When Agencies Partner: Key Components of Positive Supervision and Service Agency Partnerships

Amy Murphy, MPP
Faye S. Taxman, PhD

Center for Advancing Correctional Excellence!
Criminology, Law & Society
George Mason University
When Agencies Partner: Key Components of Successful Supervision and Service Agency Partnerships

August 2014

ACE!

Center for Advancing Correctional Excellence!
Criminology, Law & Society
George Mason University
http://www.gmuace.org
Authors

Amy Murphy, MPP
Faye Taxman, Ph.D.

CJTRAK Project Team

Faye S. Taxman, Ph.D.
University Professor
Center for Advancing Correctional Excellence
Criminology, Law and Society
George Mason University
10519 Braddock Road Suite 1900
Fairfax, VA 22032

James M. Byrne, Ph.D.
Professor
University of Massachusetts, Lowell

April Pattavina, Ph.D.
Discrete Event Model
Associate Professor
University of Massachusetts, Lowell

Avinash Singh Bhati, Ph.D.
Simulation Model Maxarth, LLC

ACE! Project Team

Michael S. Caudy, Ph.D.
Amy Murphy, MPP
Stephanie A. Maass, M.A.
Lauren Duhaime, B.A.
Heather Toronjo, MPP
Catherine Salzinger, M.A.
Gina Rosch, B.A.
Acknowledgements

Faye Taxman, Ph.D., and Amy Murphy M.P.P., of the Center for Advancing Correctional Excellence at George Mason University, acknowledge and thank staff of the Bureau of Justice Assistance (BJA), the Substance Abuse and Mental Health Services Administration (SAMHSA), and the Public Welfare Foundation. Special thanks are extended to Ed Banks, Ph.D., of BJA and Ken Robertson of SAMHSA.

Funding for the development of this manual provided by the Center for Substance Abuse Treatment, Substance Abuse and Mental Health Services Agency (SAMHSA: Contract No. HHSS283200700003I/HHSS28300002T)

The views, opinions, and content of this document do not necessarily reflect the views, opinions, or policies of the Substance Abuse and Mental Health Services Administration or the U.S. Department of Health and Human Services.
When Agencies Partner: Key Components of Successful Supervision and Service Agency Partnerships
## Contents

Guide to This Manual ........................................................................................................................................... 1

Chapter 1. Partnerships That Embrace Risk-Need-Responsivity .............................................................. 2
  The Value of Partnerships ............................................................................................................................. 2
  The Goal of Responsive Systems .................................................................................................................. 2
  How Partnership Benefits System Reforms ............................................................................................... 3
  Defining the RNR Model ............................................................................................................................. 4
  Destabilizers and Stabilizers ......................................................................................................................... 5
  Key Principles ............................................................................................................................................... 5

Chapter 2. Research Into Practice: Using the RNR Simulation Tool With Jurisdictions and Treatment Providers ................................................................. 7
  An Overview of the RNR Tools .................................................................................................................... 7
    The RNR Assess an Individual Tool: Is the person the right match for a program? ............................ 7
    The RNR Assess an Individual Tool: What can users do with the results? ........................................ 9
    The RNR Assess Jurisdiction’s Capacity Tool: Does my system offer programs that meet the needs of the population? ................................................................................................................... 12
    The RNR Program Tool for Adults: Does a specific program use evidence-based practices? .... 13
  The RNR Program Tool for Adults ........................................................................................................... 14
    How the Program Tool Works .................................................................................................................. 14
    Specialized Programs and the Program Tool ......................................................................................... 15
    Benefits to the Jurisdiction ..................................................................................................................... 17
    Addressing Providers’ Concerns ............................................................................................................. 17

Finding Gaps: Assess Jurisdiction’s Capacity Combined With the PTA ........................................... 19
  Underlying Concepts ................................................................................................................................. 20
  Jurisdiction Use Versus Individual Use ..................................................................................................... 20
  Sequencing the Portals of the RNR Simulation Tool ............................................................................. 20

Chapter 3. Treatment Providers ................................................................................................................ 21
  In-House Treatment Versus Referrals to Community Treatment Providers ........................................ 21
  Learning About Treatment Agencies ........................................................................................................ 21
  Integration ................................................................................................................................................ 22
  Identifying Needs and Finding Providers ................................................................................................ 22
  Identifying the Population’s Treatment Needs ........................................................................................ 22
Appendix A. “What Works” Resources ................................................................. 57
Appendix B. How To Use the RNR Simulation Tool .............................................. 58
Appendix C. Checklists .................................................................................... 65
Appendix D. Frequently Asked Questions About CJ-TRAK/RNR ......................... 70
Appendix E. Sample Behavioral Contract ............................................................ 72
Appendix F. Sample Informed Consent for Treatment Form .................................. 75
Appendix G. Motivational Interviewing Resources ............................................... 77
Appendix H. Contingency Management Resources ............................................. 78
Appendix I. Process Improvement Template ....................................................... 79
Appendix J. Additional Resources for Further Reading ...................................... 80

Exhibits
Exhibit 1. What Is Partnership? ............................................................................ 2
Exhibit 2. Effects of Treatment on Recidivism ...................................................... 3
Exhibit 3. Responsivity ...................................................................................... 4
Exhibit 4. Portal to the AAI on the ACE! Web Site ............................................. 7
Exhibit 5. Brief Summary of Assess an Individual Tool .................................... 8
Exhibit 6. Overview of RNR Programming Areas .............................................. 8
Exhibit 7. Examples of RNR Recommendations ............................................... 10
Exhibit 8. Recommended RNR Program Group, Estimated Recidivism Rate ......... 10
Exhibit 9. Sample of Assess Jurisdiction’s Capacity Output .................................. 13
Exhibit 10. Sample Feedback From the PTA ...................................................... 14
Exhibit 11. Sample Recommendations From the PTA ....................................... 15
Exhibit 12. Sample List of Programs by Category .............................................. 16
Exhibit 13. Specialized Court Feedback Report ............................................... 16
Exhibit 14. Sample Gap Analysis From AJC ..................................................... 19
Exhibit 15. Correctional Program Assessment Inventory Findings on the Relationship Between Program Quality and Recidivism ................................................ 24
Exhibit 16. Desired Staff Qualifications by Program Type .................................. 27
Exhibit 17. Sample Expectations With Treatment Providers .............................. 32
Exhibit 18. Plan, Do, Study, Act Model ............................................................. 43
Guide to This Manual

The goals of this manual are to (1) familiarize users with the risk-need-responsivity (RNR) framework, (2) offer practical advice to facilitate positive working relationships between and among agencies and treatment providers, and (3) demonstrate how the RNR Simulation Tool can facilitate the treatment process. We begin with an introduction to the RNR concepts and key principles. We then review the three portals of the RNR Simulation Tool: Assess an Individual, Assess Jurisdiction Capacity, and the RNR Program Tool for Adults. We also explore how to select treatment providers, how to build relationships between agencies and providers, and how to problem-solve issues with providers. The manual also highlights the importance of assessing and addressing organizational culture.
Chapter 1. Partnerships That Embrace Risk-Need-Responsivity

Reducing recidivism and relapse, while challenging, is no longer the enigma it once was. We know what works. Many effective programs and practices are available to assist clients involved in the justice system (see appendix A). We now need strategies to put effective practices into place. One strategy involves partnership between the justice system and service providers. This manual presents partnership approaches that embrace the evidence-based framework of risk-need-responsivity (RNR), which couples effective treatment and services that address systems issues with dynamic client-level factors that affect drug- and crime-free behaviors.

The Value of Partnerships

Serving clients involved in the justice system is challenging. In addition to their offending behavior, many have behavioral health issues that, left unresolved, contribute to future offenses, relapse, and poor progress under supervision or in the justice system. Positive change requires partnerships between the supervision agency and the individual—but even better progress can be made when the supervision agency also engages with community partners. One of the greatest challenges in reducing recidivism and relapse and promoting positive change in criminal justice clients is developing successful partnerships between criminal justice agencies and the providers to whom they refer clients. In an ideal world, these organizations could come together seamlessly. In the real world, there are many bumps in the road.

What is partnership? Partnership is two or more entities combining forces to achieve a common mission (see exhibit 1), but sharing a mission is only the first step. To develop a successful partnership, all entities need to commit time, effort, and resources and be willing to set aside counterproductive attitudes and habits. There are stages to establishing effective partnerships: networked, coordinated, cooperative, consolidated, and integrated (Taxman, 2010). Where do you think your jurisdiction falls on this continuum?

Exhibit 1. What Is Partnership?

What is partnership? A partnership is two or more entities combining forces to achieve a common mission. Sharing a mission is only the first step.

The Goal of Responsive Systems

Responsive systems are those that measure behaviors and attitudes and have environments that support the goals of offender change. These systems need to select appropriate treatment services, reinforce the treatment goals through justice and supervision efforts, and focus on engaging the offender in treatment to have a positive change in criminal justice clients.

Recent studies have documented the relative benefits of different methods of managing offenders (see exhibit 2). The least effective model is to incarcerate—it takes the incarceration
of 33 people to prevent 1 recidivism event. However, by using evidence-based treatments such as cognitive behavioral therapy (CBT), drug courts, or therapeutic communities, it takes nine offenders to prevent one recidivism event. The most effective method is to assign treatment based on risk and need factors of offenders, and this takes five offenders to prevent one recidivism event (Caudy, Tang, Maass, Lerch, & Taxman, 2013).

*Exhibit 2. Effects of Treatment on Recidivism*

<table>
<thead>
<tr>
<th>Impact of Treatment</th>
<th>Number Needed To Treat To Prevent One Recidivist</th>
</tr>
</thead>
<tbody>
<tr>
<td>Incarceration Treatment</td>
<td>33</td>
</tr>
<tr>
<td>Evidence-Based Treatment</td>
<td>9</td>
</tr>
<tr>
<td>RNR Treatment</td>
<td>5</td>
</tr>
</tbody>
</table>

This manual is designed to assist in building relationships that support the most effective strategy for improving offender outcomes: using risk and needs assessments to identify the type of offenders who should be targeted for effective treatment programs.

**How Partnership Benefits System Reforms**

For criminal justice personnel, the greatest benefit of working with community providers is the ability to draw on a wide variety of expertise. Rather than attempting to develop in-house generalists who can deal with all possible client issues, an agency can develop a cadre of providers to deal with myriad issues. This approach also clarifies the roles of those involved in the partnership, establishing the supervision officer as the individual who is focused on justice-related issues while motivating people for change.

In addition to the benefits of working with external providers, there are challenges: the officer and counselor may have different priorities and conflicting opinions as to what is most important for the client at any given time. They may also have different approaches. While many supervision officers now have a background in social work, counseling, or a similar field, many others have a more traditional “law and order” (i.e., compliance management) mindset. It is not all about the individual officer—each officer is part of a larger agency, and each agency has its own organizational culture, with some more open to therapeutic approaches than
others. Yet another challenge is simply finding the right provider for the offender—identifying the most important need and identifying a provider equipped to address that need. When offenders have many complex needs, the corrections agency is tasked with determining priorities and sequencing treatment appropriately (see exhibit 3).

**Exhibit 3. Responsivity**

![Responsivity Diagram](image)

**Defining the RNR Model**

From a criminal justice perspective, three factors affect clients’ risk for recidivism and chance for success under community supervision: risk, need, and responsivity.

1. **Risk**—refers to the likelihood a person will have future involvement in the justice system. Risk is influenced by prior involvement in the justice system—age of first arrest, number of prior arrests, number of prior incarcerations, and number of probation violations are common elements used in making risk determinations. The best analysis of risk uses an actuarial method for determining risk.

2. **Need**—refers to protective factors required to help ward off criminal behavior fostered under certain conditions and in some environments. Such conditions can be measured using validated assessment instruments, such as the Addiction Severity Index (substance abuse) and the Criminal Cognitions Scale (antisocial cognitions). According to the criminal justice literature, these needs are:

   - Antisocial peers or associates
   - Antisocial cognitions
   - Antisocial personality
   - Substance use disorders
   - Employment or educational deficits
   - Lack of leisure time
**Destabilizers and Stabilizers**

Related to the need for protective factors are destabilizers and stabilizers. While not directly related to offending, these lifestyle and psychosocial factors can influence a person’s situation in the community. Destabilizers include the following:

- Mental health problems
- Housing instability
- Food instability
- Other human condition deficits

Stabilizing factors can serve as protective factors against criminal involvement:

- A supportive friend or family member
- A high school diploma
- A home environment without crime involvement

3. **Responsivity**—The science behind treatment matching is based on the concept of responsivity, or making sure program services are compatible with the target population’s need. That is, the match is between the characteristics and needs of the person and the services provided by the program. Responsivity is complicated in many ways because of the need to be responsive to the person, not simply the population.

**Key Principles**

The RNR framework provides guidance as to what type of programming and services to provide to reduce the odds of reoffending. Some general principles apply:

- Problem severity should drive the intensity of treatment and the dosages.
- Moderate to higher risk for reoffending should drive more intensive programming and more clinical hours of treatment (dosage).
- The presence of more criminogenic needs should drive more intensive programming and more clinical hours of treatment (dosage).
- Clients with lower risk levels but at least three criminogenic needs should receive the appropriate dosage of treatment.
- Lower risk clients with two or fewer criminogenic needs and fewer destabilizers may not require treatment; they might be candidates for low dosages of social controls and supervision.
The treatment matching (responsivity) should be driven by a configuration of risk, need, and destabilizers. The more factors that apply to an individual, the more intensive the programming and dosage to address the behaviors and attitudes that affect offending.

As detailed in the next section, there are three portals to the RNR Tool: Assess an Individual, the Program Tool for Adults, and Assess Jurisdiction’s Capacity.
Chapter 2. Research Into Practice: Using the RNR Simulation Tool With Jurisdictions and Treatment Providers

Effective service delivery teams can address client needs, program needs, and system needs. The RNR Simulation Tool is designed to help corrections and treatment agencies meet demands to be responsive to the needs and risks of individuals in the justice system. Increased responsivity is required to reduce the risk of future offending (ACE!, 2013). This section provides more information about the RNR tools and examples of how they can be used.

An Overview of the RNR Tools

The RNR Assess an Individual Tool: Is the person the right match for a program?

The Assess an Individual Tool (also known as AAI) identifies treatment needs at the individual level. AAI1 is an online 17-question instrument that uses information about client risk, needs, stabilizers, and destabilizers to estimate risk for recidivism (however the jurisdiction defines recidivism) and make recommendations for programming. The AAI tool takes approximately 5 minutes to complete and can be self-administered or completed by a supervision officer or treatment provider. See exhibit 4 for the portal to launch AAI as it appears on the Web site of the Center for Advancing Correctional Excellence (ACE!) and exhibit 5 for a brief summary of the tool.

