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**Counseling and
Psychotherapy
Center Inc.**

The R.U.L.E. Program: Incorporating Assessments into Treatment Plans

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Objectives

- ❑ Attendees will increase their knowledge of the risk factors for sexual offender recidivism and criminal recidivism.
 - ❑ Attendees will learn how to develop and integrate evaluation and assessment results into treatment.
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CASOMB Requirements 2012

- ❑ A written treatment plan shall be developed for each sex offender based on the level of risk to sexually reoffend and needs identified in a sex offender specific assessment or evaluation.
- ❑ Level of risk to sexually reoffend and criminogenic needs shall guide treatment planning and supervision strategies.
- ❑ Providers shall make a copy of the treatment plan available to the supervising officer.

WHY ARE RISK ASSESSMENTS IMPORTANT?

- ❑ Provide a base level of risk (Low, Moderate, High; R-N-R)
 - ❑ Determines the focus and intensity of treatment (R-N-R)
 - ❑ Determines the intensity and frequency of supervision/prioritizes caseload
 - ❑ Informs the client of underlying and unrecognized issues
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Risk Assessments

- ❑ Dynamic factors have been found to predict recidivism as well as, or better than, static factors (Gendreau et al., 1996).
 - ❑ Combining both dynamic and static factors provides an even better ability to predict recidivism.
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Applications for Treatment Planning

Each tool gives us different information to incorporate in treatment planning.

- ❑ Static 99R gives low baseline of risk
 - ❑ SRA or STABLE-2007 gives current read on functioning and changeable risk factors
 - ❑ LS/CMI gives a read on violence risk factors
 - ❑ JI-R gives insight into clients cognitive and relational style; aids us in adapting approaches
 - ❑ Abel or ABID gives a sense of clients current sexual interests
 - ❑ Polygraph process aids us in eliciting information and maintaining accountability
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Preliminary Concepts

Can we agree?

- Offenders are individual people
 - There are individual differences between offenders
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Preliminary Concepts

- There are a number of factors that underlie criminal conduct, aggression, and sexually abusive behavior
 - Biology, genetics, neurodevelopment
 - Psychology, social experience, interpersonal skills
 - Social structure, environment, socioeconomics
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Preliminary Concepts

- Relevant treatment programming should consider the role of:
 - setting,
 - client characteristics,
 - staff characteristics,
 - program design,
 - program implementation, and
 - fidelity of implementation. (Andrews, 2000)
 - These contribute to the overall therapeutic environment in which treatment of sexually abusive behavior occurs.
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Major Risk Factors of Criminal Behavior

- ❑ Attitudes supportive of criminal behavior
- ❑ Social support for criminal behavior
- ❑ Deficits in self-regulation or dyscontrol
- ❑ Hedonistic self-gratification patterns
- ❑ Antisocial or deviant history
- ❑ Social distress (home, employment, leisure)
- ❑ Substance abuse (Andrews, 2000)

Common Characteristics among “sex offenders”

- Deviant arousal or interests
- Over-identification with children (CM)
- Adverse family backgrounds
- Attachment difficulties
- Intimacy deficits
- Antisocial orientation
- Mental health needs
- Cognitive impairments
- Emotional loneliness
- Social competency deficits
- Cognitive distortions
- Empathy deficits
- Inadequate coping skills
- Poor impulse control
- Negative affect
- Substance abuse

Key Differences Among Sex Offenders

- Initiation and maintenance factors
 - Motivators and disinhibitors
 - Victim preferences
 - Range of offense behaviors
 - Treatment needs
 - Supervision needs
 - Individual strengths and assets
 - Family and environmental strengths and assets
 - Ability and willingness to engage in interventions
 - Response to interventions
 - Risk to re-offend, sexually and non-sexually
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Characteristics that have Significant Influences on Clients

- ❑ Social learning, i.e. role modeling of helpers
 - ❑ Reinforcement strategies
 - ❑ Cognitive restructuring
 - ❑ Interpersonal relationships as foundations
 - Attachment
 - Sense of acceptance
 - Personally relevant and pragmatic
-

The Human Service Principles

- Matching the level of intervention to the level of risk and needs of an individual has been found to be a critical strategy in reducing re-offenses.
 - Getting the offender to respond to intervention efforts is equally important and requires extra effort on the part of treatment providers and supervising agents.
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The Risk Principle

What is it? How does it apply to sex offenders?

