CorrectTech

FOCUS ON WHAT MATTERS

Contents

1 The Risk Principle Simplified.

"Risk" is a central theme in community corrections. In fact, I'll bet that the first four concepts you learned when you entered the community corrections field were something like this:

- Assessment of criminogenic risk is vital
- An objective risk assessment should be utilized
- Intervention intensity should match risk level
- Over-treating low risk clients can make them worse

If you entered this field due to your desire to provide treatment to offenders, you may have grown tired of the emphasis on risk with this population. As a clinical psychologist who has dedicated his life to developing and implementing offender treatment programs, I understand your frustration. It can be difficult to focus on treatment in a corrections setting that emphasizes actuarial risk more than individual potential. However, risk is not just an academic concept, and the focus on risk is not ancillary to the treatment goals of community corrections. In fact, the purpose of community corrections revolves entirely around risk.

! *Risk: the possibility of an adverse event.*

2 What is criminogenic risk?

"Criminogenic" literally means "crime creating". Criminogenic risk is a measurement of the probability that a specific offender will reoffend ... if there is no intervention to lower risk. The second half of that definition is often ignored but is vital to the true meaning of the principle. Appropriate intervention can lower risk; in some cases, quite significantly. There are many misconceptions about "risk." Risk simply identifies the likelihood that an individual will commit another crime in the future. It does not speak to the severity or type of crime that may be committed. In other words, we are measuring the probability of an adverse event, not the nature of the adverse event.

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! *The short-term goal of community corrections is risk containment. "Containment" is the action of keeping something harmful under control or within limits.*

3 Why does it need to be objective?

"Objective" means not influenced by personal feelings, interpretations, or prejudice; based on facts; unbiased. Prior to the use of objective measures of risk, subjective assessment was used. Subjective assessment of risk is based on a review of the clients' history and a verbal interview with the individual about their plans and attitudes. In other words, subjective assessment is based on instinct or "gut" and therefore more reflective of the evaluator's biases and/or the likeability of, or the effective manipulation by, the offender. Objective assessment accomplishes two things:

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- **Appropriate Focus:** In order to measure the likelihood of criminal behavior, we must focus on the criteria that actually leads to crime. Risk assessment is helpful only if you are measuring the presence and/or absence of characteristics that actually correlate with criminal behavior. For example, since research has proven that low self-esteem does not predict crime, focusing on it is not helpful.
- **Decreased Bias:** Objective measurement takes the evaluator's biases out of the equation. Regardless of our education, training or experience, all of us have social and/ or cognitive biases outside of our awareness. For example, "in-group bias" is the tendency for people to give preferential treatment to others they perceive to be members of their own groups. With dozens of cognitive biases in action at all times, your brain makes decision making a real challenge. In general, evaluator's instinct, in the absence of an objective risk instrument, results in an overestimation of risk.

The first widely accepted objective risk measurement was the Level of Supervision Inventory (LSI). Originally developed by Don Andrews and James Bonta and revised in 2003, the LSI is used worldwide as an objective measure of risk. It consists of 54 items grouped in 10 psychological, sociological, and legal elements based on the recidivism literature. Currently, there are a variety of risk assessment products, including many in the public domain. The choice of an objective risk assessment should be preceded by a literature review of the various instruments to determine which one best fits the needs and structure of a given community. In fact, several states have decided to develop their own risk assessment instrument.

A Lesson from the Insurance Industry.

If you've ever purchased a life insurance policy, you've participated in a risk assessment process. When you apply for a life insurance policy, the insurance company attempts to determine how likely you are to die before the age of 70. In order to predict that "risk," they look at a variety of factors that make you higher risk for a premature death.

Some of these factors are completely out of your control. Male gender, childhood medical issues, and family history each contribute to risk and these factors cannot be changed. Risk factors that cannot be changed are known as static risk factors. No matter what you do, you can't change your family history.

Fortunately, some factors that contribute to risk for early death can be changed. High risk behaviors (behaviors that are more likely to lead to an early death, thus a large life insurance pay out) include sky diving, motorcycle riding, smoking, and heavy alcohol use. If you stop smoking, your risk of early death will decrease (and therefore your life insurance premium would go down). Risk factors that can be changed are known as dynamic risk factors. In the correctional literature, dynamic risk factors are also referred to "criminogenic needs".