Exhibit 4. Portal to the AAI on the ACE! Web Site

As explained on the ACE! Web site, the AAI portal provides “programming recommendations for individual offenders based on inputted information about their risk, criminogenic needs, and other clinically relevant factors.” The tool uses a database of offender risk-need profiles to estimate likely attributes based on the prevalence of each attribute in the national populations. Data are available from criminal justice and behavioral health screenings and assessments when making individual program and dosage recommendations to reduce individual recidivism. The portal can be used with a jurisdiction’s instruments, by itself, or in combination with other tools. Users can integrate jurisdiction-specific data regarding the prevalence of individual attributes to produce customized feedback.

1 See appendix B-1 for detailed instructions on how to use the AAI tool.
This portal also estimates a percentage reduction in recidivism to be expected if the offender is matched to the level of programming consistent with their unique needs (i.e., a program of best fit).

The RNR Simulation Tool categorizes programs into six categories based on the following primary targets: severe substance abuse/dependence, criminal thinking/antisocial cognitions, self-improvement and management, interpersonal skills, life skills, and supervision/punishment only. Exhibit 6 describes the categories and provides examples of programs in each category.

### Exhibit 6. Overview of RNR Programming Areas

<table>
<thead>
<tr>
<th>Program Category</th>
<th>Risk and Need Categories</th>
<th>Description</th>
<th>Examples of Interventions</th>
</tr>
</thead>
<tbody>
<tr>
<td>A: Interventions Targeting Severe Substance Use Disorders</td>
<td>Any dependence on heroin, cocaine, amphetamines, or methamphetamines regardless of risk level; may include co-occurring disorders</td>
<td>CBT to address drug cravings, addiction, maintenance, and recovery issues</td>
<td>Drug Court, residential treatment programs, medication-assisted treatment, intensive outpatient treatment</td>
</tr>
<tr>
<td>B: Interventions Targeting Criminal Thinking/Antisocial Cognitions</td>
<td>Moderate to high risk; high on criminal attitudes/orientation; at least two other criminogenic needs</td>
<td>Cognitive and behavioral restructuring to change maladaptive thinking patterns supportive of crime and criminal activity</td>
<td>Individual or group CBT</td>
</tr>
<tr>
<td>C: Interventions Targeting Self-Improvement and Management</td>
<td>Any abuse of alcohol or marijuana; co-occurring disorders; at least other criminogenic need; low to moderate risk</td>
<td>Cognitive efforts; developing social and problem-solving skills to address mental health issues, substance abuse, and self-control</td>
<td>Group and individual substance abuse treatment, group and individual mental health treatment, co-occurring disorder treatment</td>
</tr>
<tr>
<td>D: Interventions Targeting Social and Interpersonal Skill Development</td>
<td>Moderate to low risk with at least one criminogenic need in the area of family and peers and stabilizers of housing and mental health</td>
<td>Structured modeling of behavior to reduce interpersonal conflict and develop more positive interactions</td>
<td>Anger management, conflict resolution, domestic violence</td>
</tr>
<tr>
<td>E: Life Skills Programs</td>
<td>Moderate to low risk with at least one criminogenic need in the area of employment or education</td>
<td>Stabilize education, housing, employment, and financial concerns</td>
<td>Parenting classes, GED classes, vocational programs</td>
</tr>
<tr>
<td>F: Supervision/Punishment Only</td>
<td>Low risk and low need that does not involve any pattern of behaviors</td>
<td>Punishment geared toward low-risk, first-time offenders</td>
<td>Intensive supervision, first-time offender DUI court</td>
</tr>
</tbody>
</table>
AAI has a specialized subcategory for individuals returning to the community following incarceration; the Reentering Individual Tool addresses this special population. For example, for individuals returning to the community after incarceration, additional questions relate to the length of incarceration, the housing plan, family reunification, and health insurance. The output for the Reentering Individual Tool also includes a case planning component: The tool identifies the categories of need for the client, then asks the user to identify the three needs of priority focus. For each of these three needs, the user can write about the plan to approach them. AAI is available on Internet browsers, smartphones, and tablets for use with clients.

The RNR Assess an Individual Tool: What can users do with the results?

Supervision Officers

- Talk to the client about his or her risk level and needs and how they affect sentence/supervision.
  - Emphasize the importance of addressing needs while on supervision.
  - Acknowledge stabilizers and other areas where the client is already doing well.
  - Involve clients in case plans designed to target their criminogenic needs.
  - Consider any prior programming, client goals, motivation, and perceptions of causes of offending behavior.

Treatment Providers

- Determine whether a client is a good fit for the program.
- Differentiate dosage levels for clients based on risk and severity of needs.
- Determine what ancillary services are most needed to serve the client (see exhibit 7).
**Exhibit 7. Examples of RNR Recommendations**

**Best Fit Program Group: Criminal Thinking Interventions (B)**

Recommended Dosage Level: Moderate

Group B programs primarily target criminal thinking/lifestyle by using cognitive restructuring techniques and interpersonal and social skills development. These programs use cognitive-behavioral or behavioral methods, offer a range of dosage levels across a continuum of care, and use an evidence-based treatment manual.

Example Programs:
- Cognitive-based criminal thinking curriculums
- Behavioral interventions
- Intensive supervision with treatment to address criminal thinking

**2nd Best Program Group: Self-Improvement and Management (C)**

Group C programs primarily target self-improvement and management. These programs use an evidence-based curriculum and cognitive restructuring techniques to develop social functioning and self-management skills and reduce criminal activity.

Example Programs:
- Manualized drug treatment
- Individual or group counseling to manage triggers
- Outpatient treatment

**Talking With Clients About Risk**

- The program says you have a 64 percent chance of being rearrested within 3 years, but we can reduce that risk by providing you with programming that addresses your “target needs” (see exhibit 8).
- In your case, your target needs are drug dependence, criminal thinking, criminal peers, employment, and family support.
- The results page also shows you need a moderate dosage, which means you should attend programming 8 hours a week.

**Exhibit 8. Recommended RNR Program Group, Estimated Recidivism Rate**
Talking With Clients About Treatment

- The program shows the primary need is to address your dependence on heroin. I want to get you into either an inpatient treatment program or an intensive outpatient program. What do you think about those options?
- Since you show signs of thinking that is not prosocial, you would benefit from behavioral therapy as well, but our first priority is to treat your drug dependence.

The results are printable, so the user can review the paper results with clients in the field, rather than in front of a computer in the office. The user can also use the tool on any tablet or smartphone browser. If sharing the printout, the user should provide more specific guidance, including—

- Information on criminal thinking/antisocial cognition, drug dependence
- Information on actual programs available for clients
- The case plan with estimated dates for starting and completing treatment

Users should consider revisiting the tool after the client engages in treatment. This can help the client see progress and areas that still need work.
The RNR Assess Jurisdiction’s Capacity Tool: Does my system offer programs that meet the needs of the population?

The Assess Jurisdiction’s Capacity (also known as AJC) Tool\(^2\) is one way to conduct a needs assessment in a jurisdiction. AJC takes data about risk levels, identified needs of a jurisdiction’s population, and recidivism and uses the information to determine treatment needs. Some of the information the user will need to gather to complete the AJC tool follows:

- How the agency/jurisdiction typically defines recidivism (e.g., new arrests, new convictions, new incarcerations)
- The average recidivism rate in the jurisdiction/agency
- The estimated number of people currently under correctional control in the agency or treatment program
- Demographics (age, gender, race) of the population under correctional control
- The estimated percentage of the population classified into one of the special supervision categories, such as violent, youthful, or sex offender
- The number of risk levels the jurisdiction/agency uses to classify individuals
- The estimated percentage of the population who fall into each risk-level category
- The estimated percentage of the population who suffer from a severe substance use disorder, and which criminogenic drug is used (e.g., heroin/other opiates, cocaine/crack, amphetamines/methamphetamine)
- The estimated percentage of the population displaying a pattern of antisocial cognitions or criminal thinking
- The estimated percentage of the population with a severe substance use disorder related to alcohol or marijuana, or who use criminogenic drugs but do not meet diagnostic criteria for a severe substance use disorder
- The estimated percentage of the population diagnosed with or treated for a mental health condition within the last 12 months
- The estimated percentage of the population with certain stabilizing and destabilizing factors, such as criminal peers, full-time employment, ability to meet financial obligations, noncompletion of high school

When this information is provided, the AJC tool makes recommendations for your population’s treatment needs. The portal uses an underlying database of unique offender profiles to assess a jurisdiction’s capacity to address the risk and need factors of the offenders under its correctional control. It draws from the information provided by the jurisdiction on offender profiles and programming to identify system-level gaps in the capacity to be responsive to the

\(^2\) See appendix B-2 for detailed instructions on using the AJC Tool.
needs of the population (ACE!, 2013). This portal is geared for use by jurisdiction administrators and can be used as a strategic planning tool. See exhibit 9 for a sample data output from AJC.

*Exhibit 9. Sample of Assess Jurisdiction’s Capacity Output*

![Chart showing % of recommended by RNR Simulation Tool]

**The RNR Program Tool for Adults: Does a specific program use evidence-based practices?**

GMU and partners developed the RNR Program Tool for Adults to help criminal justice agencies better understand the resources available to them and to foster responsivity at a system level. The other purpose of the Program Tool is to help treatment providers identify their strengths and weaknesses and begin to put together a plan for program improvement. The three main goals of the Program Tool follow:

1. Classify treatment programs according to their key features and treatment targets to help facilitate treatment matching (see exhibit 6 for a description of each program category).
2. Explore how programs currently target the risk level and criminogenic needs of their clients.
3. Assess programs on their use of evidence-based practices.

The Program Tool is intended for use as a self-assessment by the providers and for the results to be shared (with the consent of the treatment provider) with agencies that refer clients to those providers. The tool provides guidance to users to improve existing programs’ adherence to evidence-based practices and also helps jurisdictions determine gaps in existing programs where client needs are not being addressed.
The RNR Program Tool for Adults

How the Program Tool Works

The Web-based Program Tool for Adults is completed by program managers or another person very familiar with the program. It takes approximately 45–60 minutes to complete, with most of the information needed available from sources such as annual reports and prior program evaluations. The program manager answers a series of questions on the content of the program, how clients are assessed, what populations the program aims to serve, the amount of programming clients receive, curricula used, and qualifications of staff.

After completing the tool, the user immediately receives feedback and recommendations (see exhibits 10 and 11):

1. The program category (Severe Substance Use Disorders, Criminal Thinking/Cognitive Restructuring, Self-Improvement and Management, Social and Interpersonal Skills, Life Skills, or Punishment Only)
2. Scores on a scale of 0 to 100 percent in the domains Risk, Need, Responsivity, Dosage, Implementation, and Restrictiveness, as well as an overall score
3. Customized recommendations for improving the program

Exhibit 10. Sample Feedback From the PTA
Because the tool is Web based, users can regularly update it to monitor programmatic changes over time. Most programs receive overall scores ranging from 50 to 70 percent. This is consistent with other initiatives and studies that have found most programs have modest quality (Lowenkamp, Latessa, & Smith, 2006).

**Specialized Programs and the Program Tool**

Because certain program types have unique features and criteria for assessing quality, the Program Tool for Adults includes the specialized tools mentioned earlier: Specialized Courts, Sex Offender, and Reentry Case Management. For each of these program types, the PTA assesses according to additional criteria and provides feedback in additional domains. For example, specialized courts receive feedback on the domains shown in exhibit 12, which were informed by research on specialized courts, including key principles identified by the National Association of Drug Court Professionals (2013) and domains identified by Shaffer (2011).

After using the tool, administrators from the jurisdiction will be able to see what programs are available in each category and the number of individuals that program can treat. Depending on a jurisdiction’s preferences, it may also be able to view the scores each program received (see exhibit 13).
As shown in exhibit 13, a red X indicates the program has limited adherence to the principle, a yellow caution indicates some adherence with room for improvement, and a green check indicates the program shows strong adherence to the principle. These specialized outputs are available for specialized courts, reentry programs, and sex offender programs.

Exhibit 13. Specialized Court Feedback Report
Benefits to the Jurisdiction

Regardless of the size of your jurisdiction or the number of providers available, you cannot make effective referrals without comprehensive knowledge of the program types, quality, and capacity in your jurisdiction. It is easy for line officers to fall into a pattern of referring clients to the same few programs or to base referrals on existing relationships or geography. Once providers have completed the Program Tool, a comprehensive list of available programs and their scores will be available for the jurisdiction. In addition to helping line officers make referrals, the tool can guide jurisdictions as a whole by identifying gaps in program areas. This information can then be used to direct funding allocation, requests for proposals (RFPs), etc. You can also build the tools into your RFPs by requiring providers complete the tool for the hypothetical program.

Addressing Providers’ Concerns

Some providers will likely be hesitant or resistant to completing the self-assessment and will have questions about how the agency plans to use the information. For that reason, recommendations and processes for making providers more comfortable with the Program Tool appear below.

Benefits to Treatment Providers

The Program Tool is designed to provide programs with baseline assessments of how well they are adhering to evidence-based practices and to provide feedback on how they can increase this adherence. Programs are urged to view initial PTA results as a starting point in identifying their strengths and areas for improvement. Providers can also use the PTA to experiment with changes to their program. For example, if a provider has a program that currently does not have a robust intake system and is considering adopting a more evidence-based approach, such as using risk assessment data and conducting need-specific additional assessments, the provider could reenter the program with the proposed changes and note if there are changes to scores. Providers developing grant proposals can enter their hypothetical program into the tool and note the scores. The purpose of the Program Tool is not to audit programs or catch them doing something wrong.

Another way providers can benefit from using the Program Tool is through increased visibility of programs within the jurisdiction. Rather than repeating the pattern of referring clients to the same small set of programs, the jurisdiction will have better knowledge of the universe of programs available. Programs that score especially well on the PTA can be used as leverage with referring agencies, judges, and local leadership to demonstrate their value to the community.
Steps to Effective Use of the Program Tool

Begin by deciding how to use the information providers will enter into the PTA. For example, a jurisdiction may require all programs that score under 60 percent in the implementation domain to identify two things they can do to improve in that area, then request that programs complete those items over a realistic time period. Once the jurisdiction has established how it will use the data, the sponsoring agency can hold a meeting of the justice agencies and treatment partners to introduce PTA (see appendix C-1). During this meeting, the agency should cover the following:

- What will the data be used for?
- How will individual program data be secure?
- What will be required of providers when they get the feedback reports?
- What are the benefits to the providers?
- Emphasize that it relates to treatment matching and better referrals (and client outcomes).
- Provide opportunities for the justice agency and the treatment provider to discuss the findings.
- Consider soliciting a few sites to pilot the tool, then integrate those experiences into the training.
- In some cases, you might complete the tool with the provider in an interview style if you think the concepts may be confusing or if you are encountering hesitance.

