

KNOW WHERE YOU ARE TO GUIDE WHERE YOU'RE GOING: A SURVEY OF RISK-
NEED-RESPONSIVITY TREATMENT PRACTICES IN JUVENILE CORRECTIONAL
PROGRAMS

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Dana L. Formon

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by

Dana L. Formon

APPROVED:

Craig Henderson, PhD
Dissertation Director

Jorge Varela, PhD
Committee Member

Darryl Johnson, PhD
Committee Member

Brandy Blasko, PhD
Committee Member

Abbey Zink, PhD
Dean, College of Humanities and Social
Sciences

ABSTRACT

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Despite the Risk-Need-Responsivity (RNR) model being a preferred method of offender treatment in adults and juveniles, research on this model for juveniles specifically is still in its infancy. This is problematic as the RNR model may not directly apply to juveniles as it stands and may be ineffective, as it was originally created for an adult offender population. Before suggesting change to RNR-based practice already existing in juvenile treatment programs, a survey of preexisting treatment representing RNR principles must first be conducted. Not only does this current study report on the degree to which juvenile justice treatment programs reflect RNR-based practice, but it also takes into consideration a variety of organizational variables found to be meaningful in evidence-based adherence. Findings indicated that the responsivity and need principles were most commonly seen represented in treatment programs. This may be because these principles ask that practitioners engage in practices that have long been considered essential to competent treatment (such as providing many effective therapeutic approaches, revising treatment plans, and providing individualized services). The risk principle was represented the least among treatment sites. With regard to organizational variables, privatization of a treatment facility was observed to most impact the responsivity principle, and sites' involvement with non-justice organizations was found to most impact total RNR adherence overall.

KEY WORDS: Risk-Need-Responsivity, Juvenile justice, Juvenile offender treatment, Organizational variables

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CHAPTER I

Introduction

Literature Review

The Risk-Needs-Responsivity Model (RNR) was developed by Donald Andrews and James Bonta as a call-to-action for successful offender rehabilitation. The model has been extensively researched for the last quarter of a decade and has been considered the gold standard of offender intervention (Bewley & Morgan, 2011; Canales, Campbell, Wei, & Totten, 2014). The model consists of three core principles: risk, need, and responsivity. The *risk* principle states that for successful rehabilitation, programs must accurately focus on an offender's unique sets of factors that place him or her at risk for recidivism. More specifically, Andrews and Bonta (2010) identified what they called the "central eight," or the eight factors that are most predictive of criminal recidivism: history of antisocial behavior, antisocial personality, antisocial cognitions, antisocial peers, substance abuse, family/marital relationships, school/work, and pro-social recreational activities. The *need* principle then focuses on areas of an offender's behavior and social world to determine the target of intervention to prevent future recidivism (substance use, antisocial attitudes, lack of education, etc.); essentially, what needs an offender may have that, if addressed properly, can actively reduce the likelihood of recidivating. This principle pays most attention to criminogenic needs; that is, needs that are directly related to dynamic (changeable) risk factors that are directly linked to criminal behavior, as opposed to noncriminogenic needs such as self-esteem or homelessness. *Responsivity* then identifies offender protective factors and strengths (such as strong family relationships) as well as specific individual characteristics of an offender that might influence the effectiveness of

treatment services (reading level, mental illness, etc.) and combines them to deliver a comprehensive and tailored approach to treatment for each individual (Andrews & Bonta, 2010).

Adherence to an RNR approach leads to greater effectiveness in reducing recidivism than previous approaches of criminal sanctions or more random provision of various treatments (Ward, Melser, & Yates, 2007). This success has been found among several groups of offenders as well, including female offenders, violent offenders, sexual offenders, and juvenile offenders (Andrews & Bonta, 2010). However, despite its promise, this literature has also been criticized for its limitations. Specifically with respect to RNR implementation, researchers and the RNR creators themselves have identified that RNR principles developed in theory are often difficult to apply in practice (Andrews & Bonta, 2007; VanBenschoten, Bentley, Gregoire, & Lowenkamp, 2016). Bewley and Morgan (2011) found that only 15.7% of state correctional facilities incorporated each of the RNR principles in some way in their treatment programs for offenders, despite the participants' beliefs that RNR is considered state-of-the-art for offender treatment. Haqanee, Peterson-Badali, and Skilling (2015) even when RNR is mandated into assessment and case management procedures, it cannot automatically guarantee that those measures will translate on their own to successful treatment. Furthermore, there tends to be larger breakdown in the implementation-to-practice process with offender populations where the research literature is less developed.