The goal of offender intervention is to decrease risk. Since static risk factors cannot be changed, interventions are focused on factors that increase risk but can be changed. Once these needs are identified, the goal becomes how to best intervene.

4 Now what?

I have a "risk score." What does that do for me? There are a variety of reasons why the concept of risk is important. It clearly has important financial and public safety concerns. Incarceration and correctional interventions in general, are expensive in terms of financial and human capital. The research is clear that lower risk offenders are, by definition, not likely to reoffend, even if no intervention is provided.

LSI Total Score	% chance of reoffending within one year
0-5	9%
6-10	20%
11-15	25%
16-20	30%
21-25	40%
26-30	43%
31-35	50%
36-40	53%
41-45	58%
46-50	69%
50-54	>70%

Source: Andrews, D.A. and Bonta, J.L. (2003). Level of Supervision Inventory-Revised. U. S. Norms Manual Supplement. Multi Health Systems. Toronto.

The long-term goal of community corrections is risk reduction. "Reduction" is the action or fact of making a specified thing smaller or less in amount, degree, or size.

Therefore, when funds are limited (i.e., always), it makes more sense to target those funds for interventions of higher risk offenders, for whom interventions can yield a meaningful result. In other words, spend the money on the client who is most likely to harm society without the intervention. Another reason to consider risk level is that research indicates that the risk level should dictate the "intensity" of intervention provided.

> "Intervention" refers to both risk containment (i.e., monitoring) and risk reduction (i.e., treatment) efforts.

5 What is "intensity"?

If you think about risk as the size of the probability that an offender will commit another crime, "intensity" is the size of the intervention provided. "Intervention" refers to both risk containment (i.e., monitoring) and risk reduction (i.e., treatment) efforts. Small interventions for high risk offenders will not yield success. That typically does not surprise anyone. However, if a lower risk offender receives a strong intervention, they could get worse! In short, if you over-intervene or under-intervene, the offender tends to get worse (i.e., are more likely to reoffend than before treatment). So, how do you define and measure intensity?

6 What does “high intensity” mean?

While the principle of matching risk level to treatment intensity level is almost universally accepted, an adequate definition of “intensity” is rarely given. The best definition is offered by Ed Latessa and Christopher Lowenkamp of the University of Cincinnati in their 2004 article titled, “Residential Community Corrections and the Risk Principle: Lessons Learned in Ohio”. The authors believe strongly in quality of treatment and have published several useful articles about its importance, but in this article they lay out a useful definition of intervention “intensity”.

- High intensity intervention equals residential placement and low intensity treatment equals non-residential treatment.

Along with providing, in my opinion, the best definition of “intensity,” this article also provided greater evidence of the importance of matching risk level to intervention intensity. A central finding in the study was:

- When low risk offenders are placed in residential facilities, their rate of reoffending is higher than for low risk offenders who do not receive residential placement.

When Research Meets Reality.

Does the study by Latessa & Lowenkamp mean that all high risk offenders should be placed in a residential program? Is it ever appropriate for a low risk offender to be placed in a residential setting? What about moderate risk offenders? Can a non-residential supervision model provide high intensity treatment? Does the quality of treatment and monitoring in a given residential or non-residential program matter? Are my local standards for residential and non-residential similar to those in Ohio, the population studied in this article?

The nature of research is that one small answer results in a host of new questions. On average, the results of this study provide an excellent starting place for public policy. However, you do not work with averages, you work with individuals. Furthermore, the number of high risk offenders on non-residential supervision vastly outnumbers the number of available residential community corrections beds. The financial and political reality dictates that most community corrections offenders will be supervised outside of a residential setting.

The concept of "dosage" is akin to, but not exactly the same as, "intensity". Some practitioners and scholars believe that the total number of hours of treatment is the primary concern. Others argue that the hours must fit within a given window of time. Still, others express anxiety about the momentum of the dosage concept because it threatens to take clinical judgment out of their hands. An exciting area of research, we will address "dosage" in our white paper, The Need Principle-Simplified in the coming weeks.

