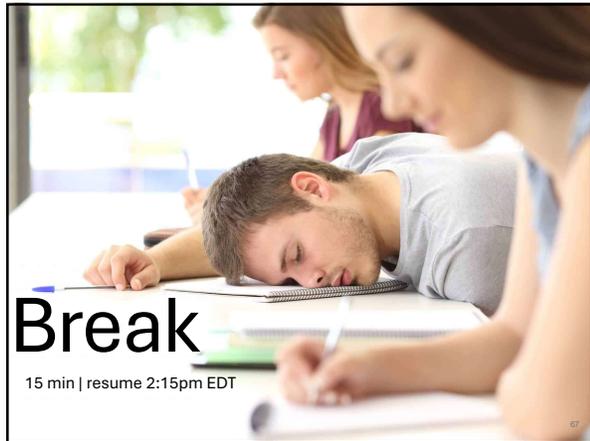
Staff hiring and training

Ongoing training of seasoned therapists

- Personnel who are committed to ideals of rehabilitation**
- Trained, qualified, appropriately supervised staff**

66

66



67

Responsivity Principle: Specific Responsivity

- Effective intervention matches learning style, motivation, abilities and strengths of offenders

Motivation for treatment		Denial
Learning/cognitive capacity		Cultural differences
Personality		Other (adverse childhood experiences, mental health, language, substance use, gender)

Andrews & Bonta (2010); Jung (2017)

68

Specific Responsivity: Motivation

- Awareness extratherapeutic changes AND therapeutic relationship

<p>• The client expects a successful outcome</p> <p>Expectancy (placebo) 15%</p>	<p>Therapeutic relationship 30%</p>	<p>Techniques 15%</p>	<p>Extratherapeutic change 40%</p>
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Asay & Lambert (1999)

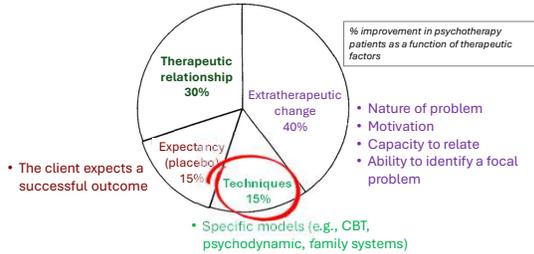
% improvement in psychotherapy patients as a function of therapeutic factors

- Nature of problem
- Motivation
- Capacity to relate
- Ability to identify a focal problem

69

Specific Responsivity:
Motivation

- Awareness extratherapeutic changes AND therapeutic relationship



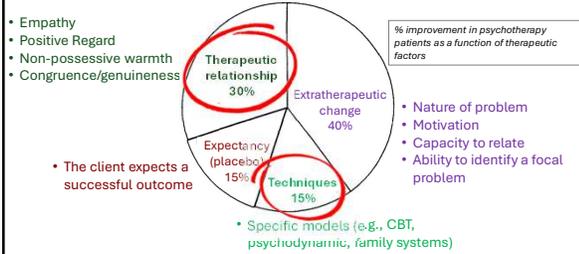
Asay & Lambert (1999)

70

70

Specific Responsivity:
Motivation

- Awareness extratherapeutic changes AND therapeutic relationship



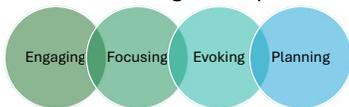
Asay & Lambert (1999)

71

71

Specific Responsivity:
Motivation

- Motivational interviewing techniques



Miller & Rollnick (2013, 2023); Stinson & Clark (2017)

72

72

Specific Responsivity: Motivation

- Motivational interviewing techniques

Engaging Focusing Evoking Planning

- 4 key principles:
 - Express empathy
 - Develop discrepancies
 - Roll with resistance
 - Support self efficacy

Miller & Rollnick (2013, 2023); Stinson & Clark (2017) 73

73

Specific Responsivity: Denial

- Often debate about putting denying sex offenders in treatment
- Denial seen as not functional and must be removed

Jung & Daniels (2012) 74

74

Specific Responsivity: Denial

- Often debate about putting denying sex offenders in treatment
- Denial seen as not functional and must be removed
- But denial is a known defense mechanism
- Serves a function (personal, other's perception, decisions)
- To make sense of denial, engagement involves
 - appropriate assessment
 - understanding of its function
 - incorporate formal feedback

Jung & Daniels (2012) 75

75

**Specific Responsivity:
(Lack of) Motivation and Denial**

- Appropriate assessment (e.g., paper/pencil, ratings, scales from larger questionnaires)
- Engagement strategies from general therapy literature
 - Beginning with least objectionable treatment target
 - Change your perspective (principle on staff practices)
 - Work through exactly what is the nature of their treatment motivation (e.g., saving face, taking away from work, denial/minimization)



Jung & Zara (2018) 76

76

Case example: Cory
Areas of specific responsivity?