One of those populations where RNR research is still largely developing is with juveniles (Singh, Desmarais, Sellers, Hylton, Tirrotti, & Van Dorn, 2014). But despite its relative infancy within the research literature, RNR is one of the most widely used

models for the guidance of assessment and case management of adolescents involved in the justice system as well (Andrews & Bonta, 2010; Haqanee et al., 2015). As Jean Piaget first noted, children are not small adults, and treatment models used for adults should not be assumed to work the same on adolescents. In similar fashion, the RNR model as applied to adults might not be as equally effective if applied to juveniles without modifications made in accord with their developmental needs. As examples, juveniles have more difficulty self-regulating their reactions, and making judgments and decisions when in emotionally charged situations (Bonnie & U.S. National Research Council, 2013). Adolescents also have a higher incidence of succumbing to negative peer pressure when engaging in risky behaviors like sexual activity, substance use, and criminal acts (Bonnie & U.S. National Research Council, 2013). As such, treatment for justice-involved juveniles will differ from adult interventions in that juvenile services should place more focus on antisocial peer associations (rather than antisocial cognitions in adults) and self-control and emotional regulation skills (rather than exploring procriminal cognitions or impulsivity in adults) (Shulman & Steinberg, 2016). Further, there is a need for more family involvement in treatment, as the family remains an important locus of influence for youth and the decisions they make.

The literature that does exist with juveniles predominantly focuses on the *individual* principles of RNR. While risk, need, and responsivity have all been examined in some manner, research has largely been conducted on these principles independent of one another. For example, while risk and need factors in juveniles tend to mirror those of adults, they have been found to be more dynamic, indicating that frequent assessment and reevaluation of these factors must be conducted with younger populations (Mulvey,

Schubert, Pitzer, Hawes, Piquero, & Cardwell, 2016). The aforementioned research did not incorporate the responsivity principle; that is, if interventions might require more frequent reevaluation or treatment plan revisions with adolescents. Research also exists indicating that risk factors might vary depending on if a juvenile offender falls into a specific category (ex. violent offenses, property crimes, sexual offenses), rather than treating juvenile offenders as a single homogenous population (Mulder, Vermunt, Brand, Bullens, & Van Marle, 2012). These researchers identified significant risk factors that fall outside of the RNR-defined “central eight,” such as the type of victim and the presence of a conduct disorder. Calley (2012) also found involvement in the child welfare system as well as several different post-incarceration placements to significantly predict recidivism, indicating that while the central eight risk/need factors defined in RNR may roughly apply to juveniles (hence the creation of related risk assessment measures), they may not be sufficient for guiding treatment. Hoge (2016) also adds that parental supervision should be heavily considered as well when determining a juvenile’s risk.

When considering responsivity, juveniles tend to respond better to reward systems and behavioral treatments than adults (Steinberg, 2010). This would indicate that when considering the responsivity principle, more standard adult therapeutic approaches (such as cognitive behavioral therapy) might be less effective if tangible reinforcers (such as those delivered in contingency management) are not provided (Steinberg, 2010). Taylor (2016) also looked at juvenile responsivity within a drug treatment court setting, and found that juveniles also require more family-related treatment components as indicated by treatment literature which points to the indication of systems therapy as being the most

developmentally appropriate for young persons. Treatment courts following closely in line with those developed for adults often neglect family-based treatment (Taylor, 2016). In short, implementing RNR in a way found to be effective with adults must be modified in accordance with the unique aspects of adolescent development. Only one study exists at this time examining the full RNR model in a juvenile justice setting (Brogan, Haney-Caron, NeMoyer, DeMatteo, 2015; Singh et al., 2014), and much like preexisting RNR research, adherence was found to lead to good outcomes, but the model was inconsistently implemented.

Consideration of mental illness has always been a focus of the RNR literature, and the extent to which mental illness should be incorporated into risk, need, and responsivity principles in juveniles and adults alike is gaining attention in research. While mental illness has ultimately not been found to be a risk factor for criminal behavior, it is extremely prevalent in justice-involved populations (McCormick, Peterson-Badali, Skilling, 2017). Furthermore, an examination of literature on the RNR principles suggests that mental health is an important responsivity variable that has the potential to moderate success of interventions targeted at risk and criminogenic need (McCormick et al., 2017). This would mean that discussion of RNR's treatment components and responsivity principle should incorporate mental health services despite the lack of a direct connection between mental illness and recidivism.