Providers will likely want to know what data they enter into the tool will be shared. For most users, the answers will be as follows:

- Nothing without approval!
- Program classification information (RNR program group)
- Summary of target population: inclusion and exclusion criteria and dosage information
- Special program features

Consider who should have access to the information in the tool. For example, you may want administrators but not line officers to have access to the programs’ scores.

What NOT To Do!

Do not...

- Send an email blast telling providers to complete the PTA without discussion or training as this will both confuse and alienate providers.
Discuss cutting funding if the “right” answers are not achieved. It is up to the individual agency how to use the results, but it is far more effective to use it as a learning and process improvement tool than a report card.

Discuss cutting programs if certain scores are not achieved. Programming should be driven by client need, not scores.

Expect miracles overnight. The most important factor is that programs are willing to examine themselves and consider making improvements so they can better serve clients.

Expect 90 percent scores. Most programs score in the 50 to 70 percent range, and the scores in the separate domains are much more meaningful than overall scores.

Finding Gaps: Assess Jurisdiction’s Capacity Combined With the PTA

As discussed earlier, the Assess Jurisdiction’s Capacity (or AJC) portal, designed for use by justice agency administrators, assesses a jurisdiction’s capacity to be responsive to the risk-need profiles of individuals in its jurisdiction. Based on data from 18 questions about the prevalence of risk and needs of individuals in the jurisdiction, the portal provides an initial recommendation of the amount and type of programming needed to adequately respond to the jurisdiction’s population. When users enter information regarding the available programs in a jurisdiction, the portal also identifies system-level gaps in the jurisdiction’s capacity to provide responsivity and recommends levels of programming the jurisdiction may need to augment to better respond to the needs of the population (see exhibit 14).

Exhibit 14. Sample Gap Analysis From AJC
Underlying Concepts

One of the challenges of introducing the RNR model to treatment providers is that providers may not be familiar with the concepts. For example, it is important to establish what you mean by “risk.” Providers may think of risk as risk of relapse, risk of failure in the program, etc. In the RNR model, risk specifically refers to risk for recidivism, measured in an objective manner by a validated instrument. Several other concepts and questions in the PTA can create confusion with providers who work with both criminal justice and non–criminal-justice populations. These include defining target populations, using screening tools and inclusion/exclusion criteria, defining a primary target with programs that take a comprehensive approach, dosage, and use of sanctions and rewards.

Resources for better understanding many of the RNR concepts are available in PDF by request (email rnrtool@gmu.edu) and in the RNR Frequently Asked Questions, available at http://www.gmuace.org/about_faq.html#cjrak (see appendix D for RNR Frequently Asked Questions).

Jurisdiction Use Versus Individual Use

While the RNR tools are designed to feed into one another, they can also stand alone. In an ideal RNR jurisdiction, the justice agency provides population-level data on clients, providers serving criminal justice clients complete the program tool, and line officers use the AAI tool to make treatment referrals for clients. However, any individual can use the Web-based tools. A line officer in a jurisdiction that is not participating in RNR can use the AAI tool to guide referrals—the only difference is that the officer will not receive recommendations for specific programs in the jurisdiction. Rather, the tool will provide recommendations for program categories. Likewise, any treatment providers interested in assessing program quality can use the PTA to determine areas where they may need improvement. Without programs participating, an agency can still use the AJC tool to determine programming needs; they will simply not be able to complete the gap analysis.

Sequencing the Portals of the RNR Simulation Tool

Once a jurisdiction, provider, agency, or other entity has decided it wants to use the entire suite of tools, where should it start? The tools can be rolled out in any order, depending on the user’s preferences. AJC is a good starting point because it provides a macro-level view of the client’s needs, helping to identify where to target resources. At the same time, introducing PTA early in the process may be useful to give providers adequate time to complete the tool, ask questions, and reflect on their scores. Many jurisdictions do not collect or have easy access to risk and need data, so those jurisdictions would benefit from starting with the AAI tool and using the data collected to inform the AJC tool.
Chapter 3. Treatment Providers

In-House Treatment Versus Referrals to Community Treatment Providers

There is no easy answer as to whether probation, corrections, or justice agencies should use in-house treatment and clinical staff versus referrals to community treatment providers. Much depends on the community and/or the organization. With in-house treatment, it is clear what clients are receiving, while corrections agency employees may lack the level of expertise found in, for example, an inpatient substance dependence treatment facility. There is a place for both in the continuum of treatment. Correctional agencies will function best when they draw upon the training of their own staff and enhance it with outside expertise, especially when addressing complex and/or severe issues, such as deeply rooted criminal thinking or serious drug dependence.

Another factor to consider when determining whether to treat in-house or outside is the general atmosphere of the supervision agency and the attitudes of the officers. If you were to conduct an internal self-assessment, would you find staff promote rehabilitation and recovery, or is there more a “law and order” approach? (See chapter 4 for more information about assessing organizational culture.)

Learning About Treatment Agencies

A first step in promoting RNR in your jurisdiction is completing an inventory of currently available programming, both in-house and through outside providers. This list provides a starting point for defining the pool of your agencies.

How should you complete this inventory? Start with in-house programs and determine what is available. You will want to gather the following minimal information about services offered through your agency:

- Primary area(s) of client need (substance dependence, vocational skills, antisocial cognitions) that your program addresses
- Number of individuals the program can serve in a year
- Types of programming offered to participants and the amount of effort the programs take
- Types of clients who are eligible and not eligible for a program
- Types of intervention/curriculum used to address a problem
- Any major issues or challenges of the program in the past year

If there is no formal system in place for tracking referrals, consider implementing one to improve record-keeping and client services.
Once you complete this scan of in-house programs, you can turn to providers in the community. If you are in a particularly large or program-rich jurisdiction, this may be a large task. Start with the programs you are familiar with, then attempt to discern the programs your department refers to most frequently. Keep in mind that many providers offer multiple programs, so be sure to assess each service separately. This is important because they provide different services.

The RNR PTA can be valuable for conducting an environmental scan of programs in the jurisdiction, assessing both what programs are available and their quality. In the meantime, how can you complete this provider scan if your agency is not tracking referrals? You may need to (1) conduct a survey of officers or case managers in your department, asking where they have referred clients in the past year; and (2) work with outside agencies, such as your local department of human services and department of health.

Integration

Working with outside providers should not feel like moving to a different country. Jurisdictions can implement various strategies to make systems more seamless, such as the following:

- Share policy and procedures manuals.
- Share management information and data systems.
- Share the intake assessments, risk/needs assessments, and other data on clients.
- Invite providers to agency trainings and meetings.
- Visit the site of a treatment agency and observe processes.
- Hold regular meetings or conference calls to discuss client progress.

Identifying Needs and Finding Providers

Once your agency has determined that you need to seek new outside providers for treatment services, you should develop a wish list related to providers and determine how you will find them. You will also need to address practical concerns, such as how the providers will be paid—through a contract with your agency, billing via Medicaid or other insurance, charging clients per unit of service? If your agency has funding available to pay providers, you can issue RFPs listing the areas where you need providers and what the terms of the contracts will be.

Identifying the Population’s Treatment Needs

The Assess Jurisdiction Capacity (ACJ) tool is the answer to identifying the needs of your jurisdiction. First, determine your clients’ treatment needs, if you have not already done so. If you are using a needs assessment such as the Correctional Assessment and Intervention System
(CAIS)$^3$ or the Level of Service Inventory–Revised (LSI-R),$^4$ you should be able to enter data into the AJC to determine the number of clients in your jurisdiction who have issues such as serious substance dependence, criminal thinking, mental health issues, and other major treatment needs. The AJC tool will identify the programs you need and the number of clients in your jurisdiction who would benefit from this type of programming. Remember that programming should focus on high- and moderate-risk clients, though you do need to be mindful of lower risk people who may have high needs (for example, a 20-year-old who is dependent on heroin but has not yet built up a long arrest history).

From the AJC output, you can create a wish list of programming that would best serve your population. Your wish list should establish—

- Types of treatment needs
- Desired therapeutic approaches
- Number of treatment slots needed
- Geographic area needed
- Hours of dosage needed
- Ancillary services you would like providers to have available
- Desired education, training, and experience of provider staff

Start with criminogenic needs; that is, those needs that are directly related to reoffending. If you have a choice between spending limited treatment dollars on programs that treat substance dependence and criminal thinking or skills such as life skills or social skills, the better option is programming for substance dependence and criminal thinking.

Not all substance abuse is created equal, and not all abusers will benefit from the same type of treatment. For example, your environmental scan may reveal you have 200 clients who need treatment for severe substance dependence, and appropriate treatment slots are currently available for only half of those clients. Even within the category of severe substance dependence programs, there are many interventions that target the need. Service options may include inpatient treatment, intensive outpatient treatment, medication-assisted treatment (MAT), and therapeutic community. The key is not the name of the program or where it is offered but what it does and the types of clients it serves. For example, if heroin is a major drug of choice, the population can benefit from MAT (e.g., with methadone, Suboxone, Vivitrol), which can stabilize the person and assist him or her to better understand behavioral therapy.

---

$^3$ CAIS is a supervision strategy model that weaves together a risk assessment and a needs assessment—in one face-to-face assessment interview.

$^4$ LSI–R is a quantitative survey of offender attributes and their situations relevant to the level of supervision and treatment decisions.
Finding High-Quality Providers To Meet the Needs of Clients

There are several common issues among providers who work with the criminal justice population that may appear in your jurisdiction, such as the following:

1. Little attention to criminal thinking and criminal lifestyles that affect the population
2. Alcohol and drug education programs being used to treat clients with substance dependence disorders
3. Many varieties of “life skills” programs that do not target the moderate- to high-risk clients’ criminogenic needs
4. What are some limitations with the programming in your jurisdiction?

Treatment Quality Matters

Everyone works hard and wants to offer the best services possible, but research has demonstrated that most programs available are of modest quality. Using the Correctional Program Assessment Inventory, Lowenkamp, Latessa, and Smith (2006) found the quality of programs was directly related to how effective they were in reducing recidivism (see exhibit 15). They also found, in a survey of 38 programs, only one rated as high quality. Similarly, analyses of data entered into the PTA indicate most programs score in the 50 to 70 percent range, and only one program has scored above 90 percent overall.

Exhibit 15. Correctional Program Assessment Inventory Findings on the Relationship Between Program Quality and Recidivism

<table>
<thead>
<tr>
<th>Score Level</th>
<th>Number (N)</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>High Score (N = 1)</td>
<td></td>
<td>22%</td>
</tr>
<tr>
<td>Moderate Score (N = 13)</td>
<td></td>
<td>8%</td>
</tr>
<tr>
<td>Low Score (N = 24)</td>
<td></td>
<td>2%</td>
</tr>
</tbody>
</table>

The first step in finding high-quality providers is to examine the providers your agency already uses. Have your providers completed internal or external evaluations? If you do not have these data available, you can recruit providers to complete the RNR PTA, described earlier. If a complete audit of program quality is not feasible, you may want to focus on a few observable factors to help you determine if you want to continue the relationship with each provider. In
both examining the content and quality of current programming and finding new providers, you will want to keep the following factors in mind:

- The most efficient way to find higher quality programming is to look for programs that use an evidence-based curriculum and those that have had an external evaluation completed (Lowenkamp, Latessa & Smith, 2006; Andrews & Dowden, 2005).
- High-quality programs use evidence-based practices. Find out what curricula the programs use, and check the evidence on them. Some places to research curricula include NREPP (http://www.nrepp.samhsa.gov) and CrimeSolutions, the National Institute of Justice’s repository of evidence-based practices (http://www.criminalusions.gov).
- High-quality programs target key factors, rather than taking a “kitchen sink” approach when it comes to services. This means that programs assess clients or receive appropriate assessment results before treating the clients to ensure that the clients’ needs match the treatment services. They then target those needs with appropriate programming (Andrews, Bonta, & Hoge, 1990).
- One size does not fit all. There is no magic program that works for all offenders. Each offender will have different treatment needs, so programs need to differentiate their approaches based on the client (Andrews & Bonta, 2010; Lipsey & Cullen, 2007).
- High-quality programs have appropriate dosage. There is a limited amount of data on dosage needs, and these numbers vary according to the target need the program addresses, but the current recommendations are around 100 hours for less severe disorders, 200 hours for moderate issues, and 300 hours for severe disorders (Bourgon & Armstrong, 2005; Taxman, Byrne, & Thanner, 2002; Lowenkamp & Latessa, 2005; Lipsey, 1999; Kroner & Takahashi, 2012); Sperber, Latessa, & Makarios, 2013a; Sperber, Latessa, & Makarios, 2013b).
- Effective implementation matters. High-quality programs include robust intake process, designated completion criteria; effective means of communication among staff; use of coaching and technical assistance; use of treatment manuals; and use of a manualized form of treatment (Landenberger & Lipsey, 2005a,b; Andrews & Dowden, 2005; McGrew, Bond, Dietzen & Salyers, 1994; Stanard, 1999; Simons, et al., 2010; Taxman & Bouffard, 2000; Fletcher, Lehman, Wexler, Melnick, Taxman, & Young, 2009; Taxman & Belenko, 2012).
- High-quality programs do not try to do too many things. Rather, they focus on a primary target, plus a minimum number of secondary targets, and refer to other programs for ancillary services as needed (Andrews, Bonta, & Hoge, 1990).

The Program Tool can assist with this effort as it delves into a given program to assess its quality and its adherence to evidence-based practices in the six domains described in the previous section (risk, need, responsivity, implementation, dosage, and restrictiveness).
Questions for Provider Candidates

Prior to bringing a provider into your treatment network (or deciding to keep the provider in your network), you need to gather information on the services it offers and how it implements those services. You can build this request for information into your RFPs and contracts (see appendix C-2). Some sample questions follow:

- Who is your target population?
- What therapeutic approach(es) do you take or plan to take?
- How many clients did you serve over the last 12 months? How many can you serve in 12 months?
- What percentage of sessions did clients attend last year?
- How much staff turnover have you experienced?
- What assessments do you conduct at intake?
- What is program completion based on?
- How many times per week do the program staff meet and for how long?
- What restrictions do you have on who can enroll (e.g., sex offenders, violent offenders)?
- What curriculum or curricula do you use? What percentage of each curriculum do you use?
- What percentage of clients successfully complete the program?
- What are the most common reasons for noncompletion?
- Do you track outcomes for those who complete the program? If so, what percentage of clients relapse/get rearrested/go back to jail?