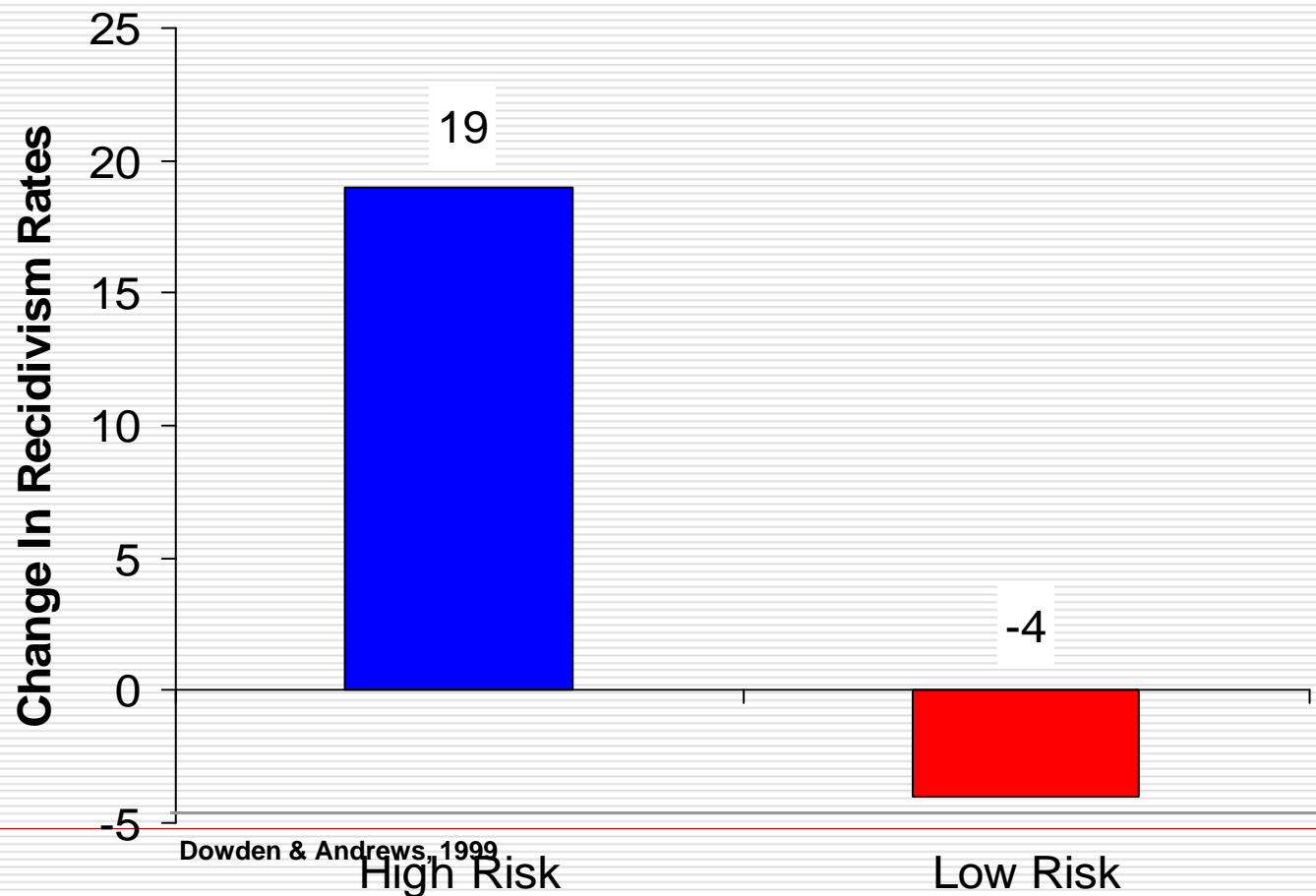
- ❑ The highest risk level cases should be matched with the most intense level of human services.
 - ❑ Sex offenders are not all the same. Their level of risk for reoffense varies.
 - ❑ Applying the same level of intervention or supervision may waste resources on some and under do it for others.
-

Risk Principle

- ❑ Target the offenders with higher probability of recidivism with closer supervision
 - ❑ Provide more intense services to higher-risk offenders
 - ❑ Excessive targeting of lower risk offenders can lead to increases in recidivism rates (Wilson & Yates, 2009)
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The Risk Principle & Correctional Intervention Results from Meta Analysis

Edward J. Latessa, Ph.D.