Underneath the broad umbrella of mental health, research has indicated that the impact of substance use on treatment response has been significant. Offenders (adults and juveniles) with co-occurring disorders including a substance use disorder tend to have longer incarceration times, violate community supervision more often, are arrested

more often, and are more difficult to manage in custodial settings (Peters, Wexler, & Lurigio, 2015). Part of this could be attributed to a kindling effect that substance use can have on the expression of other mental disorders that complicate treatment and justice involvement (NIDA, 2010). More specifically, life stress may precipitate an increase in substance use which may also trigger additional mental health problems. In youth, both substance use and comorbid mental health are associated with delinquent activity and a higher risk of justice involvement. Not only can mental illness, substance use, and justice involvement interact, but substance use has also been found to complicate successful completion of corrections-mandated treatments and community supervision (NIDA, 2010). Therefore, intervening with substance use is important both to prevent justice involvement in the first place as well as being an important issue to address once they are involved in the justice system to forestall further involvement.

In adults, supervision failure is often the result of a positive drug test or a failure to comply with mental health treatment plans (Glaze & Bonczar, 2007; Langan & Levin, 2002; Taxman, Perdoni, & Caudy, 2013). Substance use is also a prevalent issue among delinquent youth, with the more frequently offending juveniles having the highest incidence of substance use disorders (Assink, van der Put, Hoeve, de Vries, Stams, & Oort, 2015; Loebher, Green, Lahey, Frick, & McBurnett, 2000; Young, Dembo, & Henderson, 2007). Substance use was found to elevate the risk of recidivism in youths, and to also produce a worsening course of delinquent behavior (van der Put, Creemers, & Hoeve, 2014). Substance use in adolescents is also highly correlated with comorbidity and mortality in juveniles (Brannigan, Schackman, Falco, & Millman, 2004) and displays of violence (Kopak & Proctor, 2016), emphasizing the need for effective treatment for

this population. Guebert & Olver (2014) also stress the need for treating substance use, suggesting that it be an immediate target for young offenders, but cautioning that it should not be considered in isolation from other criminogenic needs because substance use is associated with antisocial peers, poor school performance, and other juvenile RNR risk factors.

While the need for substance use treatment among justice-involved adolescents is uniform in the literature, much like broader RNR considerations, the implementation of such treatment can be difficult. More specifically, substance use is inherently more difficult to address in treatment if the adolescent is justice-involved, compared to those who are not (van der Put et al., 2014) because of the aforementioned interaction between substance use and procriminal behavior. Drug abuse also comes with particular problems seen with less frequency in other psychopathologies, such as low motivation to change and treatment nonadherence, making drug abuse treatment associated with smaller effect sizes than treatment for other risk factors in recidivism studies (James, Stams, Asscher, De Roo, & van der Laan, 2013). Because of this, James and colleagues (2013) surmise that substance use must be treated first for all other treatment goals to reach maximum effect. Additionally, van der Put et al. (2014) advise that treatment incorporate the offender's family due to the fact that adolescents often do not consider their own substance abuse to be problematic. With the addition of family involvement, juvenile adherence and engagement in treatment can increase, engaged family can also serve as additional prosocial support as well as facilitating adherence to community supervision guidelines with increased activity in their child's life (Liddle, Dakof, Henderson, & Rowe, 2010). Family involvement comes with its own set of challenges however; it

assumes there is family present to participate in treatment, the family acts as a positive influence, and that the family is motivated to assist in a difficult treatment course.

While there is research to help guide effective treatment, little empirical study exists on the delivery of criminal and mental health treatment in delinquent youths from the perspective of the treatment provider. Unfortunately, while delinquent adolescents have a high frequency of substance use problems, require quick and intensive services, and benefit from recidivism reduction through an RNR framework, the literature lacks specific guidelines on how to implement the RNR model in practice. While risk and need measures exist and research has suggested that certain treatment approaches are effective with justice-involved youth, the current research base does not address how widely these components are implemented nationally. The majority of research is concerned with risk assessment to predict recidivism, and not examining each of the components of the RNR model (Brogan et al., 2015; Singh et al., 2014).

The research on treatment with adolescent offenders also paints a somewhat pessimistic picture. Examination of the use of juvenile RNR measures by juvenile probation officers by Peterson-Badali, Skilling, and Haqanee (2015) noted that only 1.4 criminogenic needs on average were addressed while juveniles were on supervision, and 40% of juveniles in their sample had no needs addressed at all. Vincent, Guy, Gershenson, and McCabe (2012) also found that juvenile treatment providers and probation officers failed to make treatment decisions based on risk levels unless institutional policy mandated training in RNR, despite a simultaneous training emphasis on administering risk-need measures. When RNR treatment and risk-need assessments were built into policy, the tools were more often used in disposition and placement

decisions, service referrals, and supervision. Without such policy, there tended to be a greater institutional emphasis on detention and punishment (Vincent, Guy, Perrault, Gershenson, 2016). Of course, quality training and policy can only do so much, and staff commitment and belief in the efficacy of implementing services through the RNR framework is also imperative (Guy, Nelson, Fusco-Morin, & Vincent, 2014; Vincent et al., 2016). This often includes perceptions that treatment is efficacious and easy to provide (Hunter, Han, Slaughter, Godley, & Garner, 2017).