Staff Qualifications Matter

A good program has excellent staff. It is important to inquire as to the staffing of the program, particularly the clinical services. For any given type of program, make sure you know what to look for. Just as you would never consider having a MAT program with staff who have no formal medical training, you should not have a criminal thinking program with staff who have no psychological training. Exhibit 16 displays qualifications to check according to the program type.
### Exhibit 16. Desired Staff Qualifications by Program Type

<table>
<thead>
<tr>
<th>Target Problem</th>
<th>Clinical or Corrections?</th>
<th>Education</th>
<th>Additional Qualifications</th>
</tr>
</thead>
<tbody>
<tr>
<td>Severe substance dependence</td>
<td>Primarily clinical</td>
<td>M.D. or N.P. with relevant specialty, Psy.D., Ph.D., M.S.W., LCSW, other master’s degree in relevant field for counseling or group sessions</td>
<td>Certified Addiction Counselor (CAC), relevant experience, training/certification in program curriculum and implementation</td>
</tr>
<tr>
<td>Criminal thinking/cognitive restructuring</td>
<td>Primarily clinical</td>
<td>Psy.D., Ph.D., M.S.W., LCSW</td>
<td>Relevant experience, training/certification in program curriculum and implementation</td>
</tr>
<tr>
<td>Self-improvement and management</td>
<td>Primarily clinical</td>
<td>N.P., Psy.D., Ph.D., M.S.W., LCSW, other master’s degree in relevant field, B.S.N. or bachelor’s degree in relevant field</td>
<td>CAC, relevant experience, training/certification in program curriculum and implementation</td>
</tr>
<tr>
<td>Interpersonal skills</td>
<td>Either</td>
<td>N/A</td>
<td>Relevant experience, training/certification in program curriculum and implementation</td>
</tr>
<tr>
<td>Life skills</td>
<td>Either</td>
<td>N/A</td>
<td>Relevant experience, training/certification in program curriculum and implementation</td>
</tr>
<tr>
<td>Punishment/supervision only</td>
<td>Corrections</td>
<td>Bachelor’s degree in relevant field</td>
<td>Relevant experience</td>
</tr>
</tbody>
</table>

### Red Flags

While you should expect challenges, you should watch for larger issues that can derail successful treatment and/or partnerships such as the following:

- Provider cannot provide any outcomes data on prior participants: This could mean it does not collect data/followup or does not wish to share “the bad news.”
- Program conducts no screening or intake instruments.
- Provider has graduation rates lower than 60 percent; low graduation rates can indicate poor screening for appropriate participants or lack of appropriate support for participants.
- Provider indicates serious financial turmoil, internal strife, or high staff turnover rates.
- Provider cannot clearly articulate the objectives of the program in a few sentences.
- Program has no set completion criteria, or graduation is based on time in the program, rather than completion of requirements or reduction in symptoms.
- Provider uses a “hodgepodge” of curricula, drawing from too many sources and using only a fraction of each.

Any of these issues should alert you that the provider may have critical flaws that detract from its ability to provide high-quality treatment services.

**Mixing Offenders and Nonoffenders**

Is mixing offenders and nonoffenders in the same program a red flag to you? The risk principle of the RNR model asserts that not only should you pay attention to client risk levels and focus services and resources on higher risk people, but you should attempt to segregate low-risk offenders from high-risk offenders because exposure can harm the lower risk offenders (Lowenkamp, Latessa, & Holsinger, 2006; Andrews & Dowden, 2006). Does this mean you should avoid programs that mix offenders with nonoffenders? At this time, there is no literature on mixing offenders and nonoffenders; there is only literature on mixing people of various criminal justice risk levels (even nonoffenders can have a risk level because they may have a criminal history but no current involvement). You may want to mitigate this issue by referring only low-risk offenders to such programs and consider limiting high-risk clients to corrections-only programming.
Chapter 4. Assessing and Addressing Organizational Culture

Every organization and agency has its own organizational culture, and this culture affects how staff interact with one another and how they interact with their clients and contractors. Some differences are the result of recent changes in the field, such as the adoption of evidence-based practices in supervision agencies and the shift from a more punitive focus to a more therapeutic focus.

Conduct a Self-Assessment

Is your agency using effective practices in making and following up with referrals? How do you know if your agency takes a therapeutic approach versus a punitive approach? There are several clues to what kind of organizational culture you have (see appendix C-3). Consider the following questions:

- What language do officers use when discussing a client? Are they “offenders,” “criminals,” or “knuckleheads”? Are they “clients,” “people,” “returning citizens,” or “individuals”?
- Have many of the officers and supervisors received training in motivational interviewing (MI), and do they employ it on a regular basis?
- How does the agency respond to technical violations? Do officers use violations as an opportunity to find out more about what is going on in the client’s life and what may have caused him or her to slip? Do they ignore technical violations and let them pile up until there are enough to reincarcerate? Do they provide or refer to increased treatment for drug violations? Does the office have a graduated sanctions grid in place?
- How do officers respond when a client is doing well? Do they employ social or material rewards to reinforce the positive behavior?

A strong partnership is built on teamwork. Does your agency or providers do the following?

- Hold meetings where staff from multiple agencies and providers come together; at those meetings, they share general information about the needs of the offender population
- Recognize that treatment providers across different organizations use similar program eligibility requirements (e.g., all substance abuse programs use the American Society of Addiction Medicine criteria or Addiction Severity Index–Lite)
- Share resources
- Have common data everyone can access
- Have written agreements in place for providing space for treatment services in correctional facilities
- Have joint policy and procedure manuals for programs
For an in-depth examination of office culture, conduct an organizational survey. The National Criminal Justice Treatment Practices Survey includes several scales and measures to assess line officers, supervisors, managers, and executives in correction agencies according to the following (Taxman, 2007):

- Attitudes toward punishment and rehabilitation
- Organizational readiness for change
- Organizational climate and culture
- Treatment practices beliefs
- Interdepartmental collaboration

The survey and manual are available at https://www.icpsr.umich.edu/icpsrweb/NAHDAP/studies/27962

What are the benefits of surveying and measuring organizational climates? Understanding an organization’s climate will help determine whether the organization will be friendly toward reform and the degree to which staff and leadership value therapeutic approaches. You may find your organization or a target organization is not ready to shift toward a more therapeutic model and that more basic groundwork, such as dissemination of information about evidence-based practices, is needed first.

Agency and provider practices are also influenced by external pressures, including political climate, managed care, and local regulations. Research has shown that certain external factors can influence an organization’s ability to change or to effectively deliver services. These factors include Federal funding (e.g., Medicaid, Medicare, Affordable Care Act), Federal regulations, and pay-for-performance models (Taxman & Belenko, 2012).
Chapter 5. Building Relationships and Partnerships

The following are important for building a good relationship with treatment providers:

1. Have realistic expectations!
2. Communicate your expectations clearly.
3. Know providers’ expectations.
4. DOCUMENT, DOCUMENT, DOCUMENT!!

Determine what you need from providers before entering into partnerships with them. If you are soliciting providers through an RFP, spell out expectations in the RFP and make sure providers demonstrate in the applications that they understand the expectations and have the willingness and capacity to meet those expectations.

If your agency is making referrals but not providing funding, you can outline your expectations in a memorandum of understanding (MOU). See appendix C-4. When putting together an MOU, RFP, or treatment contract, keep in mind the following:

- What are the exact services that will be provided, at what frequency, and for what length of time?
- What level and frequency of communication do you require? Remember that this may vary by type of treatment or risk level/severity of client symptoms.
- Who will initiate the communication and how will it take place (regular phone calls, regular meetings, shared data system, etc.)?
- Will the provider allow you to make site visits and conduct observations?
- How will the provider respond to lateness, missed appointments, or other noncompliance?
- If a client is receiving multiple types of services concurrently, will the provider communicate with other treatment providers, and how?
- What does it mean to successfully complete the program?

Also keep in mind that there may be pieces of information the treatment provider cannot and will not share with the justice agency because of Health Insurance Portability and Accountability Act (HIPAA) regulations and client confidentiality regulations (42 CFR, Part 2).

Exhibit 17 provides recommendations for areas to include in the MOU. Making effective referrals is a two-way street, so identify the provider’s expectations of your agency, and build those expectations into the MOU or contract. Expectations may include frequency of communication, sharing risk/needs assessment data, and reinforcing the treatment during supervision visits.
Exhibit 17. Sample Expectations With Treatment Providers

<table>
<thead>
<tr>
<th>Expectation</th>
<th>Residential Substance Dependence Treatment</th>
<th>Community-Based GED Class</th>
</tr>
</thead>
<tbody>
<tr>
<td>Frequency of Communication</td>
<td>Weekly and as needed</td>
<td>Monthly attendance; test scores</td>
</tr>
<tr>
<td>Information Shared by Agency</td>
<td>Client risk level and relevant assessments (e.g., Addiction Severity Index)</td>
<td>Client risk level and relevant assessments</td>
</tr>
<tr>
<td>Information Shared by Provider</td>
<td>Treatment engagement, drug test results, results of clinical assessments, any infractions</td>
<td>Attendance, engagement, modules completed</td>
</tr>
<tr>
<td>Documentation</td>
<td>Shared data system or regular phone calls/meetings</td>
<td>Shared data system or regular emails</td>
</tr>
<tr>
<td>Services</td>
<td>At least X treatment hours per week using evidence-based curricula</td>
<td>Classes and regular testing</td>
</tr>
<tr>
<td>Other</td>
<td>Make yourself available if client wants to have a meeting with you and the counselor; consider visiting client in facility</td>
<td>Dropping by a class once a month will show both the client and the provider you are invested in the client’s success</td>
</tr>
</tbody>
</table>

Remember that your expectations should be different depending on the services provided. It may help to categorize programs and develop criteria/requirements in each category. Your categories could include in-custody drug or mental health treatment; in-custody treatment for criminal thinking or other cognitive-based interventions; in-custody life skills (GED, financial literacy) programs; residential, community-based drug treatment; outpatient drug treatment; community-based treatment for criminal thinking or other cognitive-based interventions; community-based mental health treatment; and community-based life skills programs.

Documentation

If you do not document something, it did not happen. If a provider agrees to a certain frequency of contact, put it in the MOU. If you speak to a provider about a client, put it in the client’s file. If a client expresses concern or positive feedback about a provider, document it and share the information with your colleagues. This can be done either on paper or electronically, depending on how your agency maintains files, but for these pieces of information, you should include the date, the client and provider in question, the type of communication, and what was expressed.
Chapter 6. The Warm Hand-Off: Making Referrals Effectively and Conducting Followup

Treatment Matching: The Right Treatment for the Right Client

You cannot treat clients effectively without first measuring their needs. Your agency may employ a validated risk/needs assessment tool, such as the LSI-R or the Ohio Risk Assessment System (known as ORAS), but many do not. The tool may measure risk only without assessing needs, or it may measure needs but not inform case planning. Tools with a case management component, such as the Level of Service/Case Management Inventory (known as LS/CMI), take the assessment a step further and make recommendations for providing treatment to the client.

If your jurisdiction does not have such a tool in place or is not using the assessments to drive programming, the RNR Simulation Tool (Criminal Justice Targeted Research and Application of Knowledge [CJ-TRAK] project suite of tools) can be used to enhance treatment matching. The AAI provides estimates of the client’s risk for recidivism and recommendations for treatment, based on a few questions about the risk level and needs. The principles of effective treatment matching include measuring risk and needs, finding quality providers, addressing the most pressing and criminogenic needs, considering the client’s readiness and what he or she wants to work on, and revisiting the assessments on a regular basis.

If you have risk/needs assessment data on a client, make sure you access it before making a referral. You also need to take into account client preference and client ability to participate. For example, some treatment is not appropriate for clients with limited literacy; clients with 9–5 jobs cannot go to treatment Thursday at 10 a.m. You need to also consider the quality of the program.

I found the right providers. Now what?

Can you choose a treatment provider, instruct your client to go to the provider for treatment, and call it a day? Only if you want to set up clients for failure! There are steps and strategies you should use to make sure referrals are effective. The first step is finding the right provider for the client, as discussed in the prior sections and ahead.

Once you have determined the appropriate provider, you should contact the provider directly to find out if there is space available for a new client. It can be frustrating for a client to attempt to initiate treatment, only to learn treatment is not available or has a waiting list. When you establish that space is available, find out some of the logistics to make the client’s initial visit go as smoothly as possible (see appendix C-5). Here are some questions you should ask the provider:

- Is the address on your Web site the correct location? Is it easy to find?
- What time should the client get there? Should he or she come early for the initial visit?
Should the client call to make the initial appointment, or can you make the appointment?

What does the client need to bring to the initial appointment?

Is there a dress code?

What are the consequences if the client misses a session? Multiple sessions?

What are the consequences if the client is late for a session?

Are you accustomed to providing services to criminal justice-involved clients?

Are there types of offenders who are not eligible for this program (e.g., if client fits in a special category such as violent or sex offender)?

What does the intake process look like?

What strategies do you use if the client is not engaging appropriately in treatment?

If any of the answers to these questions give you serious reservations about the provider, consider making a different referral.

When you make the referral to the client, go over the information you received and ask for his or her thoughts and concerns (see appendix C-6). These are some questions you should ask the client:

- Have you had any prior experiences with this provider or a similar one?
- What are your concerns about going to this provider?
- What are your concerns about starting treatment in general?
- Will this time and location work for you? Do you need to rearrange any other parts of your schedule to accommodate this treatment?
- How will you get to the provider and how will you get home?
- Do you have childcare during that time?
- What can I do to help you be successful in this treatment program?
- Is it OK if I contact the provider in a few weeks to make sure you are progressing in the treatment? (You may need a HIPAA release\(^5\) to do this.)

Make sure you problem-solve with the client regarding concerns he or she has, logistical or otherwise. The client will not be successful in treatment if he or she has serious reservations. As you have no doubt seen, some clients will need more “hand holding” than others to start treatment, and this will also vary based on the type of treatment. Getting a client to engage in treatment for drug dependence or criminal thinking will be a more complex process than getting him or her to vocational training. If you have a client who seems especially hesitant

\(^5\) For substance abuse treatment, agencies need to ensure that the HIPAA release meets the requirements of 42 CFR.
about starting a treatment program, consider escorting him or her to the facility and taking a tour together.

Prioritizing Needs

Needs that are criminogenic—that is, associated with reoffending, criminal thinking, or dependence on a serious drug—should be prioritized to have the best outcomes. It can be difficult to convince clients of the importance of these needs over more practical concerns, such as getting a job or finishing school. The role of a probation officer or other corrections agency personnel is to steer the client toward the treatment that will prevent reoffending.