Risk Principle

- ❑ Risk assessments target various maladaptive behaviors
- ❑ Risk assessment tools that are general or generic will classify general criminality
- ❑ Risk assessment tools that focus on maladaptive sexual behavior allow targeting this area most specifically
- ❑ There are several risk issues to consider

The Need Principle

- ❑ What is it? How does it relate to sex offenders?
 - ❑ Target crime-producing needs and risk factors that are otherwise fulfilled through maladaptive behavior.
 - ❑ “Treatment needs” (Ogloff & Davis, 2004) are the dynamic risk factors associated with risk for re-offense.
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Major Risk and/or Need Factor and Promising Intermediate Targets for Reduced Recidivism

Edward J. Latessa, Ph.D.

Factor	Risk	Dynamic Need
History of Antisocial Behavior	Early & continued involvement in a number antisocial acts	Build noncriminal alternative behaviors in risky situations
Antisocial personality	Adventurous, pleasure seeking, weak self control, restlessly aggressive	Build problem-solving, self-management, anger mgt. & coping skills
Antisocial cognition	Attitudes, values, beliefs & rationalizations supportive of crime, cognitive emotional states of anger, resentment, & defiance	Reduce antisocial cognition, recognize risky thinking & feelings, build up alternative less risky thinking & feelings- Adopt a reform and/or anti-criminal identity
Antisocial associates	Close association with criminals & relative isolation from prosocial people	Reduce association w/ criminals, enhance association w/ prosocial people

Adopted from Andrews, D.A. et al, (2006). The Recent Past and Near Future of Risk and/or Need Assessment. *Crime and Delinquency*, 52 (1).

Major Risk and/or Need Factor and Promising Intermediate Targets for Reduced Recidivism

Edward J.

Latessa, Ph.D.

Factor	Risk	Dynamic Need
Family and/or marital	Two key elements are nurturance and/or caring better monitoring and/or supervision	Reduce conflict, build positive relationships, communication, enhance monitoring & supervision
School and/or work	Low levels of performance & satisfaction	Enhance performance, rewards, & satisfaction
Leisure and/or recreation	Low levels of involvement & satisfaction in anti-criminal leisure activities	Enhanced involvement & satisfaction in prosocial activities
Substance Abuse	Abuse of alcohol and/or drugs	Reduce SA, reduce the personal & interpersonal supports for SA behavior, enhance alternatives to SA