When discussing treatment delivery as it relates to policies and procedures within a justice organization, the role that organizational variables play in effective service delivery should also be mentioned. Organizational variables in this case include broad institutional characteristics that might influence treatment providers and successful treatment provision, such as staff morale, supervisory training, and available resources. Broadly, organizational variables have also been found to play a role in effective treatment (Henggeler, 2004; Roman & Johnson, 2002) and has shown that simply adhering to treatment manuals alone also does not guarantee success without an understanding of the intervention itself, the providers of the intervention, service settings, and how the organization at large will support the delivery of empirically-supported treatment (Henderson, Young, Jainchill, Hawke, Farkas, & Davis, 2007). Lehman, Greener, and Simpson (2002) found that for a treatment setting to effectively adopt new evidence-based treatment, institution-wide motivation for change, training and support resources, staff training and optimism, and program climate have been associated with positive implementation.

Not only can organizational variables play a role in effective treatment, they have also been found to maintain evidence-based practice (Lundgren, Krull, Saxe Zerden, & McCarty, 2011). Hunter et al. (2017) found that even after evidence-based interventions are introduced to a treatment facility, after staff undergoes appropriate training and follow-up support has been offered, most programs do not fully adhere to the evidence-based protocols. To improve staff optimism and adherence, higher levels of staff and supervisor education, and access to appropriate internet resources were necessary to achieve adherence to empirically supported treatment (Lundgren et al., 2011).

In juvenile treatment programs specifically, additional organizational variables associated with evidence-based treatment adherence also included size of the treatment setting (with larger settings adhering more) and type of setting (private settings adhered better than public settings, and larger settings had more adherence than smaller settings) (Lundgren, Krull, Saxe Zerden, & McCarty, 2011). Additionally, staff characteristics such as training, demographics (e.g. age, gender, highest level of education), preferred theoretical orientation, length of employment, perceived stress, and perceived program needs within the institution were found to guide evidence-based practice success (Lundgren, Chassler, Amodeo, D'Ippolito, & Sullivan, 2012). Henderson et al., (2007) also found program connectedness with non-justice organizations, staff support for new programs and quality of treatment, administrative commitment, and presence of training opportunities to foster evidence-based practice in substance abuse programs for juveniles.

The Current Study

The current study seeks to explore the extent to which RNR principles are currently present in a nationally representative sample of treatment programs for justice-

involved youth. Furthermore, it is also clear that several organizational variables may hinder or assist in proper delivery of evidence-based practice, and therefore may also meaningfully impact the presence of RNR-related treatment. According to a recent conceptual review on the RNR model with juveniles (Brogan et al., 2015), only one empirical study of juvenile programs exists (Singh et al., 2014), and this study did not explore to what extent the program of study engaged in RNR-based practice, or to what degree those principles were represented. Brogan et al. (2015) also identified several potential barriers to implementing RNR principles including inadequate or improper risk/need identification, questionable utility of case management plans, and/or other organizational variables noted by Henderson et al. (2007; e.g., limited training and resources, and a lack of network connection). Before continuing to refine RNR frameworks for justice populations, Hoge (2001) emphasized the importance of determining what is already available and occurring within the justice system. This is especially important given the amount of variability that exists among institutions in the utilization of risk-need measures and selecting appropriate treatment. For this study, the ability for treatment programs to address risk, need, and responsivity principles depended on (1) the risk assessment instruments used, (2) whether or not a needs assessment is included, and the extent to which treatment plans and treatment needs are reevaluated, and (3) the degree to which the institution meets general and specific responsivity (discussed in more detail below). The representation of risk, need, and responsivity principles within the treatment programs were measured on ordinal scales (see Henderson et al., 2007; Knudsen & Roman, 2004; and Taylor, 2016 for similar approaches), based

on the strength in which the principles are followed (specific operationalization is detailed in the Methods section).