- Poor treatment motivation
- Denial or problematic minimization
- Developmental delay / learning disability
- Personality patterns:
 - Psychopathy
 - Borderline
 - Other: _____
- Culture-specific concerns
- Demographic: female
- Mental health instability
- Adverse childhood experiences
- Active substance abuse or dependency

77

77

Case example: Cory
Areas of specific responsivity?



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78

78

Specific Responsivity: Learning/Cognitive Capacity

- Appropriate assessment
- Use visual conceptualizations
 - e.g., the “hill”
- Use activities to engage
 - e.g., illustrate boundaries
 - Application
- Repetition
- Network meetings

79

79

Specific Responsivity: Culture, Gender, and Sexuality

- Assess:
 - self-awareness
 - client (e.g., patriarchal values, language comprehension, discrimination/political unrest, sexuality and gender)
- Sensitivity to specific needs related to diverse cultural background
 - e.g., First Nations (Canadian Aboriginal), South Asian, recent immigrants, current political climate
 - May face difficulties in group settings with predominantly White members
- Gain perspective on intersectionality

80

80

Specific Responsivity: Psychopathy

Treatment outcome research have produced various conclusions:

- Treatment makes psychopaths worse
- Treatment has no impact or psychopaths are untreatable
- Cautiously optimistic

- Psychopathic features may inhibit treatment responsivity:
 - Manipulations, lying, conning, irresponsibility
 - Staff splitting, abusiveness, aggression
 - Glibness, superficial charm/flirtatious

Rice et al (1992); Skeem et al (2002); Wong (2000); Quayle (2008)

81

81

Specific Responsivity: Psychopathy

- What treatment makes psychopaths worse
 - Little or no staff supervision
 - Put psychopaths in charge of running programs
 - Nude encounter groups
- What are promising features of treatment with psychopaths?
 - High-intensity
 - Cognitive-behavioral
 - Incorporate relapse prevention
 - Target substance abuse, anger arousal, antisocial thinking, and cognitive distortions



Quayle (2008); Wong & Hare (2005)

82

82

Specific Responsivity: Borderline

- Many inhibitory behaviors of BPD that reduce responsivity to treatment:
 - mood instability
 - impulsivity
 - idealization of others, followed by devaluation
 - recurrent suicidal behavior
 - inappropriate, intense anger, difficulty controlling anger
- Dysregulation similarities seen between BPD patients and sex offenders (emotional, interpersonal, behavioral, cognitive)
- Dialectical Behavior Therapy techniques

Shingler (2004)

83

83

Responsivity Principle: Where do we begin?



1. Assess using appropriate measures
 - mental illness, SCL-90; stage of change, SOTIPS
 - personality, PCL-R or self-report, PPI-R; cognitive capacity, WAIS-V
2. Structured, CBT program
3. Therapeutic elements: Genuine warmth and regard, nonconfrontational approach, positive reinforcement for treatment progress, gentle but firm direction to clients
4. Incorporate alternative or supplemental programming to address responsivity issues as they emerge

84

84

**Responsivity Principle:
Specific Responsivity**

Use a checklist:
(see handout)

- Poor treatment motivation
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- Developmental delay / learning disability
- Personality patterns:
 - Psychopathy
 - Borderline
 - Other: _____
- Culture-specific concerns
- Demographic: female
- Mental health instability
- Adverse childhood experiences
- Active substance abuse or dependency

85

85

Case example: Daniel



Use a checklist:
(see handout)

- Poor treatment motivation
- Denial or problematic minimization
- Developmental delay / learning disability
- Personality patterns:
 - Psychopathy
 - Borderline
 - Other: _____
- Culture-specific concerns
- Demographic: female
- Mental health instability
- Adverse childhood experiences
- Active substance abuse or dependency