Criminogenic Needs

Criminogenic

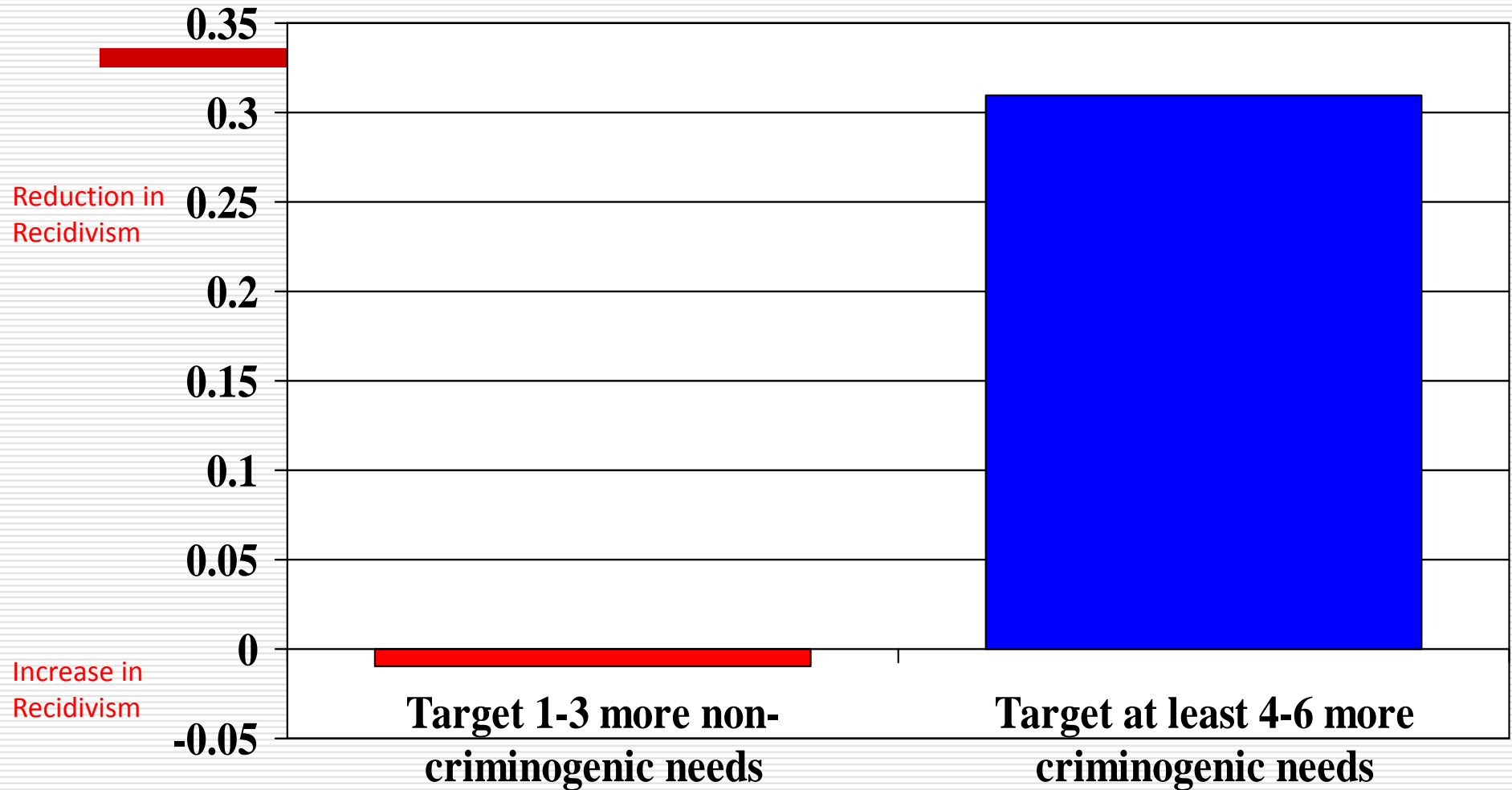
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- Anti-social friends
- Substance abuse
- Problem solving difficulty
- Impulsive behavior
- Poor socialization
- Attachment issues
- Hostility-anger

Non-Criminogenic

- Anxiety
 - Low self-esteem
 - Creative abilities
 - Medical needs
 - Physical conditioning
 - Psychological discomfort
-