Within the exploration of RNR-based practice in programs serving justice-involved youth, I hypothesized that the risk principle will be most extensively implemented, with programs using well-known, validated, and structured risk assessments to a greater extent than they were representing principles of need or responsivity (these terms are operationally defined below). This hypothesis was grounded within the RNR literature suggesting the risk principle was found to have been implemented more often than any other principle (Haqanee et al., 2015; Miller & Maloney, 2013). Further, the practice of including risk-need assessments during justice intake processes has become more popular and commonplace (VanBenschoten, Bentley, Gregoire, & Lowenkamp, 2016). Often, risk and need can be measured at the same time through a structured assessment like the YLS/CMI; however, not all risk assessments contain a needs assessment portion. Singh et al. (2014) noted that the implementation and utilization of risk assessment specifically has become more commonplace, but the same cannot be said for need. For this reason, I hypothesized that the need principle would be represented more extensively than the responsivity principle. This would incorporate sites using needs assessments, substance use assessments, *and* engaging in treatment plan reviews.

In instances when RNR principles have not been fully implemented (which is most of the time), literature has found that it is often because programming and treatments may not be fully available (Gebo, Stracuzzi, & Hurst, 2006; Shook & Sari, 2007). For example, an organization may identify that a juvenile has substance use and

mental health needs upon assessment, but may not be able to provide those treatments themselves, or have network referrals in place that address each of the components. In measuring country-wide data, Mark et al. (2006) indicated that while many programs were inclusive in their overall assessment of juveniles (also screening for pregnancy, HIV/AIDS, dual diagnoses, etc.), at best half of the programs examined provided specific treatments for the problems indicated within the assessments. In a survey of probation officers, Haqanee et al. (2015) found that many officers indicated a lack of suitable programming that targeted specific criminogenic needs such as a history of antisocial behavior, antisocial personality, antisocial cognitions, and antisocial peers. When sufficient programming existed it was often at the cost of lengthy waiting lists. For these reasons, it was further expected that the responsivity principle would be the least represented principle. Sites were expected to offer fairly low degrees of access to empirically supported treatments *and* less likely to tailor treatment to the needs of the juvenile offenders they served.

As previously mentioned, organizational variables have been indicated to impact the degree to which empirically supported treatments can be delivered effectively, and therefore may also serve as barriers and facilitators to the existence of RNR principles in the treatment programs. Research has indicated several organizational factors that may be meaningful in influencing the use of more evidence-based practices, which include whether or not the program is privately funded, network connectedness with non-justice programs, staff perception of program needs, availability of training opportunities, internal support for new programming, and supervisory emphasis on quality of treatment

programming (Henderson et al., 2007; Lundgren et al., 2011; Lundgren et al., 2012; Roman, Ducharme, & Knudsen, 2006).

When administering evidence-based protocols for psychotherapy in conjunction with pharmacotherapy to substance using offenders, privately funded settings were more often found to be adherent to not only the pharmacotherapy treatments, but in implementing the psychotherapy components as well (Roman et al., 2006). When examining drug treatment practices in juvenile offenders, Henderson et al (2007) noted that increased joint activities and connections between treatment facilities and non-justice focused organizations, more staff training opportunities, and management commitment to treatment quality also enhanced the implementation of evidence-based practice. In terms of barriers, Lundgren et al. (2012) found that staff and program director stress both lead to feelings of burdensomeness in implementing evidence-based practice. More specifically, there was also found to be a difference between stress endorsed by supervisors and implementing evidence-based practice (Lundgren et al., 2011). It was therefore hypothesized that these variables may impact the representation of RNR principles within treatment programs. More specifically, it is hypothesized that privately funded organizations, sites with increased connections to non-justice organizations, increased staff training, and management commitment to quality of services will be associated with higher rates of RNR representation. Also, it is predicted that these variables will most contribute to the representation of the responsivity principle as this principle is often heavily influenced by training, funding, and the provision of other positive resources (Haqanee et al., 2015; Shook & Sari, 2007; Taylor, 2016). Likewise, higher levels of perceived program needs and minimal training opportunities are expected

to be the strongest predictors to RNR-based practice. In addition to overall reductions in the representation of RNR-based treatment, these variables are again expected to impact the responsiveness the most because research indicates that principle is already difficult to adhere to fully (Gebo, Stracuzzi, & Hurst, 2006; Mark et al., 2006; Singh et al., 2014).