Having a place to live, an education, and steady employment are all elements in a person’s life that provide stability, which in turn make them more likely to succeed on supervision. Some issues may have to be stabilized before addressing the criminogenic needs—for example, if the client does not have a place to live, you will want to address this need immediately. When it comes to other practical concerns, you will need to work with the client to impress upon him or her the value of tackling the primary criminogenic needs first.

Nuts and Bolts

Whether you can compel the client to attend the recommended treatment will depend on several factors. When possible, you should write the recommended treatment and frequency into the client case plan. In some cases, the case plan and conditions for the client have been predetermined by a judge or parole board. In those cases, you may want to develop a separate, nonbinding behavioral contract with the client (see appendix E for an example of a behavioral contract). Behavioral contracts are different from typical supervision and conditions of release because contracts are developed through a combined effort of criminal justice personnel and clients to target short-term behaviors to achieve long-term success (Taxman, Sheppardson, & Byrne, 2004). The behavioral contract can include both the officer’s and the client’s expected contributions to the supervision process, such as how often the client will attend treatment and how often the officer will check in with the client.

To effectively communicate with providers about individual clients, you will need to put into place a HIPAA release of information form, MOU, or other agreement for sharing information about clients. It is likely your department already has a HIPAA release form\textsuperscript{6} you can use as a template. If not, your county social services or mental health departments can be a good resource. The HIPAA waiver will set forth the types of information the client will allow you and the treatment provider to share and which providers are permitted to communicate with you.

Consent forms are another useful tool. Treatment providers should require clients to provide written consent to receive services, and they can include in these forms permission to share information with the referring agency. Once such a consent is in place and signed, the

\textsuperscript{6} For substance abuse treatment, agencies need to ensure that the HIPAA release meets the requirements of 42 CFR.
treatment provider can give you regular updates (see appendix F for an example of an informed consent form).

Decide how frequently you want to check in with the provider. This can vary by client, by supervision level, and by program. For example, if you have a low-risk client who reports to probation once a month and has enrolled in a conflict resolution class, you will not need to check in with the provider frequently. For this type of client and program, you may want to check that the client attended the first session, then ask the provider to alert you only if several sessions are missed or there are chronic problems with the client. On the other hand, if you have a high-risk client who is attending an outpatient drug treatment program, you should plan to communicate more frequently with the provider, at least once every 2 weeks. You should also plan to ask the client open-ended questions about how each treatment program is going when you meet with him or her.

It will also be helpful to establish with the providers what behaviors or issues will trigger contact with you. Put together a list of behaviors you want to be informed about (e.g., chronic lateness, missed sessions, arguments with other participants or staff, general lack of engagement).

**Integrated Data Systems**

The most efficient way for agencies and providers to share data can be to have a shared data system. Many client tracking systems used in corrections agencies have referral/treatment modules. You may want to look into whether it is possible to give treatment providers access to this module and have them enter treatment data directly into this system. Developing an integrated system for sharing data will save time and effort for both the providers and the agency and will facilitate more effective client management. For example, if the treatment provider indicates in the system that the client is struggling in treatment, the probation agency can address this in supervision visits and discuss options with the client. The provider can identify additional treatment needs and indicate those in the shared database to facilitate future referrals.

**Limitations**

Keep the following in mind when sharing information across systems:

1. All entities have multiple reporting requirements. The treatment provider reports to the referring agency but may also report to the clients’ insurers, their funding agencies/foundations, and other government entities, especially if the client is under multiple types of supervision (e.g., both probation and parole). Likewise, the corrections agency is likely working with several different providers and will also have reporting requirements with the courts, justice partners, and supervisors.

2. There are limits to what information can be shared. Some treatment providers are protected by doctor-patient privilege and need to limit the information they can feed back to the referring agency.
If you are experiencing problems communicating with a partner, it is vital to consider the other restraints each of you face. Expectations about communication should differ depending on the volume of referrals to the provider. A provider that receives 100+ referrals from probation should have formal policies in place and be familiar with probation’s communication expectations, but a provider that sees only a few probation clients is less likely to have these things in place, so you will need to work to establish realistic expectations for communication.

**Followup**

Once a client successfully enrolls in a program, your work is not done! You need to conduct followup with both the client and the provider to ensure treatment goes well. Supervision visits should include checking in on any and all programming in which the client has enrolled. Do not simply ask, “How’s it going?” or “Are you still in program X?” Some clients will volunteer relevant information at just those prompts, but many others will need more directed questions such as, “Have you missed any sessions?” “What are you getting out of this treatment?” “How is the relationship with you and the facilitators?” Document all this information in the client file (see appendix C-7).

Followup with the provider is crucial too, to fill in any blanks. Even if you have shared information systems or another way to track treatment attendance, you should find it valuable to speak with the provider and get more information about client progress. The client may provide information relevant to his or her supervision to the provider that was not shared with the justice agency as a result of a more therapeutic relationship. Having this information at your disposal increases your ability to provide support to the client or make additional referrals as needed. If the provider conducts assessments or drug testing, request this information because it can also help inform effective supervision strategies.

Not all clients require the same amount of contact with their supervision officers, and not all clients require the same officer-provider contact. For clients undergoing treatment for a serious, criminogenic need, the contact with the provider should be more frequent and more intensive. Remember to check in with the client about the treatment, and do so in the early part of the supervision visit. Do not leave the topic of treatment as an afterthought, checking off a box at the conclusion of the meeting.
Chapter 7. Problem-Solving in Programs and Systems: Getting Over Bumps

Through the supervision process, you are bound to come across roadblocks with both probationers and treatment providers. These challenges can serve as opportunities to develop and build your existing relationships. They can give you insight into triggers for clients and issues that may be common to a given provider or even a group of providers.

Is Treatment Working?

Treatment situations are nuanced. It is challenging to disentangle the various factors that may impede treatment success. The best way to determine how well the treatment is working is continual communication with both the client and the treatment provider. You will need to pay attention to the client’s symptoms; for example, if the client is enrolled in a criminal thinking program, has he or she begun to take responsibility for prior acts? It is also important to have realistic expectations of the treatment—even a high-quality, well-matched program will not work miracles overnight.

Staff Changes Affect Programs and Quality

Attrition is inevitable in both treatment provider organizations and corrections agencies. Officers and counselors get promoted, change units, retire, and move. Changes in personnel can create challenges for the treatment providers, especially if there has been a positive relationship with the prior contact. Agency personnel can facilitate successful transfer by effectively communicating with both the provider and the successor. Your agency may already have procedures in place to facilitate succession, but if not, you should make it a priority when transferring clients to share as much information as possible. At a minimum, the successor will need to know the clients’ risk levels, needs, home circumstances, health insurance, employment and education situation, and any current or previous treatment. Make sure, too, to provide contact information for all treatment providers and share the methods of communication you use with each provider.

Inadequate Communication From Providers

“An ounce of prevention is worth a pound of cure.” When it comes to working with outside agencies or other service providers, you will benefit in the long run from establishing clear expectations for communication at the outset. You can formalize these expectations through an MOU, a contract with the provider, or even an RFP. Written expectations should include desired frequency of communication, preferred methods of communication, and events that should trigger communication. In-person visits to the provider should be conducted regularly. These visits give you the opportunity to learn more about the program and demonstrate to the provider you and your agency value your relationship with that provider. They also demonstrate to the client that the probation officer is invested in the client’s treatment.
If a provider’s communication with you does not meet your expectations, remind the provider of the expectations set forth in the contract or MOU and also problem-solve with the provider. Discuss with providers whether they find your expectations of communication reasonable and feasible. Ask open-ended questions such as, “What can my agency do to facilitate communication with your organization?” and “For what types of events or incidents do you think it’s appropriate for you to contact my agency?” Remind the provider (and yourself) that the purpose of the communication is to facilitate the treatment process for the client.

You also need to track when communication issues with treatment providers occur. If they become a regular occurrence with a given provider, you may need to take more serious action. This does not necessarily mean terminating the provider relationship. Rather, it could mean revisiting whether your communication expectations are realistic and revising them accordingly, being more proactive with the provider (e.g., calling for updates rather than waiting for them to initiate communication, setting up regular meetings with the provider). If you are considering terminating the provider relationship, whether in general or for a specific client, you will need to take several factors into consideration, including whether the contract allows termination, the provider’s success rate with criminal justice clients, client satisfaction with the provider, and the experiences of others in your office with this provider.

**Client Noncompliance**

Client noncompliance is a vague term that covers a range of undesirable behaviors, from being late for an appointment to being rearrested for a major crime. Keep in mind that, while your agency likely has a system for graduated sanctions or other systematic way of dealing with noncompliance, the treatment provider may not have any such system in place. When providers deal primarily with individuals outside the criminal justice system, they may need your expertise in dealing with noncompliance or punt the issue to you.

To effectively address client noncompliance as it relates to outside treatment providers, you will need to first have in place a mechanism for information sharing between you and the treatment providers, as discussed earlier. You may learn about a client’s noncompliance either through client self-report or from the treatment provider. Noncompliance in areas that do not affect the client’s treatment plan does not need to be shared with the provider.

Noncompliance can be an opportunity to build the working alliances between you and the client, you and the treatment provider, and the client and the treatment provider. The experience does not have to be entirely negative. One example is learning from the provider that the client has not been showing up for mandatory treatment sessions that are a condition of his or her community release. Once again, it is vital to get as much information from the provider as possible, such as the number of sessions missed and attended, whether the client was on time for sessions attended and engaged in the treatment, whether the client notified
the provider that she or he would not attend, any reasons given for nonattendance, and any major issues that may be going on in the client’s life that could prevent treatment attendance (see appendix C-8).

Once you have gathered this information, you should discuss with the provider staff the steps they have taken or plan to take with the client. In the case of multiple, skipped treatment sessions, you should contact the client right away, rather than wait for the next supervision visit. If you already have a good working relationship where the client is open with you, you may find it useful to give the client an opening to share about the missed sessions first. If this happens, be sure to affirm the client for being honest with you. If not, let the client know you have spoken with the treatment provider and you know he or she is out of compliance with the treatment condition. Ask the client open-ended questions or ask to describe in his or her own words what has been going on with treatment. If you have been trained in MI, it can be useful to employ MI techniques (see appendix C-9). Some examples of open-ended questions appropriate to this situation follow:

- What do you think about this treatment as a fit for you?
- What are some things going on in your life that make it difficult for you to attend treatment?
- What are you hoping to get out of treatment?
- What do you like and dislike about this treatment program?
- What can the provider do to increase your attendance?
- What can probation do to increase your attendance?

One of the key pieces of information you can get from this conversation is whether the client missed sessions because of logistical issues, life issues, not wanting to go to treatment in general, or not wanting to go to this particular treatment. Once you have this information, you can problem-solve with both the client and the provider.

**Difficult and Resistant Clients**

Clients can be sensitive to their own needs and draw upon any tensions between treatment providers and referring agencies. Or they can request services that are not feasible. Or they can be resistant because “change is hard work.” All these are examples of why you need to discuss what you heard with the partnering agency or organization and not take the client at his or her own word. The client’s goal may be to get out of treatment entirely or to simply create drama or tension.

**Treatment Readiness and Motivational Interviewing**

At both the program level and individual level, efforts should be focused on treatment engagement. Level of engagement will affect how your client responds to treatment, including program quality, program appropriateness, and client characteristics such as treatment
readiness. Often you can use your professional judgment to make an initial assessment of the client’s readiness for treatment. If you suspect a client is not far enough along the spectrum of readiness to treat, you can assess using a standard tool, such as the Texas Christian University (TCU) tool. Such tools will assess factors such as clients’ expectations about treatment and supervision, their ability to set realistic goals, the belief they can change, and available external supports (Miller & Rollnick, 2002).

What do you do when the assessment reveals low treatment readiness? MI uses nonconfrontational techniques to target readiness factors. If you have not received training in MI, you should check whether this training is available in your jurisdiction because it is valuable in increasing client engagement. MI focuses on helping clients understand their need for change, better appreciate their crime cycle, and develop attitudes that support change (Taxman, Shepardson, & Byrne, 2004). It is a strategy for working with clients, not a closed-ended curriculum, and its use should not be limited to clients with a low level of readiness for change. You will also want to exercise MI techniques to sustain motivation in clients who are already engaged in the treatment process.

The following are the principles of MI:

1. Motivation to change is elicited from the offender and not imposed from without.
2. It is the offender’s task, not line staff’s, to articulate and resolve his or her ambivalence.
3. Direct persuasion is not an effective method for resolving ambivalence.
4. The approach for MI is generally a quiet and eliciting one.
5. The line staff are directive in helping the offender to examine and resolve ambivalence.
6. Readiness to change is not an offender trait but a fluctuating product of interpersonal interaction.
7. The therapeutic relationship is more like a partnership or companionship than expert/recipient roles (Taxman, Shepardson, & Byrne, 2004).

See appendix G for more resources about MI.

**Contingency Management**

Contingency management (CM), or the systematic use of rewards with designated target behaviors, has proven successful in treatment programs, especially drug treatment. CM can be practiced by the treatment provider, the supervision officer, or both. Rewarding clients for engaging in positive behaviors and avoiding negative behaviors can be an effective means of motivation, but it needs to be done in a systematic fashion so the rewards are tied to certain behaviors. A systematic CM scheme involves selecting target behaviors, assigning point values to each behavior, and determining reward levels (i.e., the number of points a client has to earn to receive the first, second, third reward).
CM includes both social and material rewards. Examples of social rewards are decreased reporting requirements, time off probation, verbal or written praise, or a letter to an employer or family member. Material rewards should be something the client values, which you can discern by asking. Rewards might be transit passes, gift cards, snacks, and tickets to events.

If you decide to use CM in your supervision plan, you need to decide what behaviors you will reward and how; for example, by developing a point system. If you select treatment attendance as a target behavior, let the treatment provider know and request verification of attendance. You want to tie the reward-earning behaviors to the client’s goals and supervision requirements. If the client’s supervision plan requires abstinence from drugs and participation in drug treatment, you can tie points and rewards to clean drug tests and treatment attendance.

CM can also provide an opportunity to build partnership with the treatment providers. Corrections agency staff may find they are limited in the ability to give material or social rewards to clients, and providers may have more flexibility, especially if they are independent organization. For example, your agency may not allow you to reward the client for negative drug tests because “that’s what they’re supposed to do anyway,” but if the private provider wants to use CM, you can report drug test status to the provider so the client gets credit.