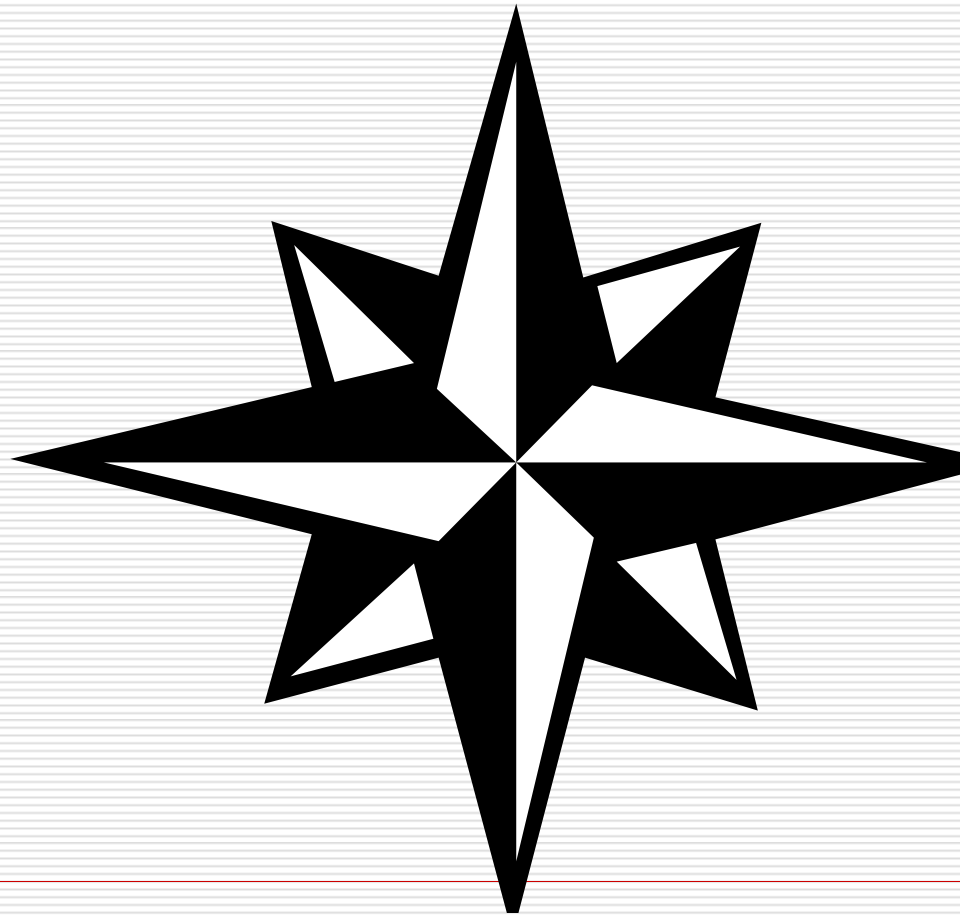
Targeting Criminogenic Need: Results from Meta-Analyses

Edward J. Latessa, Ph.D.



Source: Gendreau, P., French, S.A., and A.Taylor (2002). What Works (What Doesn't Work) Revised 2002. Invited Submission to the International Community Corrections Association Monograph Series Project

So how do we do this?



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- Integrating assessment outcomes into treatment planning involves considering ...
 - Treatment modalities available
 - Current treatment culture
 - Individualizing treatment plans in a manualized context
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Treatment Modalities

- ❑ Group therapies are believed to be the most effective mode of treatment for adult offenders (but there is no data on this).
 - ❑ Treatment providers need to maintain a *pro-social culture* or milieu within the group setting to avoid counter-productive communication and learning among the offender-clients.
 - ❑ Group discussions have a number of known values and create opportunities to *learn vicariously* through observing others and learning from a shared growth process.
 - ❑ Group therapy sessions will ideally have *two therapists* facilitating the process for role modeling purposes.
 - ❑ Group therapies best allow for monitoring for fidelity of implementation of program models and interventions.
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Treatment Modalities

- ❑ Group settings do allow for heterogeneous mixtures of offender types. Programs commonly co-mingle offenders who have adult assault victims, exhibitionists, and/or child victims.
- ❑ This enriches the therapeutic culture as the *different offender-types typically have varied viewpoints* and perspectives and are able to provide constructive alternative social perspectives to each other.
- ❑ ID individuals are often not active participants in groups, i.e. are less likely to offer such constructive feedback.

Treatment Culture

- ❑ Research in recent years has demonstrated effective outcomes can be accomplished from *treatment efforts that are more engaging* and where treatment providers promote and model effective interpersonal strategies such as encouragement and support.
- ❑ Modeling pro-social behavior and offering positive reinforcement is known *to increase the offender-clients' investment in the change process*, leading to more disclosures and greater levels of compliance with treatment programming.
- ❑ This leads to a higher likelihood the offender-client will complete treatment, which is known to be correlated with lower recidivism.

Treatment Culture

- *Increased self-regulation can occur when the offender-client takes greater responsibility for the genesis and nature of his real problems.*
 - The *culture of engagement*, rather than one of control and coercion, can lead to a deeper level of ownership and opportunity for the offender-clients to develop their capacities for meeting their real needs in healthier, non-abusive, ways.
-

Treatment Culture

- Model treatment programs provide services to offender-clients in ways that facilitate learning new, healthy, coping skills and encourage the offender-client to implement these new skills in their daily lives, thereby supporting the offender-client to seek a better life and life style.
 - Therefore, treatment providers must manage the treatment culture as well as match the treatment approaches with the learning and personality characteristics of the offender-client.
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Treatment Planning