CHAPTER II

Method

Data Source

Data for this study was obtained from the National Institute on Drug Abuse's Criminal Justice Drug Abuse Treatment Studies (CJ-DATS) research cooperative. Data were archived with the Inter-University Consortium for Political and Social Research (ICPSR; <https://www.icpsr.umich.edu/icpsrweb>). This nationally representative survey of substance use and general mental health treatment practices in the adult and juvenile justice systems sought to collect information on access to treatment, availability of treatment, utilization of empirically-supported programs, type and quality of existing services, and organizational variables that are likely to influence practice (discussed more below) (Taxman, Young, Wiersema, Rhodes, & Mitchell, 2007). For the purpose of the current study, only the juvenile sample was utilized. Data obtained specifically from treatment program directors was examined as these respondents were provided with the most comprehensive surveys regarding treatment practices. Lower-level staff data were not given identification codes to match these participants with higher-level director or organizational surveys; therefore, this level of data collection could not be utilized.

The CJ-DATS data broadly includes an adult prison sample, a juvenile residential facilities sample, and a community sample consisting of both adults and juveniles. Facilities were identified using a random stratified sampling approach, and selected primarily from the American Correctional Association's 2003 national directory and the 2000 Bureau of Justice Statistics' prison census, resulting in an initial sample size of 2,685 facilities (Taxman et al., 2007). Small institutions that held a capacity of less than

25 were removed, as were group homes, diagnostic centers, and specialty facilities (ex. designated for the chronically mentally ill, geriatric population, juvenile runaways, foster care, etc.). One hundred adult institutions and 70 juvenile institutions were included in the final sample of executives, directors, and staff, with an average response rate of 70.8% (Taxman et al., 2007). The facilities in the final sample included data from a broad range of programs, which included correctional clinical and alcohol/drug agency directors, prisons, juvenile detention centers, local community correction settings (probation, parole, jails, etc.), and community treatment facilities. While the variety of facilities is impressive, it is important to recognize that researchers aimed at measuring large, state-funded secured institutions (hence the exclusion of smaller facilities), which may bias the sample towards more metropolitan areas or large institutions with more funding.

Operational Variables

In order to determine the representation of RNR principles within treatment programs, the principles of risk, need, and responsivity were defined for this study by the questions contained within the CJ-DATS survey. The questions that best addressed principles of risk (ex. using structured risk assessments), need (ex. the identification of criminogenic and non-criminogenic needs), and responsivity (ex. adhering to empirically-supported treatments, treatment matching based on assessed risks and needs) were selected.

Measurement of risk. Representation of the risk principle was defined through the use of structured risk assessments. On an ordinal scale (0-3), the use of the Youth Level of Service/Case Management Inventory (YLS/CMI; Hoge & Andrews, 2006)

and/or the Structured Risk Assessment of Violence Risk in Youth (SAVRY; Borum, Bartel, & Forth, 2006) were awarded a designation of “3”, indicating that this was considered the best way to represent the risk principle. These two measurements can be considered “ideal” as they are the most common risk assessments that have historically been utilized within the implementation of the RNR model in juvenile offenders (Brogan et al., 2015; Vincent et al., 2016). After the YLS/CMI and SAVRY, all other empirically tested risk assessment measures were assigned a score of “2” (such as the Wisconsin Risk Need Assessment (Eisenberg, Bryl, & Fabelo, 2009), Washington State Juvenile Court Assessment (Barnoski, 1998), Jesness Inventory-Revised (JI-R; Jesness, 2003), etc.) as they are based in varying amounts of evidence, but are not considered best practice or lack the strong evidence base of the YLS/CMI or SAVRY in determining risk. A value of “1” was reserved for programs that identified using “homegrown” or organization-created risk tools (Colorado Youthful Offender Level of Service Instrument, North Dakota Risk Assessment Instrument, etc.). As defined by Vincent, Terry, and Maney (2009), these instruments are oftentimes developed outside of a sound evidence base for the purposes of meeting an institution’s specific desires. While some of these tools may be based on risk factors identified in research, or adapted from empirically sound, pre-existing measures, many lack evidence of reliability or validity (Vincent et al., 2009). Finally, a “0” was assigned if a program utilized no risk measure at all.

Measurement of need. Representation of the need principle was measured three ways: by examining the amount to which a treatment program utilized needs measurement of the “central eight,” if the program also conducted assessment of substance use, and if the treatment program provided reassessment of treatment needs.