86

86

**Responsivity Principle:
Create Alternative Approaches**



increasing time
commitment

- Creating new programs
- Supplemental individual sessions
- Outsource services
- Develop individualized workbooks

87

87

Responsivity Principle:
Take home messages

- Use appropriate influence strategies
- Identify and assess potential barriers to treatment
- Be clear:

Responsivity issues are NOT criminogenic needs
- Effective interventions should match the general learning styles and characteristics of offenders
 - Why?
 - Individuals taking part in inappropriate programs exhibited a decrease in recidivism, BUT less of a decrease compared with those in appropriate programs.

88

Daniel

- Abusive childhood
- Age 21, abused niece
- Age 33-36, 5 victims

• 90-95th percentile range (high risk)
 • 2.9x higher than typical Cdn SO

Static-99R Score Summary		
Risk Factor	Yes = 1, No = 0	Under 60 Release Score
1	Age at Release? (Score range is -3 to 1)	-1
2	Ever lived with lover ≥ 2 years?	0
3	Index non-sexual violence, any conviction?	1
4	Prior non-sexual violence, any convictions?	0
5	Prior sex offenses? (Score range is 0-3)	3
	Prior sentencing dates (excluding index)?	0
	Convictions for non-contact sex offenses?	0
	Any unrelated victims?	1
	Any stranger victims?	1
	Any male victims?	1
Total Score =		6

89

Daniel

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- Age 33-36, 5 victims

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	Convictions for non-contact sex offenses?	0
	Any unrelated victims?	1
	Any stranger victims?	1
	Any male victims?	1
Total Score =		6

Institutional high intensity treatment

6 months CBT / RP

Cognitive skills; attitudes, beliefs; assertiveness; relationships; empathy; crime cycle; RP

90



94



95



96

Implementation Considerations:
Evaluating current state



- Assess current practices (or external review)
- Assess profile of individuals served
- Assess resources

Jung (2017) 97

97

Implementation Considerations:
Evaluating current state



Risk Principle

- Is a validated risk measure used?
- Is it used to direct resources?
- Do we have a way to vary intensity?



Need Principle

- Are targets criminogenic?
- What is missed?
- Are some actually responsivity issues?



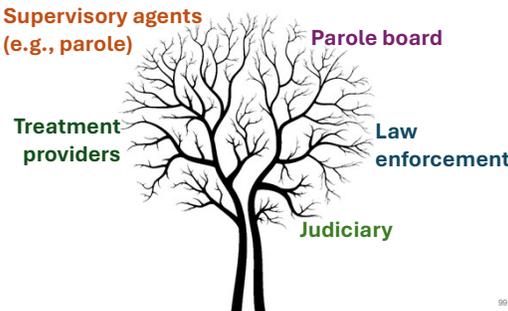
Responsivity Principle

- Is CBT used?
- Is specific responsivity assessed?
- How are we addressing them?

98

98

Implementation Considerations:
Communicating RNR externally



Supervisory agents (e.g., parole) Parole board

Treatment providers Law enforcement

 Judiciary

99

99

Implementation Considerations: Sustainable fidelity to RNR

- Reactive**
 - Address staff when reverting to old ways
 - Motivate and inspire
- Proactive**
 - Establish a process to evaluate
 - Create policies or standards

Jung (2017) 100

100

Take Home Messages: What Did I Learn?

- Implementing the principles of RNR is evidence-based practice
- Adherence with RNR has the potential to
 - reduce recidivism
 - reduce criminal victimization
 - efficiently use institutional and community resources
- Following the risk principle means
 - conducting sound RNR assessments
 - using validated assessment instrument(s)
 - matching the amount of supervision (and treatment intensity) to the level of risk

101

101

Take Home Messages: What Did I Learn?

- Part of the risk assessment involves
 - identifying static risk factors and criminogenic needs
- Criminogenic needs are
 - directly linked to criminal behavior
 - targets of treatment interventions
 - NOT all needs that an offender has
- Treatment can be effective if
 - it focuses on criminogenic needs
 - structured, cognitive-behavioral interventions are used
 - a therapeutic alliance is established
 - it matches personal factors that can facilitate learning styles, motivations, and abilities of the offender, AND personality, gender, and ethnicity

102

102



103



104