- ❑ Sexual offenders are diverse populations. As such, effective treatment planning requires a balance between “individualized” treatment and programming that is “manualized.”
 - ❑ The implementation of treatment strategies based on the assessment outcomes needs to follow evidence based practice guidelines as related to each offender-clients’ characteristics, needs, and risk factors.
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Treatment Planning

- *Adjunct therapies* and services may be needed to address the full range of needs of any particular offender-client.
 - Many cases will require *on-going case management supports* outside the traditional role of psychotherapists and may place additional responsibilities on supervising staff.
-

Typical Treatment Plan Elements

- ❑ Increase offender-client *motivation and engagement* with treatment
 - ❑ Reduction of *deviant sexual interest* and arousal patterns
 - ❑ Increasing *pro-social attitudes, values, and beliefs*
 - ❑ Increasing *awareness of adverse affects* on victims and increasing empathy
 - ❑ Increasing capacities to *self-regulate* one's own emotions and meet those emotional needs in healthy ways
 - ❑ Increase capacities to have *emotionally fulfilling intimate relationships*
 - ❑ *Decrease the influences of negative peers* and social challenges
 - ❑ *Increase pro-social behavioral self-regulation skills*, i.e. self-control of impulses and relapse prevention skills development
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TREATMENT TARGETS AND EXPECTATIONS FOR SEX OFFENDERS

- Complete any restitution to the victim(s)
 - Complete clarification letter to the victim(s)
 - Write and present to treatment group an autobiography
 - Discuss and deal with deviant fantasies
 - Identify low, medium and high risk situations and how to manage & avoid them
 - Identify sexual assault cognitive distortions
 - Complete a deviant cycle
 - Manage anger in a responsible manner
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TREATMENT TARGETS AND EXPECTATIONS (continued)

- Be open about sexuality
 - Learn and develop here and now cycles
 - Complete a relapse prevention plan with risk responsive interventions and practice it daily
 - Have an informed support network and use it
 - Maintain stable employment
 - Maintain a stable living arrangement
 - Be financially responsible
 - Healthy intimate relationship
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TREATMENT TARGETS (continued)

- Maintain commitments to self, others, work, etc.
 - Emotional & behavioral self-regulation (demonstrated)
 - Family reunification if appropriate
 - Participate in family therapy
 - Journaling
-

Community Supervision

WARNING SIGNS

Warning signs provide the client-offender as well as Probation, Parole, support persons and Treatment Staff with a means of determining early precursors to being at risk to act out. Warning signs indicate that the individual may be in cycle, that he/she is going down the "road of trouble", of engaging in some type of negative activity. These are, **Dynamic RISK FACTORS**.

RISK FACTORS

- Risk Factors can be:
 - Emotional
 - Cognitive
 - Interpersonal
 - Physical
 - Behavioral
 - Self-statements
-

EXAMPLES OF RISK FACTORS

□ Emotional Risk Factors

- Feeling alone
 - Constant worrying
 - Feeling entitled
 - Feeling depressed
 - Emotionally repressed
-

□ Cognitive Risk Factors

- Deviant Fantasies
 - Homicidal or Suicidal thoughts
 - Thoughts of using drugs/alcohol
 - Thoughts of using pornography
-

□ Interpersonal Risk Factors

- Exaggerating stories
 - Taking victim stance
 - Showing off/Bragging
 - Snap judgments about others
 - Having to win/be on top
-

□ Physical Risk Factors

- Personal Hygiene (change)
 - Not sleeping/sleeping too much
 - Upset stomach, nervousness
 - Fidgety/biting fingers
 - Self-harm, e.g., cutting, purging
-

❑ Self-statement Risk Factors

- It's no use
 - Nothing matters
 - I will never...
 - Nothing is going right
 - If I only...
-

❑ Behavioral Risk Factors

- Missing Work
 - Failing to make appointments
 - Developing old/new habits:
smoking, drinking, swearing
 - Isolating
 - Reports of road rage/driving recklessly
-

-
- Integrating evaluations and assessments into treatment within the R.U.L.E. Program**
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Sexual deviance goals

- ❑ Client will accept responsibility for his sexual history and misconduct
 - ❑ Client will make and maintain his commitment to change
 - ❑ Client will begin or increase recognition of harm done to victim(s)
 - ❑ Client will increase his understanding of his degree of risk for re-offense and identify action steps to help him reduce his risk
 - ❑ Client will improve his ability to solve problems and more effectively meet the relationship needs in his life
-

Sexual deviance interventions

- ❑ Client will complete assigned RULE treatment homework (e.g. victim report, detailed offense report, identify high risk situations, thinking errors, clarification letters, write autobiography or life story)
 - ❑ Client will prepare for polygraph examination and take examination within 3-6 months of being in program (Full History)
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How are we doing?