For the purposes of the CJ-DATS database, needs reassessment will utilize the survey item “How often do the following people participate in updating treatment plans?”, which includes primary counselors, case managers, correctional staff, and the juvenile and their family, and answer choices of: never, occasionally, about half the time, often, and always. A value of “3” was to be assigned to programs that incorporated a needs assessment by using the YLS/CMI and indicated that at least one individual (of those included above) were involved in a treatment update process. A “2” was to be assigned to programs that utilize some other needs assessment and indicate that at least one individual partakes in a treatment plan update. “Other needs” assessments would include needs or risk/needs measures that are not the YLS/CMI, such as the Risk and Resiliency Checkup or Juvenile Intervention and Assessment System, which contain needs assessments but do not have the same research base as the YLS/CMI. Programs were to receive a “1” for utilizing either a needs assessment *or* endorse taking part in treatment plan revision. A “0” was assigned to a program that does not use a needs assessment nor endorses any staff member engaging in treatment updates. Addition of substance use assessments was also considered. To account for this, one extra point (“1”) was added if the program utilized a standardized assessment tool for substance abuse (ex. ADI, ADS, DAST, etc.). Thus, measurement of need representation occurred on an ordinal scale of 0-4, with “ideal” representation incorporating the use of the YLS/CMI, treatment plan revisions, and a substance use assessment.

Upon examining the distribution of the data, scores across the need variable required redefining. Thus, a score of “1” represented programs that engaged in treatment plan review, or substance use assessment, or a needs assessment; a score of “2” was

given if a program endorsed treatment plan review and conducted a substance use assessment; a score of “3” represented a program that engaged in need assessment and substance use assessment; and a score of “4” was reserved for sites that engaged in treatment plan reviews, substance use assessments, and need assessments.

Measurement of responsivity. Both general and specific responsivity were included in conceptualizing the representation of the responsivity principle. General responsivity refers to the use of evidence-based treatments, and six techniques specifically have been identified that adhere best to the general responsivity principle: role-playing, modeling, repeated practice of alternative behaviors, cognitive restructuring, skills building, and reinforcement (Andrews & Bonta, 2010; Taylor, 2016). Furthermore, Brogan et al., (2016) have also noted that multisystemic therapy (MST) and functional family therapy (FFT) to be highly efficacious in the treatment of juveniles. For the purposes of this study, general responsivity was measured on an ordinal scale from 0-6, and like Taylor (2016), the score will be based on the number of empirically-supported general responsivity components. This included: cognitive approaches, behavioral management approaches, social skill development, family counseling, individual drug counseling, and/or role-playing. For example, if a program contained all of these components in some way, it will be assigned a score of “6” for general responsivity, if a program contains two of these components it will be assigned a score of “2”, and “0” will be reserved for programs that offer none.

Specific responsivity refers to matching appropriate treatments to meet the needs of each juvenile in the program. This utilized the following question from the CJ-DATS database: “To what extent does your program individualize treatment of offenders by

having different requirements and activities for different offenders.” Programs who selected the answer choice “All offenders have individualized treatment requirements” received a score of “4”; programs who provided individualized services for “most offenders” received a score of “3”; programs providing individualized treatment to “about half” of the offenders received a score of “2”; programs that only offered individualized treatment to “some” offenders received a score of “1”, and programs reporting “The requirements and activities for all offenders are the same” received a score of “0.” An extra point (“1”) was added to sites’ specific responsivity scores if a mental health assessment was also incorporated; thus, specific responsivity representation was measured on an ordinal scale of 0-5.

When taking both general and specific responsivity components into consideration, the whole variable of responsivity will be measured on an ordinal scale of 0-11, with a value of 10 indicating an “ideal” offering of empirically-supported techniques covered by Andrews and Bonta (2010), mental health assessment, and treatment plans that were created individually for all juvenile offenders.

Upon examining the distribution of the data, it was discovered that there was very little variability in the general responsivity data (see Table 4 in Results). More specifically, a large percentage of sites endorsed most if not all components of general responsivity. Thus, for this study, responsivity was ultimately measured by the degree to which sites endorsed practices in agreement with *specific* responsivity, and was measured ordinally on a scale of 0-5. This allowed for greater variability in the data.

Measurement of organizational variables. Organizational variables for this study were measured either dichotomously or ordinally, based on the measure used to

represent the organizational variable in question. Operationalization of these variables based on the CJ-DATS survey is included in Table 1.

Table 1

Operationalization of Organizational Variables

Organizational Variable	Item(s) from CJ-DATS Survey	Scoring
Privatization of program	“What type of organization do you work for?” (<i>Question #5, form S3B</i>)	0 = Not a private agency 1 = Private agency
Program engagement with other, non-justice organizations	“Please identify the level of involvement that your facility/location has with other organizations or offices on issues related to providing substance abuse services to offenders.” (<i>Question #48, form S3B</i>)	Based on the number of organizations listed that are not justice-related: mental health programs, health care programs, housing authority, faith-based organizations, vocational/educational services, other (specify).
Internal support for new programs	“Staff perception of ability to make suggestions” items (<i>Question #58, form S3B</i>)	Higher scores indicate more support for new programs and institutional willingness to explore other treatment options.
Management emphasis on quality of services	Management/quality of treatment subscale from the “climate for treatment” items based on Schneider, White, & Paul (1998); (<i>Question #56, items b, c, e, g, f, n, form S3B</i>)	Higher scores represent more supervisor emphasis and support of program quality and improvement.
Training opportunities	Training subscale of the organizational needs assessment (<i>Question #19, items e through i, form S3B</i>)	Lower scores indicate more training is available, higher scores indicate less training is available.
Perceived organizational needs	Overall organizational needs assessment based on Lehman, Greener, & Simpson (2002) (<i>Question #19, form S3B</i>)	Higher scores indicate less perceived need of resources (etc.) within the treatment program.