7 Why would it make them worse?

> *"The cure may be worse than the disease." – Scottish Proverb*

All interventions have side effects. As some unfortunate cancer patients will attest, sometimes the cure is worse than the disease. Therefore, it is vital to consider the pros and cons of all interventions. Some of the down sides of residential placement for low risk offenders are as follows:

- **"The Social Learning Effect":** Low risk offenders tend to learn high risk behaviors and attitudes from high risk offenders. In practice, I have observed that high risk offenders tend to be stronger leaders, positive or negative, in group therapy sessions and residential environments. The well-intended idea of using low risk offenders as role models for high risk offenders is not likely to help the high risk clients, AND is likely to make the "role model" higher risk.
- **"The Ripple Effect":** When you place a low risk offender in residential, it has a ripple effect in the rest of their life. You take away their support system (that has, relatively speaking, been prosocial) and replace that social influence with a group of high risk offenders. Similarly, placing an offender in residential placement means that person will lose their job (if they have one), leaving them more time to observe, talk to, and imitate their residential cohorts, higher risk offenders.

- **"The Double Trouble Effect":** When you label (verbally and/or socially) a person as someone who is abnormal enough that we must take them out of society (i.e., place them in residential), they tend to adopt that new identify. Furthermore, when the offender is discharged from residential placement two things happen:
  - **"The Scarlett Letter Effect":** Due to the stigma of being incarcerated, prosocial community members shun the offender returning home. Out of concern for their own safety and the potential impact on their children, they withdraw their social support. In other words, upon returning home, the offender is punished by the prosocial members of the community.
  - **"The New Tattoo Effect":** Returning home from incarceration is like getting a new tattoo. You have a new story to tell and other like-minded persons want to hear that story. Due to the distinction of "doing time", high risk community members encourage the "war stories" and celebrate a rite of passage. In other words, upon returning home, the offender is positively reinforced by antisocial community members.

Lesson from Medicine.

The medical industry has changed dramatically in the last three decades. Historically, when a medical professional determined that a patient needed a particular intervention, they prescribed it and the insurance company paid for it. These interventions often included very expensive hospital or inpatient stays. In the mid-1990s, the advent of Health Maintenance Organizations (HMO) arrived. Largely a response to the growing costs of medical care, HMOs no longer automatically paid for expensive treatment options. Leaning heavily on research, HMOs began challenging conventional wisdom about medical providers' judgment and practices.

In the past, a 28-day stay in an inpatient substance abuse treatment program was the norm. However, after a review of the literature, HMOs determined that for most people, outpatient services, provided at a fraction of the cost, were just as effective. The same line of thinking was applied to every arena of medical care. Despite the ardent concerns of the public and medical associations, the change in medical intervention decision making gained momentum and changed medical practice in the U.S. dramatically. Procedures that formerly required several days in the hospital were now completed on any outpatient basis. In short, the new paradigm can be summed up as follows: Use the least expensive intervention that shows promise of addressing the problem.

An interesting discovery occurred during this transition. In many cases, a less expensive intervention produced better results than a higher level of care. Why? Guess who are in hospitals? Sick people. Guess what happens when you spent lots of time with sick people? You get sick. In many cases, it was discovered that the side effects of being in the hospital (e.g., sepsis infection), outweighed the benefits of the treatment. In other words, the treatment was worse than the illness. Alternatively, if you are really sick and avoid going to the hospital too long, it is likely that your health deteriorates.

8 What factors contribute to risk?

Just like the insurance industry, the risk model for offenders has very specific factors to consider. These models were developed in the exact same way that life insurance risk levels are determined. The life insurance industry looks at factors that correlate with early death. The criminal risk model looks at factors that correlate with future criminal behavior. Similarly, some of these factors can be changed ("dynamic risk factors" or "needs") and others are static. Our next white paper, The Need Principle Simplified, will address "The Key 3" and how various offender situational and personal characteristics interact to increase or decrease criminogenic risk.