- Does our goal fit with the RNR schema?
 - What is the source of our information or decision to include this goal?
 - Does every client need each of these goals or interventions?
 - On what basis might you omit a goal or intervention?
-

General Criminality Goals

- ❑ Client will disclose his criminal history
- ❑ Client will accept responsibility for his misconduct
- ❑ Client will identify the pattern of thoughts, feelings, and behaviors that form his pattern of criminal behavior or sexual misconduct
- ❑ Client will explore and identify his faulty thinking that supported his criminal behavior or sexual misconduct
- ❑ Client will identify and implement self-corrective interventions to enable him to change his faulty thinking and problem behaviors

Criminality interventions

- ❑ Client will complete assigned RULE treatment homework and review in weekly group sessions (e.g. thinking errors, offense cycle, relapse prevention plan, assertiveness training, etc.)
 - ❑ Client will discuss his status and progress with implementing self-corrections to his faulty thinking
 - ❑ Client will explore and identify healthy ways to get his relational needs met
-

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Self-regulation skills goals

- ❑ Client will increase his ability to identify and manage his emotional needs
 - ❑ Client will improve his coping and problem solving skills
 - ❑ Client will increase his ability to manage his life without unhealthy substance use
 - ❑ Client will improve his ability to develop meaningful relationships
-

Self-regulation interventions

- ❑ Client will complete assigned RULE treatment homework (e.g. self-control exercises, alcohol /drug awareness, emotional self-regulation, etc.)
 - ❑ Client will complete Anger Management Training
 - ❑ Client will process emotional issues in group therapy to gain experience in healthy coping and problem solving
 - ❑ Client will explore and identify healthy ways to get his relational needs met
-

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Cooperation with Treatment & Supervision goals

- ❑ Client will comply with parole conditions including clean drug tests and group attendance
 - ❑ Client will comply with GPS requirements
 - ❑ Client will comply with residence restrictions based on California law
 - ❑ Client will maintain a crime-free lifestyle
 - ❑ Client will cooperate with RULE Program rules, expectations and contract
 - ❑ Client will successfully complete the RULE Program
-

Cooperation Interventions

- ❑ Therapist will provide monthly progress reports to AOR documenting client status on elements of the RULE Program, risk factors, and general information regarding client adherence to requirements
 - ❑ Client will complete his own RULE Progress Report status form provided by the treating therapist
-

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Lifestyle Stability goals

- ❑ Client will be encouraged to maintain meaningful employment.
 - ❑ Client will be encouraged to acquire and maintain reasonable housing that is in compliance with State law and CDCR policy.
 - ❑ Client will be encouraged to implement the relationships skills that he is learning from treatment.
 - ❑ Client will be encouraged to enroll in appropriate community resources and social services.
-

Lifestyle stability interventions

- ❑ Client will self-report his housing and employment status during weekly check-in in group.
 - ❑ Client will self-report regarding his experiences and responses to implementing relationship skills learned in group.
 - ❑ Therapist will provide community resource referrals for social services and supports on an as needed basis.
-

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-

Social Supports goals

- Client will establish and maintain an appropriate circle of support.
- Client will associate with pro-social adults.
- Client will establish meaningful adult relationships.
- Client will inform a potential sex partner of his status in order to maintain honesty and accountability in his relationships.