See appendix H for more resources about CM.
Chapter 8. Making Improvements to Programs

The average overall scores received by programs that complete the RNR PTA range from 50 to 70 percent, indicating much room for improvement. It is highly unusual for programs to receive scores at or above 90 percent when they first complete the tool. We encourage programs to reflect on their scores by domain and ask the following questions (see appendix I for an example of a process improvement template):

- Were any of your scores surprising to you?
- What do you think are the characteristics that make your program effective?
- What changes were you already planning to make to your program?
- For each domain of the RNR Program Tool, what is one thing you are doing well and one thing you can do to improve the quality of your program?
- What can outside entities, such as criminal justice agencies, departments of health and human services, or other treatment providers, do to help you improve program quality?

A good benchmark to use for quality improvement is to reflect on the domains where programs scored lower than 70 percent and develop plans to try to bring those scores up to 80 percent or higher.

Plan, Do, Study, Act

Even if you are not using the RNR Simulation Tool, the “plan, do, study, act” (PDSA) model for quality improvement can help providers improve services. With PDSA, organizations identify problems in their programs and brainstorm solutions to those programs. The PDSA model has been specifically applied to improve substance abuse treatment programs and systems through research by NIATx. See exhibit 18.

Exhibit 18. Plan, Do, Study, Act Model

1. Plan
   What solution will you test?
   What is the anticipated outcome?

2. Do
   What steps will you take?
   When?
   Who is responsible?

3. Study
   What are the results?
   How do they compare to baseline?
   Was it implemented as planned?

4. Act
   Adopt
   Adapt
   Abandon
To get started with a PDSA cycle, select a domain where the score is under 70 percent (hint: it is best to start with your lowest). Ask the following questions (Luongo, 2011):

- What’s not working well?
- How do you know?
  - Do you have performance measures for your project/program/system?
  - Are data about performance available and shared?
  - Are there client/team member complaints?
- Specify the problem; for example:
  - “Not enough clients in the program”
  - “High rate of dropouts”
  - “No one reaches reward number 2”
  - “Treatment attendance is lower than expected”
  - “Takes 2 months to sanction a client”

Once you think you have a comprehensive list of problems to tackle, list them:

- What problems have been identified and classified?
- Establish problem priority.
- What do you want to accomplish?
  - How will you know you got there?
    - Baseline measurements?
    - What is the target?
These are the steps to a PDSA cycle:

**PLAN**

**What solution/change are you going to test to solve the problem?** Identify potential solutions. For instance, if your problem is clients coming to treatment sessions late, examine whether there are transportations issues, motivation issues, or time management issues, and identify potential solutions. Keep in mind the reason for lateness may be different for different clients, so the solution may need to be multifaceted.

**What is your anticipated outcome?** Identify the desired outcome. Do you want 100 percent of clients to be on time 100 percent of the time? Is this a reasonable expectation?

**DO**

**What steps will you take to specifically test this solution?** Who is responsible for doing what and when? Identify both the steps and who will carry out each step. For instance, if lateness is because of transportation issues, you may decide to implement a transit voucher system or pick up clients and bring them to treatment. If you do the former, you need to determine how to pay for vouchers; where and when to procure the vouchers; who is eligible to receive the vouchers; when they can receive the vouchers; and who on staff is accountable for obtaining, distributing, and tracking vouchers.

**STUDY**

**What are the results of testing the solution?** How do the results compare to the baseline measures? Was the solution or change tested/implemented as you planned? Did the implementation of the voucher system go smoothly? Why or why not? Were you able to procure funding for the vouchers? How long did it take to get the vouchers? Did your procedures work? Were clients satisfied with the system? Did you achieve the desired result of clients being on time? If not, was it because of flaws in the voucher system or because other issues were contributing to clients being late?
Once you have completed the first three steps, make the decision to adopt, adapt, or abandon the proposed solution.

**Adopt:** The solution you proposed is a viable resolution for this problem. Document the voucher system in the treatment manual, and make sure the funding is sustainable. Disseminate information about the voucher program to staff.

**Adapt:** The solution doesn’t quite resolve the problem. Repeat the PDSA process until the solution can be adopted or abandoned. Maybe half of the clients who were late are now on time for group, but the other half still do not get there on time. Those clients may not live close to transit and may need additional supports.

**Abandon:** The proposed solution is not a viable resolution to the problem; select another solution to test. If lateness does not decrease or the voucher system was overly burdensome to staff or resulted in complaints from clients, you may want to abandon the idea entirely and test another solution, such as a vanpool to drive clients to treatment.

If PDSA is a new approach for you, your agency, or your treatment programs, practice it! Below are sample scenarios based on common experiences you can use to test your comprehension of PDSA and hone your skills at process improvement. Keep in mind whether the RNR Simulation Tool could help in these scenarios and how (see appendix J for further readings).

### Sample PDSA Scenarios

1. Probation department K does not share risk and needs information with any providers. This results in (a) individuals of varying risk levels placed together in the same programs, and (b) duplication of some assessments.

2. Jurisdiction Q collects risk data but nothing on needs. Referrals to programs are based on line officers’ opinions as to what the offenders need and/or the offenders’ request for programming.

3. Program B’s clients are consistently late for group therapy. There are 10 participants, and at least half are late for any given session, causing disruption and making it hard to start the group on time and stay on track. It is usually the same people showing up late.

4. Drug Court C’s participants are taking 2 or more years to complete what should be a 1-year program. No one has graduated in the last 6 months. Most people are testing positive in the early weeks of phase 2 of the program and are required to restart phase 1 when they violate the rules.
5. Program X is a Thinking for a Change program delivered to jail inmates by a community-based provider. At least once a week they are not able to deliver the treatment because of activity in the facility, such as a lock-down, search, or corrections officers’ changing the schedule.

How would you address each of these scenarios? Who would you involve? What solutions(s) would you propose? How would you determine if your solution works? If a solution does not work, what is your next step?

But I don’t have any money!

Yes, it’s easy to make improvements to programs when you have plenty of funding and staff. That’s not the reality for most providers. Most are operating on tight budgets and barely have time to complete the RNR Program Tool, let alone implement improvements. We understand, so for each domain of the RNR tool, we have developed a series of program changes that can be implemented cheaply or for free.

Fifty-One Things Providers and Agencies Can Do Quickly and Cheaply

**Key Items:** Use of a validated risk assessment and focus on appropriate risk levels

1. Do you know your clients’ risk levels? If you do not currently receive this information, ask for it! The referring criminal justice agency should be willing and able to provide this information. If not, you can use the simple, 7-item risk tool available on the CJ-TRAK Web site: http://www.gmuace.org/tools/

Ok, I know my clients’ risk levels. Now what?

2. If you are serving high-risk clients, consider whether your program is structured enough for that group. We know that high-risk clients benefit from greater intensity and controls.

3. Are you currently serving both high- and low-risk clients in the same groups? If your program has the capacity to do so, consider having separate tracks for higher and lower risk clients. Keep in mind that part of the risk principle is to provide intensive services to high- and moderate-risk people. Providing the same intensity to lower risk individuals can, in some cases, increase the likelihood of recidivism (Andrews & Dowden, 2006).

4. Increase your level of communication with the referring justice agency regarding client progress for high- and moderate-risk people.
5. When client circumstances change (that is, a client has a change in a stabilizing or destabilizing factor, such as losing a job or is staying in a shelter), contact the referring justice agency to make sure it is aware. You should have a consent form, HIPAA release, or MOU that allows you to share this information.

6. Consider risk levels preenrollment. If your program is better suited to one risk group over another, consider using risk level as an inclusion/exclusion criterion.

**Key Items:** Program focuses on a primary target; uses appropriate content based on the target

1. Focus at least 70 percent of your dosage on the clients’ primary need area. This means that if your program targets people with severe substance use disorders, at least 70 percent of the clients’ time in the program should be focused on interventions that target substance dependence. Spend no more than 30 percent of the time on ancillary services, such as mindfulness, trauma-informed therapy, and vocational training. You can always refer clients to other providers for those services.

2. Review your answers on the RNR PTA. Count the number of secondary targets your program identified in question 11. If the number is 4 or higher, get rid of at least half of those targets and find someone else in the network who can focus on those targets for clients who need that help.

3. Focus on symptom reduction. If your program lasts a month or longer, measure symptoms at intake, halfway through the program, and exit, at a minimum. If it lasts a month or less, measure symptoms at intake and exit. For example, if you are a program that targets severe substance use disorders, you should use a validated instrument such as American Society of Addiction Medicine criteria or the Addiction Severity Index.

4. Use the AAI tool to determine (1) whether the person’s top three needs are within the scope of your program and (2) what ancillary services the person needs. Can you include these ancillary needs in your program’s scope without taking away from the primary intervention? If not, can you refer to appropriate additional services?

5. Recommendation for justice agencies to better partner with providers: Develop in the network people who are experts in different areas such as gangs, criminal thinking, meth, and MAT.
Key Items: Program content with better evidence, use of rewards and sanctions, and attention to specific responsivity factors

1. For any curriculum, use at least 70 percent of it. Curricula are generally designed to be used as wholes, and they lose effectiveness if you self-select modules.

2. Assess client readiness for treatment (e.g., with the Texas Christian University TCU tool). For clients who assess as not being ready for treatment, use MI techniques to increase their motivation.

3. Implement social rewards, such as written praise, graduation ceremonies, or fewer urinalysis tests or other requirements.

4. If you are already using rewards, consider revising the behaviors you are rewarding. For more information about developing reward systems, see the section on contingency management in chapter 8.

5. If you are using a reward system, do so in a systematic way and be transparent about the process so that clients know (1) what behaviors are associated with rewards, (2) when rewards can be earned, and (3) what types of rewards are available.

6. Track demographics with regard to successful completion. Are men performing better in the program than women? Maybe your program needs to revise its approach with female clients.

7. Track the reasons people don’t complete and make programming more responsive around those issues. Transportation issues? Childcare needs? Time of day sessions are held?

8. Track when noncompliance happens. Do clients falter after a “honeymoon” period? Do they relapse right before graduation? Maybe clients need more support, controls, or incentives around challenging times. Examining your program’s data can lead to greater responsivity.

9. If you are not currently using a treatment manual, develop one by documenting what case workers, counselors, and other staff do, or acquire a standard manual (of an evidence-based intervention) and use it.

10. If more than 50 percent of your participants are women, develop programming for women.

11. If more than 50 percent of your participants are under age 30, develop programming for younger adults.

12. Recommendation for justice agencies to better partner with providers: Symptom reduction equals time off probation.
Key Items: Appropriate clinical hours; sufficient duration based on target; sufficient intensity based on target; sufficient frequency based on target, phases, and aftercare

1. Establish a continuum of care where clients can step down or step up the level of treatment and supervision based on their symptoms.
2. When given the choice between a longer program that meets less frequently and a shorter program that meets more frequently, choose the former.
3. Use phases.
4. Use aftercare.
5. Use a combination of didactic groups plus practice groups, including role-play, activity, and homework to engage clients.
6. Encourage participants to supplement programs with use of self-help groups.
7. Encourage use of sober living environments for clients with many destabilizing lifestyle factors.
8. Respond to noncompliance by intensifying treatment or dealing with client motivation, rather than relying on sanctions or reporting.

Key Items: Completion criteria; appropriate administration based on target; appropriate staff credentials based on target; staff communication; program evaluation; use of a treatment manual, coaching, technical assistance, quality assurance protocols

1. Understand the difference between accreditation and evaluation. Seek outside evaluators when possible.
2. Is your program using incentives? If so, is this done in a systematic way (e.g., clear guidelines on what you reward and how)?
3. What are current completion criteria? If you are basing completion on length of time in program or attendance at X number of sessions, for example, consider changing to successful completion of requirements, reduction in symptoms.
4. Review recommendations for staff credentials (see chapter 3 for more information). Recommendations vary by program type, so this does not necessarily mean hiring additional (and costly) master’s-level staff. There is a role for paraprofessionals, and relevant experience is also extremely important.
5. If your program has no treatment manual in place, select and use one, or develop one based on current practices.

6. Coach staff, especially on new techniques or curricula. Coaches can be supervisors or peers.

7. Request technical assistance for areas you want to strengthen.

8. Participate in a peer review process with other local providers who target similar needs and clients.

9. If your program employs a sanction and/or reward systems, be transparent about it. Tell clients at intake, put it in the participant manual, develop a plan with the client, or post the rules where clients will see them.


11. Develop a fidelity checklist specific to your program. This checklist can then be disseminated to anyone who wishes to conduct observations of your program.

12. Supervisors of groups should periodically sit in on groups.

13. Track completion rates.

14. Develop your program’s relationship with criminal justice agencies: Submit progress reports; have MOUs and HIPAA and/or consent forms in place.

15. Have a policy in place for inconclusive drug tests.

16. Recommendation for justice agencies to better partner with providers: Probation can create relationships with local colleges to find students (master’s level, undergrad thesis) to conduct program evaluations.

**Key Items:** Social controls in programs are also useful to enhance the impact of the content and dosage of programs

1. Share drug test data with probation or other referring justice agency.

2. If you are conducting drug testing, do so randomly, not on a schedule.


4. Conduct more check-ins with high- and moderate-risk clients.
## Abbreviations and Acronyms

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>AAI</td>
<td>Assess an Individual</td>
</tr>
<tr>
<td>ACE!</td>
<td>Center for Advancing Correctional Excellence</td>
</tr>
<tr>
<td>AJC</td>
<td>Assessing Jurisdiction’s Capacity</td>
</tr>
<tr>
<td>CAC</td>
<td>Certified Addiction Counselor</td>
</tr>
<tr>
<td>CAIS</td>
<td>Correctional Assessment and Intervention System</td>
</tr>
<tr>
<td>CBT</td>
<td>cognitive behavioral therapy</td>
</tr>
<tr>
<td>CJ-TRAK</td>
<td>Criminal Justice Targeted Research and Application of Knowledge</td>
</tr>
<tr>
<td>CM</td>
<td>contingency management</td>
</tr>
<tr>
<td>HIPAA</td>
<td>Health Insurance Portability and Accountability Act</td>
</tr>
<tr>
<td>LCSW</td>
<td>Licensed Clinical Social Worker</td>
</tr>
<tr>
<td>LSI-R</td>
<td>Level of Service Inventory, Revised</td>
</tr>
<tr>
<td>MAT</td>
<td>medication-assisted therapy</td>
</tr>
<tr>
<td>MI</td>
<td>motivational interviewing</td>
</tr>
<tr>
<td>MOU</td>
<td>memorandum of understanding</td>
</tr>
<tr>
<td>NREPP</td>
<td>National Registry of Evidence-based Programs and Practices</td>
</tr>
<tr>
<td>N.P.</td>
<td>Nurse Practitioner</td>
</tr>
<tr>
<td>PTA</td>
<td>Program Tool for Adults</td>
</tr>
<tr>
<td>RFP</td>
<td>request for proposals</td>
</tr>
<tr>
<td>RNR</td>
<td>Risk-Need-Responsivity</td>
</tr>
<tr>
<td>SAMHSA</td>
<td>Substance Abuse and Mental Health Services Administration</td>
</tr>
</tbody>
</table>
References


Appendix A. “What Works” Resources

The Campbell Collaboration: An online resource, the Campbell Collaboration produces systematic reviews on the effectiveness of interventions in the fields of education, crime and justice, social welfare, and international development (http://www.campbellcollaboration.org).