9 When High Risk is Too High: The Psychopath

Imagine what you would be capable of if you were completely self-interested and did not experience fear or guilt. While it is tough to even imagine, it is safe to say that your behavior would change dramatically. Such is the world of the psychopath, and if you haven't already supervised or treated one in your community corrections agency, you will soon.

Like most things in life, the expansion of community corrections ushers in positives and negatives. The positives include decreased cost, reunited families, superior treatment opportunities, and increased ability for offenders to maintain employment. The down sides include the need for

zoning for new facilities while dealing with the Not In My Backyard (NIMBY) Effect and, of vital importance, the need for increased acknowledgement of, and recognition of, psychopathy. When community corrections was a smaller player in the criminal justice field, the need for evaluation of psychopathy was limited. That is no longer the case. With an increasing percentage of offenders going through community corrections of some sort, the likelihood of the presence of a psychopath increases.

Psychopaths generally do not experience emotions, remorse, or empathy. In extreme cases, they do not care whether you live or die as long as their needs are met in the meantime. Professor Robert Hare is a Canadian criminal psychologist, and the creator of the Psychopathy Checklist-Revised (PCL-R), a highly specialized psychological assessment used to determine whether someone is a psychopath. Credited with coining the term "psychopath", Dr. Hare has interviewed and researched this population of predators in prison and elsewhere for decades. He explains:

> ! *It stuns me, as much as it did when I started 40 years ago, that it is possible to have people who are so emotionally disconnected that they can function as if other people are objects to be manipulated and destroyed without any concern.*

While not all psychopaths are violent (or even involved in the criminal justice system), many are. They are highly likely to create new victims and can wreak havoc on a community corrections agency and staff. Assessment is not a simple task and the PCL-R should not be used unless specialized training is obtained. Many psychopaths get worse with treatment and attempting to engage them in treatment based on empathy and/or relationships is a waste of time. Given their degree of selfishness, the only angle that has any promise is one borne out of self-convenience and self -centeredness. Group therapy should be avoided as their contamination of other clients is remarkable.

Psychopathy is not a difference in degree of risk. It is a different animal and should not be taken lightly. In short, every community corrections agency should have access to a professional trained and skilled in psychopathy evaluation. If you wait to discover it the hard way, the consequences will be felt by many people for a long time. All community corrections administrators should begin by reading "Without Conscience: The Disturbing World of the Psychopaths Among Us" by Robert Hare. Hare.org is a great resource for information and training opportunities.

Author Commentary.

While the danger of over-intervening with low risk offenders is generally acknowledged and respected, there is a trend toward policy makers ignoring the opposite side of the coin. For a variety of political and financial reasons, high risk offenders are receiving low intensity interventions under a "fail first model". Instead of matching intensity of the intervention to the assessed risk level, high risk offenders are being provided low intensity interventions with the idea that when they fail, they will be provided a higher level of supervision. This policy has negative consequences for the following stakeholders.

- **Victims:** The fail first model increases the likelihood of new victims. "No New Victims" must be part of the Hippocratic Oath of community corrections.
- **Offenders:** High risk offenders have experienced failure most of their lives. A fail first approach almost guarantees another failure for high risk offenders. In many cases, we have a small window of opportunity to reach a high risk offender before it is too late. Another failure may slam that window on our fingers (and theirs).
- **The EBP Movement:** Fortunately, there are a growing number of advocates for implementing Evidence Based Principles (EBP) in community corrections. By adhering to the "do not over treat" side of the coin, but silently ignoring the "do not under-treat" flip side, we threaten the success of the entire EBP movement.

Lastly, it is my personal belief that one of the most important elements of risk has to do with an offender's ability, or inability, to create structure in their world without external forces. Some high risk offenders, with the assistance of strong, caring probation officers, can create structure without residential placement. Similarly, some low risk offenders, even with help, cannot adequately create their own structure and therefore need the controlled environment of residential in order to focus on change. Future research on this topic is likely to help us better identify where offenders should be placed, not just their risk level. Practitioners have access to more data than most researchers. Perhaps your own experience and data holds part of the answer to this question. Use your data!