Social supports interventions

- ❑ Client will complete assigned RULE treatment homework (e.g. communication skills, listening skills, expressing self to others, empathy skills, etc.). Client will discuss relationship needs in group therapy sessions.
 - ❑ Client will explore and discuss the type of personal associates he has in his treatment group and therapist.
 - ❑ Client will learn healthy relationship skills in group and will report to group his progress towards implementing those skills.
-

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Criminogenic vs. Non-Criminogenic Needs

Criminogenic

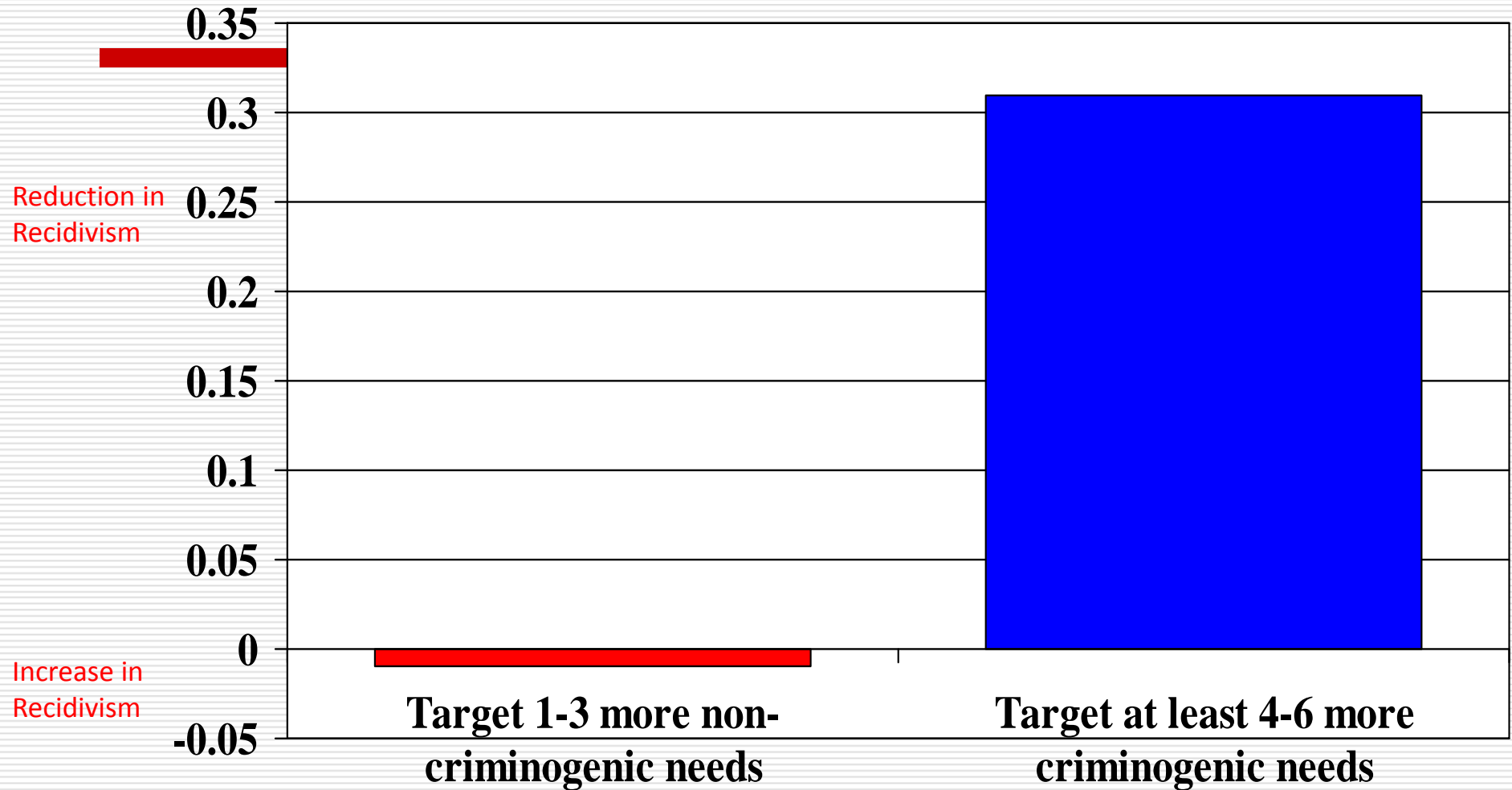
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Individualized treatment plans

- ❑ Individualized plans cannot be developed without an assessment
 - ❑ Each assessment tools adds it's own bit of information to aide in planning
 - ❑ Each client needs his/her own plan rather than a generic one-size-fits-all
 - ❑ Over treating or under treating offenders can increase risk for reoffense
-