Crimesolutions.gov: Administered through the National Institute of Justice's Office of Justice Programs, Crimesolutions.gov is an online resource that provides information on “what works” based on rigorous research evaluations in the fields of criminal justice, juvenile justice, and crime victim services. This online resource presents reviews of justice practices and provides ratings based on the evidence of program or practices, classifying them as effective, promising, or shows no effects.

Appendix B. How To Use the RNR Simulation Tool

B-1. Assess an Individual Tool Detailed Instructions

http://www.gmuace.org/tools/assess-individual

Before Starting a New Assessment

1. To save/edit profiles in the Assess an Individual portal of the RNR Simulation Tool, you must be a registered user
   a. For more information on how to register to use the CJ-TRAK tools, click here.

Starting a New Assessment

1. From the home screen of the CJ-TRAK Web page, select "Launch" located in the Assess an Individual icon below the main instructions.
   a. You can also select Assess an Individual from the navigation bar located at the top of the CJ-TRAK home page.
2. Read the instructions on the page and then select Start New Assessment.
3. Clicking this link will direct you to the Assess an Individual data entry form.
   a. This form prompts you to provide information regarding an individual's demographics, risk, and needs.
4. For registered users with jurisdiction data available (see Assess Jurisdiction’s Capacity instructions for more information), prior to entering information about the individual, you will be asked to select if you would like to use National Data or My Jurisdiction's Data.
   a. Note: Recidivism estimates will be most accurate when using your jurisdiction's data.
   b. National data use the simulation database for recidivism estimates.
   c. My jurisdiction's data use your data only.
5. Users are asked to specify how they would like to define recidivism for the individual they are assessing. This is used to designate the type of recidivism displayed in the Assess an Individual output.
   a. Rearrest means new crimes
   b. Reconviction means conviction for new crimes
   c. Reincarceration means readmission to a prison/jail
   d. All include technical violations
6. Users are asked to specify the setting of the individual they are assessing to provide the most accurate estimate of recidivism.
7. Demographic data: Questions 1–4 ask for demographic information about the individual being assessed.
   a. Note: The individual's initials and date of birth are used to create a unique identifier for saved assessments.

8. Type of client: Question 5 asks you to indicate if the individual is classified as one of several common classifications of offenders (e.g., sex offenders, domestic violence offenders, chronic offenders). If the individual does not belong to any of these groups, select General Offender.

9. Question 6 asks you to indicate the criminal justice risk level of the individual you are assessing. This should be based on the risk assessment tool used in your jurisdiction.

10. Once you have responded to questions 1–6, you have the option to Save and Continue or Save and Come Back Later.

11. After clicking Save and Continue, questions 7 and 8 prompt you to input data on the distribution of primary criminogenic needs in your population.
   a. These needs include clinically defined severe substance use disorders for "hard" drugs and/or criminal thinking.

12. Questions 9 and 10 ask about the mild-to-moderate substance use disorders and mental health needs of the individual being assessed.
   a. While these needs are not criminogenic (not directly linked to offending behavior), they are clinically relevant and can affect the individual's performance in treatment/supervision.

13. Questions 11–17 ask you to indicate if the offender has any lifestyle stabilizers or destabilizers.
   a. These include emotional support, education, employment, housing, financial, antisocial associates, and family environment.
   b. Destabilizing influences can interfere with an individual's ability to succeed during treatment/supervision.

14. After completing these questions, you will again have the option to Save and Continue, Save and Come Back Later, Save and Go Back (this will take you back to the previous page where you can edit your responses to questions 1–6), or Print My Responses.

**Accessing Saved Assessments (for registered users only)**

1. Once you are logged into the CJ-TRAK system, select Launch located in the Assess an Individual icon below the main instructions on the home screen of the CJ-TRAK Web page
   a. You can also select Assess an Individual from the navigation bar located at the top of the CJ-TRAK home page.
2. Choose the assessment you would like to view/edit from the My Saved Assessments list on the right side of the page.
   
a. Note: Labels for saved assessments are a combination of the individual's initials and month/day of birth.

3. Once you have chosen an assessment, you can edit/update information for each question according to the instructions above.

**B-2. Assess Jurisdiction's Capacity Tool Detailed Instructions**

http://www.gmuace.org/tools/assess-capacity

**Before logging in—**

1. To enter/edit the Assess Jurisdiction's Capacity portal of the RNR Simulation Tool, you must either be a registered Administrative Account holder or a Basic Account holder not linked to an Administrative Account.
   
a. For more information on how to register to use the CJ-TRAK tools and the different account options available, click here.
   
b. After you complete the registration process, you will automatically be linked to the Assess Jurisdiction's Capacity data entry form.
      
      ▶ You will have the option to complete this form immediately or complete it at a later date.
      
      ▶ Until you complete this form, all portals of the RNR Simulation Tool will generate only outputs based on nationally representative data.
      
      ▶ Once you have completed this form, you will be able to view your jurisdiction’s capacity outputs and generate jurisdiction-specific outputs using the Assess an Individual portal.

**After logging in as an Administrative Account holder or a Basic Account holder that is not linked to an Administrative Account—**

1. From the home screen of the CJ-TRAK Web page, select Launch located in the Assess Jurisdiction's Capacity icon below the main instructions.

2. You can also select Assess Jurisdiction's Capacity from the navigation bar at the top of the CJ-TRAK home page.

3. Carefully read all instructions on the page and then select Enter Jurisdiction Information.

4. Clicking this link will direct you to the Assess Jurisdiction's Capacity data entry form.
   
a. This form prompts you to provide an overview of your jurisdiction by inputting aggregate information on the estimated proportion of your population who fall into the specified demographic, risk, and need categories.
Note: These values reflect the percentage of your population who fall into each specific category.

Note: These values must add up to 100 percent, or the tool will give you an error message and prompt you to reenter the data to sum to 100 percent.

Note: In any place on the tool where you do not know the percentage of your population that has a given characteristic, check the Don't Know answer choice below the primary response fields.

- When you select Don't Know, the tool will rely on nationally representative estimates to fill in the responses you have left blank
- Relying on the national data does not prevent the tool from generating your jurisdiction's capacity output; it simply tells the system to replace the missing value with the most likely response option for that question from the national data based on the other information you have provided.
- When you do not know the answer and cannot identify a data source where you can get this information, selecting Don't Know is the preferred option over guessing what percentage of your population may have a certain characteristic.

5. In question 1, users are asked to specify the primary measure of recidivism for their jurisdiction.
   a. Rearrest means new crimes
   b. Reconviction means conviction for new crimes
   c. Reincarceration means readmission to a prison/jail
   d. All of the above options include technical violations
   e. Note: Users should provide their jurisdiction's general and gender-specific recidivism rates for the primary measure of recidivism selected.

6. Users are then asked (question 2) to specify the setting of their jurisdiction.

7. Demographic data: Questions 4–6 prompt you to input aggregate data about the demographic breakdown of your population.

8. Type of clients: Question 7 asks you to indicate the percentage of your population that is classified as one of several common classifications of offenders (e.g., sex offenders, domestic violence offenders, habitual offenders).

9. Question 8 asks you to indicate how many risk categories you have, what categories your jurisdiction uses to classify risk, and the percentage of your population that falls into each category.
b. In the justice system, these data most often come from a validated risk assessment tool such as the Level of Service Inventory–Revised (known as LSI-R), Correctional Offender Management Profiling for Alternative Sanctions (known as COMPAS), or the Ohio Risk Assessment System (known as ORAS).

c. If your jurisdiction has created your own indicator of recidivism risk level, complete this item using the data from your own tool.

10. Once you have responded to questions 1–8, you have the option to Save and Continue or Save and Come Back Later.

11. After clicking Save and Continue, the next three items (9–11) prompt you to input data on the distribution of primary criminogenic needs and clinical destabilizers in your population.

   a. These needs include clinically defined severe substance use disorders for "hard" drugs and/or criminal thinking (item 9).

   b. You are also prompted about the percentage of your population with mild to moderate substance use disorders and mental health disorders (items 10 and 11).

12. Finally, in questions 12–18, you are prompted to input the percentage of your population with common destabilizers that may affect an individual’s engagement and performance in treatment or under correctional supervision.

13. After completing these questions, you will again have the option to Save and Continue, Save and Go Back (this will take you back to the previous page where you can edit your responses to questions 1–8), Save and Come Back Later, or Print My Responses.

B-3. Program Tool for Adults Detailed Instructions

http://www.gmuace.org/tools/program-tool

Before Starting a New Program Tool for Adults

1. To save/edit profiles in the Program Tool for Adults portal of the RNR Simulation Tool, you must be a registered user.

   a. For more information on how to register to use the CJ-TRAK tools, click here.

Starting a New Program Tool for Adults

1. From the home screen of the CJ-TRAK Web page, select Launch located in the RNR Program Tool for Adults icon below the main instructions.

   a. You can also select RNR Program Tool for Adults from the navigation bar located at the top of the CJ-TRAK home page.

2. Read the instructions on the page, and then select Start The RNR Program Tool for Adults.
3. Clicking this link will direct you to the RNR Program Tool for Adults instructions page. From this page you can—
   a. Find out: What information do I need to know to complete the RNR Program Tool for Adults?
      - Selecting this option will take you to a page that describes all the information needed to fully and accurately complete the RNR Program Tool for Adults. This page can also be printed for future reference.
   b. View the informed consent document
      - Selecting this option will take you to the informed consent for this study. You will be prompted to electronically sign this document the first time you use the RNR Program Tool for Adults. At this point, you can click this option again to review the informed consent document.
      - This option is only available the first time you enter the Program Tool Portal. Once you have electronically signed the informed consent, you will not need to sign it for subsequent entries.
   c. Start the RNR Program Tool for Adults
      - Selecting this button will take you to the first page of the RNR Program Tool for Adults. At the end of each page of the tool you can decide to Save and Continue, Save and Come Back Later, or Save and Go Back to a previous page.
      - Page one asks for basic information about the program, including its name, target population, capacity, completion rate, and attendance.
      - Page two asks more detailed questions about the program's target and content.
      - Page three asks a few more questions about the program content.
      - Page four asks questions about the dosage of the program, including total number of hours, duration, frequency, and length of sessions.
      - Page five asks questions about program implementation, including completion criteria, staff credentials, evaluations, and coaching.
      - Page six asks a few final questions about changes to the program over time, training received by staff, and some challenges the program has experienced. At the end of page six, selecting Save and Continue will take you the output page. You can also select Print my Responses to print a list of the responses you provided for each question of the program tool.
      - The output page describes the program group into which your program was classified and how your program scored in each of the six scoring areas addressed in the tool: risk, need, responsiveness, dosage, implementation, and restrictions.
Accessing Saved RNR Program Tools (for registered users only)

1. Once you are logged into the CJ-TRAK system, select Launch located in the RNR Program Tool for Adults icon below the main instructions on the home screen of the CJ-TRAK Web page
   a. You can also select RNR Program Tool for Adults from the navigation bar located at the top of the CJ-TRAK home page.

2. Choose the assessment you would like to view/edit from the My Saved Programs list on the right side of the page.
   a. Note: Labels for saved programs are generated from Program Name entered on the first page of the RNR Program Tool for Adults.

3. On this page you can view, edit, or delete a previously completed assessment or an assessment you saved to return to later.
Appendix C. Checklists

C-1. Steps to Effective Use of the Program Tool for Adults

When meeting with justice agencies and treatment partners, be sure to cover the following questions. Check off the items as you complete them, and write notes where needed.

<table>
<thead>
<tr>
<th>Done?</th>
<th>Questions</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>What will the data be used for?</td>
</tr>
<tr>
<td></td>
<td>How will individual program data be secure?</td>
</tr>
<tr>
<td></td>
<td>What will be required of providers when they get the feedback reports?</td>
</tr>
<tr>
<td></td>
<td>What will providers get out of it?</td>
</tr>
</tbody>
</table>

C-2. Questions for Provider Candidates

Some sample questions you may want to use when gathering information from a provider include:

<table>
<thead>
<tr>
<th>Done?</th>
<th>Questions</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Who is your target population?</td>
</tr>
<tr>
<td></td>
<td>What therapeutic approach(es) do you take or plan to take?</td>
</tr>
<tr>
<td></td>
<td>How many clients did you serve over the last 12 months? How many can you serve in 12 months?</td>
</tr>
<tr>
<td></td>
<td>What percentage of sessions did clients attend last year?</td>
</tr>
<tr>
<td></td>
<td>How much staff turnover have you experienced?</td>
</tr>
<tr>
<td></td>
<td>What assessments do you conduct at intake?</td>
</tr>
<tr>
<td></td>
<td>What is program completion based on?</td>
</tr>
<tr>
<td></td>
<td>How many times per week does the program meet and for how long?</td>
</tr>
<tr>
<td></td>
<td>What restrictions do you have on who can enroll (e.g., sex offenders, violent offenders)?</td>
</tr>
<tr>
<td></td>
<td>What curriculum or curricula do you use? What percentage of each curriculum do you use?</td>
</tr>
<tr>
<td></td>
<td>What percentage of clients successfully complete the program?</td>
</tr>
<tr>
<td></td>
<td>What are the most common reasons for noncompletion?</td>
</tr>
<tr>
<td></td>
<td>Do you track outcomes for those who complete the program? If so, what percentage of clients relapse/get rearrested/go back to jail?</td>
</tr>
<tr>
<td></td>
<td>Fill in your own options!</td>
</tr>
<tr>
<td></td>
<td>Fill in your own options!</td>
</tr>
</tbody>
</table>
C-3. Conduct a Self-Assessment

Consider the following questions to address what kind of organizational culture you have:

<table>
<thead>
<tr>
<th>Done?</th>
<th>Questions</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>What language do officers use when discussing a client?</td>
</tr>
<tr>
<td></td>
<td>Have many of the officers and supervisors received training in motivational interviewing, and do they employ it on a regular basis?</td>
</tr>
<tr>
<td></td>
<td>How does the agency respond to technical violations?</td>
</tr>
<tr>
<td></td>
<td>How do officers respond when a client is doing well?</td>
</tr>
</tbody>
</table>

C-4. Memorandum of Understanding or Request for Proposals

When putting together a memorandum of understanding, request for proposals, or treatment contract, keep in mind the following:

<table>
<thead>
<tr>
<th>Done?</th>
<th>Questions</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>What are the exact services that will be provided, at what frequency, and for what length of time?</td>
</tr>
<tr>
<td></td>
<td>What level and frequency of communication do you require? Remember this may vary by type of treatment or risk level/severity of client symptoms.</td>
</tr>
<tr>
<td></td>
<td>Who will initiate the communication and how will it take place (regular phone calls, regular meetings, shared data system, etc.)?</td>
</tr>
<tr>
<td></td>
<td>Will they allow you to make site visits and conduct observations?</td>
</tr>
<tr>
<td></td>
<td>How will the provider respond to lateness, missed appointments, or other noncompliance?</td>
</tr>
<tr>
<td></td>
<td>If a client is receiving multiple types of services concurrently, will the provider communicate with other treatment providers, and how?</td>
</tr>
<tr>
<td></td>
<td>What does it mean to successfully complete the program?</td>
</tr>
</tbody>
</table>

C-5. Contacting a Provider

Find out some of the logistics to make the client’s initial visit go as smoothly as possible. Here are some questions you should ask the provider:

<table>
<thead>
<tr>
<th>Done?</th>
<th>Questions</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Is the address on your Web site the correct location? Is it easy to find?</td>
</tr>
<tr>
<td></td>
<td>What time should the client get there? Should he or she come early for the initial visit?</td>
</tr>
<tr>
<td></td>
<td>Should the client call to make the initial appointment, or can I make the appointment?</td>
</tr>
<tr>
<td></td>
<td>What does the client need to bring to the initial appointment?</td>
</tr>
<tr>
<td></td>
<td>Is there a dress code?</td>
</tr>
<tr>
<td></td>
<td>What are the consequences if the client misses a session? Multiple sessions?</td>
</tr>
</tbody>
</table>
C-6. Discussions With Clients

When you make the referral to the client, go over the information you received and ask for his or her thoughts and concerns. These are some questions you should ask the client:

<table>
<thead>
<tr>
<th>Done?</th>
<th>Questions</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>What are the consequences if the client is late for a session?</td>
</tr>
<tr>
<td></td>
<td>Are you accustomed to providing services to criminal justice-involved clients?</td>
</tr>
<tr>
<td></td>
<td>Are there types of offenders who are not eligible for this program (if client fits in a special category such as violent or sex offender)?</td>
</tr>
<tr>
<td></td>
<td>What does the intake process look like?</td>
</tr>
<tr>
<td></td>
<td>What strategies do you use if the client is not engaging appropriately in treatment?</td>
</tr>
<tr>
<td></td>
<td>Is childcare available?</td>
</tr>
<tr>
<td>☐</td>
<td>Fill in your own options!</td>
</tr>
<tr>
<td>☐</td>
<td>Fill in your own options!</td>
</tr>
<tr>
<td></td>
<td>Have you had any prior experiences with this provider or a similar one?</td>
</tr>
<tr>
<td></td>
<td>What are your concerns about going to this provider?</td>
</tr>
<tr>
<td></td>
<td>What are your concerns about starting treatment in general?</td>
</tr>
<tr>
<td></td>
<td>Will this time and location work for you? Do you need to rearrange any other parts of your schedule to accommodate this treatment?</td>
</tr>
<tr>
<td></td>
<td>How you will get to the provider and how you will get home?</td>
</tr>
<tr>
<td></td>
<td>Do you have or need childcare during that time?</td>
</tr>
<tr>
<td></td>
<td>What can I do to help you be successful in this treatment program?</td>
</tr>
<tr>
<td></td>
<td>Is it ok if I contact the provider in a few weeks to make sure you are progressing in the treatment?</td>
</tr>
<tr>
<td>☐</td>
<td>Fill in your own options!</td>
</tr>
<tr>
<td>☐</td>
<td>Fill in your own options!</td>
</tr>
</tbody>
</table>
C-7. Followup

Conduct a followup with both the client and the provider to ensure treatment is going well, and document this information in the client file. These are some questions you should ask:

<table>
<thead>
<tr>
<th>Done?</th>
<th>Questions</th>
</tr>
</thead>
<tbody>
<tr>
<td>✗</td>
<td>Have you missed any sessions? What were the reasons?</td>
</tr>
<tr>
<td>✗</td>
<td>What are you getting out of this treatment? Are there things you don’t like about the treatment?</td>
</tr>
<tr>
<td>✗</td>
<td>How is the relationship with you and the facilitators?</td>
</tr>
<tr>
<td>✗</td>
<td>How does this treatment compare to other treatment you have received?</td>
</tr>
<tr>
<td>✗</td>
<td>What can this agency do to help you succeed in this treatment?</td>
</tr>
<tr>
<td>✗</td>
<td>Fill in your own options!</td>
</tr>
<tr>
<td>✗</td>
<td>Fill in your own options!</td>
</tr>
</tbody>
</table>

C-8. Client Noncompliance

Get as much information from the provider as possible, including information on the following:

<table>
<thead>
<tr>
<th>Done?</th>
<th>Questions</th>
</tr>
</thead>
<tbody>
<tr>
<td>✗</td>
<td>The number of sessions missed</td>
</tr>
<tr>
<td>✗</td>
<td>The number of sessions attended</td>
</tr>
<tr>
<td>✗</td>
<td>Whether the client was on time for sessions attended</td>
</tr>
<tr>
<td>✗</td>
<td>Whether the client engaged in the treatment</td>
</tr>
<tr>
<td>✗</td>
<td>Whether the client notified the provider that she or he would not attend</td>
</tr>
<tr>
<td>✗</td>
<td>Any reasons given for nonattendance</td>
</tr>
<tr>
<td>✗</td>
<td>Any major issues that may be going on in the client’s life that could prevent treatment attendance</td>
</tr>
<tr>
<td>✗</td>
<td>Fill in your own options!</td>
</tr>
<tr>
<td>✗</td>
<td>Fill in your own options!</td>
</tr>
</tbody>
</table>
C-9. Client Noncompliance Next Steps

Discuss with the provider what steps they have taken or plan to take with the client. Ask the client open-ended questions or to describe in his or her own words what has been going on with treatment, using motivational interviewing if trained in this approach. Some examples of open-ended questions appropriate to this situation follow:

<table>
<thead>
<tr>
<th>Done?</th>
<th>Questions</th>
</tr>
</thead>
<tbody>
<tr>
<td>□</td>
<td>What do you think about this treatment as a fit for you?</td>
</tr>
<tr>
<td>□</td>
<td>What are some things going on in your life that make it difficult for you to attend treatment?</td>
</tr>
<tr>
<td>□</td>
<td>What are you hoping to get out of treatment?</td>
</tr>
<tr>
<td>□</td>
<td>What do you like and dislike about this treatment program?</td>
</tr>
<tr>
<td>□</td>
<td>What can the provider do to increase your attendance?</td>
</tr>
<tr>
<td>□</td>
<td>What can probation do to increase your attendance?</td>
</tr>
<tr>
<td>□</td>
<td>Fill in your own options!</td>
</tr>
<tr>
<td>□</td>
<td>Fill in your own options!</td>
</tr>
</tbody>
</table>
Appendix D. Frequently Asked Questions About CJ-TRAK/RNR

How long does it take to complete the tool?

The Assess an Individual (AAI) tool takes under 10 minutes to complete if you have the needed information and/or can ask the offender the questions on the tool. The RNR Program Tool for Adults (PTA) takes approximately 45 minutes to complete, and the user will generally need to gather some program information beforehand. The Assess Jurisdiction’s Capacity (AJC) tool takes approximately 20 minutes to complete.

Who has the tool been designed for? Is it generally corrections or both corrections and treatment providers using the tool?

The suite is designed for collaboration between treatment and corrections. Ideally, a corrections agency initiates use of the suite and meets with community- or facility-based treatment providers to disseminate the PTA, which is then completed by the programs, and the corrections agency is able to see the results. The corrections agency is responsible for completing the AJC tool. For the AAI tool, line officers from the corrections agency enter the data (or the jurisdiction provides data on individual offenders to GMU, and the officers can skip this step), and/or community providers can access the AAI tool and use it to determine whether an individual would benefit from their program.

Can the RNR tool be used with clients who are not in the criminal justice system?

For example, in a medication-assisted program, the client might not be in the justice system but have high criminal thinking and fit most of the characteristics of a high-risk criminal justice client. While the AAI is designed for criminal justice-involved clients, it can also be used for noncriminal justice-involved clients. When asked about risk level, select “no risk tool is used.” In the case of a noncriminal justice-involved client, users would ignore the recidivism risk output and look only at the treatment recommendations. The PTA tool can also be used by treatment providers whose clients are not all involved in the criminal justice system.

While effective programs can produce positive results for individual offenders, has there been research to test the theory that systems using the RNR framework for their entire organization produce cost-effective results?

The RNR tools are relatively new (launched in January 2013), so long-term results are not yet available. As we test the tools with different jurisdictions, we are developing case studies to determine how they are using the tools and what results they produce.
Can the simulation tool be easily modified as different special populations emerge (e.g., veterans courts)?

The specialized court portion of the RNR program tool is designed to adhere to guiding principles that apply to any problem-solving court, not only drug courts. As we see new populations emerge that require specialized treatment emerge, we are working to develop enhancements to the tools that reflect the needs of those special populations. For example, we are currently developing a version of the program tool that is responsive to the needs of sex offenders.

How does the tool score the free text fields?

The free text fields are not scored. They allow users to record additional relevant program information and provide valuable information to the George Mason University team so we can continue to update and improve the tool to accurately reflect programs.

Who completes the tools and how do they gather all the necessary information?


The most appropriate person to complete the PTA is the staff member who is most knowledgeable about the program, such as a program manager. The AAI tool should be completed by line officers or front-line treatment staff, and the AJC tool should be completed by an agency staff member who knows the jurisdiction’s aggregate or system-level data well.
Appendix E. Sample Behavioral Contract

Name: ________________________________________________________________

Case Number: _________________________________________________________

Supervision Officer/Case Worker: _________________________________________

Probation □ Parole □

Start Date: ________________ End Date: __________________________

[Risk Tool] Total Score: __________ Date: __________ Instrument: __________

Special Conditions:
____________________________________________________________________
____________________________________________________________________
____________________________________________________________________

I. Criminogenic Need

History: ______________________________________________________________

Assessments: _________________________________________________________

Triggers: _____________________________________________________________

Long-Term Goal: _____________________________________________________

<table>
<thead>
<tr>
<th>Short-Term Steps</th>
<th>Offender Responsibilities</th>
<th>Officer Responsibilities</th>
<th>Date To Be Completed</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5.</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Additional Needs To Be Addressed:

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

II. Criminogenic Need

History: __________________________________________________________

Assessments: _______________________________________________________

Triggers: __________________________________________________________

Long-Term Goal: _____________________________________________________

<table>
<thead>
<tr>
<th>Short-Term Steps</th>
<th>Offender Responsibilities</th>
<th>Officer Responsibilities</th>
<th>Date To Be Completed</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5.</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Additional Needs To Be Addressed:

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

Offender Interests

1. ________________________________________________________________

2. ________________________________________________________________

3. ________________________________________________________________

4. ________________________________________________________________
Compliance: Sanctions and Incentives Matrix

Client Signature: __________________________________________  Date: __________

PO Signature: __________________________________________  Date: __________

CPO/DCPO/SRPO:

Approved: ☐  Disapproved: ☐

Comments:
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
Appendix F. Sample Informed Consent for Treatment Form

Name: ____________________________________  Date of Birth: __________________________

I understand that as a patient of [insert provider name], I am eligible to receive a range of services. The type and extent of services that I will receive will be determined following an initial assessment and thorough discussion with me. The goal of the assessment process is to determine the best course of treatment for me.

I understand that all information shared with the clinicians is confidential and no information will be released without my consent. During the course of treatment, it may be necessary for my therapist to communicate with providers at [insert justice agency or other provider]. In all other circumstances, consent to release information is given through written authorization. Verbal consent for limited release of information may be necessary in special circumstances. I further understand there are specific and limited exceptions to this confidentiality, which include the following:

1. When there is risk of imminent danger to myself or to another person, the clinician is ethically bound to take necessary steps to prevent such danger.

2. When there is suspicion that a child or elder is being sexually or physically abused or is at risk of such abuse, the clinician is legally required to take steps to protect the child and to inform the proper authorities.

3. When a valid court order is issued for medical records, the clinician and the agency are bound by law to comply with such requests.

I understand that while psychotherapy and/or medication, may provide significant benefits, it may also pose risks. Psychotherapy may elicit uncomfortable thoughts and feelings or may lead to the recall of troubling memories. Medications may have unwanted side effects.

I understand that the counselors will be in contact with my probation officer on a regular basis and authorize the counselors to share information about my treatment attendance.

I have been given the opportunity for discussion of any concerns that I have regarding treatment. I will be informed and take part in my treatment and goal planning.

I understand—

- That I may withdraw my consent in writing at any time.
- That I must notify the provider if my insurance carrier or coverage changes.
› That payment will come through ________________________________

› That if I must cancel an appointment, I am required to contact the office 24 hours prior to the appointment. Voice mail is available 24 hours a day, 7 days a week.

__________________________________________  
Client/Guardian Signature  Date

__________________________________________  
Clinician Signature  Date
Appendix G. Motivational Interviewing Resources

- Center for Evidence-Based Practices, Motivational Interviewing: http://www.centerforebp.case.edu/practices/mi
- Enhancing Motivation for Change in Substance Abuse Treatment: http://www.ncbi.nlm.nih.gov/books/NBK64967/
- National Registry of Evidence-based Programs and Practices, Substance Abuse and Mental Health Services Administration (http://nrepp.samhsa.gov/MotivationalInterviewing.aspx)
Appendix H. Contingency Management Resources


Appendix I. Process Improvement Template

This template can be used as a starting point for jurisdictions and providers to work together to develop an improvement plan, based on selected benchmarks (e.g., improve scores by 20 percent in 6 months).

List your scores below:

<table>
<thead>
<tr>
<th>Risk</th>
<th>Needs</th>
<th>Responsivity</th>
<th>Dosage</th>
<th>Implementation</th>
<th>Restrictiveness</th>
</tr>
</thead>
</table>

Were any of the results surprising to you?

What do you think are the components that make your program effective?

For the categories Need, Responsivity, and Implementation, identify one thing you think you are doing well and one improvement you can implement.

Need:

Responsivity:

Implementation:

Identify two items from the prior list that you will work on in the next 6 months.

Identify what the justice agency can do to help you with program improvement.
Appendix J. Additional Resources for Further Reading