Demographics. In addition to the outcome variables used in hypothesis testing, the following demographic information will also be collected: respondent's gender, age, ethnicity, highest level of education, field of education, and work setting. Also, licensure or accreditation of the organization by an outside agency was recorded as well.

Data Analysis

Descriptive statistics. To describe the data in the best way possible, several descriptive statistics were examined and reported on, including:

- a) The total number of juvenile substance use treatment sites/program directors used in the study,
- b) Total number and percentage of treatment sites that are licensed or accredited,
- c) Frequencies of respondent characteristics (proportion of the sample that is male v. female, percentages of the sample that functions within various work settings, respondents' highest level of education and field of education, description of ethnic composition of the sample),
- d) Frequencies and percentages of sites' endorsed strengths with certain populations (ex. female, dual-diagnoses, etc.),
- e) Correlations of each RNR principle to the organizational variables in question,
- f) And frequencies and distributions of sites reporting RNR-centric practice and their representation of each principle (ex. number of sites that scored a 0, 1, 2, etc. for each principle).

Data screening. Because the data was largely ordinal in nature, nonparametric statistical tests were used in lieu of parametric procedures. Thus, these tests were robust to any violations in assumptions of normality, skew, and kurtosis. However, distribution of each RNR principle was considered when testing the first hypotheses (that risk would be most represented and responsivity would be least represented), as post-hoc tests would require symmetry among group differences. Risk, need, and responsivity principle raw scores were converted to z-scores for this reason. Z-scores not only allowed for standardization between the ordinal scales used in this study, but also placed them along a normal distribution to allow for comparison across principles.

Hypothesis testing. With respect to examining which RNR principles were most commonly represented in current juvenile treatment practices, the z-scores calculated for risk, need, and responsivity were compared using the Friedman Test, a nonparametric alternative to the repeated measures analysis of variance. The Friedman Test would indicate if differences existed between groups measured ordinally. However, because this test was only an omnibus examination of differences, Wilcoxon Signed-Rank Tests would be used with a Bonferroni correction if a significant difference existed, to determine between which groups significant differences were found. While repeated measures tests are oftentimes used for longitudinal data, repeated measures examination remains acceptable for the purposes of this study as the same respondent would complete reporting of risk, need, and responsivity-related practices. To determine if organizational variables served as barriers or facilitators to the survey of RNR representation, negative binomial regressions were used with each organizational variable (i.e. a single organizational variable relative to the strength risk, need, responsivity, and total RNR

representation). Should multiple significant organizational variables be found to serve as predictors of principle representation, a negative binomial model would be utilized to include all significant predictors in the individual regressions discussed above. Negative binomial regressions were chosen for this data analysis as they serve to model for count data/ordinal variables. Such tests are also used when data are overdispersed, or contain irregularity in distribution.

Participant/Sample Information

For this study, a sample of 64 sites was obtained from the CJ-DATS database, each with its own program director responding to the site's overall representation of treatment practice. One site needed to be removed for missing data ($n = 63$). For demographic information on the program directors and sites involved in the survey, see Table 2 and Table 3, respectively. Overall, the 63 program directors were predominantly female ($n = 35$), between the ages of 45 and 54 ($n = 25$), and Caucasian ($n = 47$). Forty-seven percent of the respondents obtained graduate-level education, with 32% of the degrees attained in the field of social work, and 46% of the degrees attained in a field *other than* criminal justice, psychology, or sociology. Most respondents (65%) described their site as a community treatment setting. Seventy-six percent of the sites were accredited by an outside organization, with over half of the sites noting accreditation from a state agency, followed by the Joint Commission on the Accreditation of Health Care Organizations (JCAHO), and the American Correctional Association (ACA). A majority of sites in the study endorsed treatment practices geared towards youth and adolescent offenders, and 20 of the sites also noted having practices specific for dual-diagnosis cases.

Table 2

Demographic Information of Program Directors

	N	% of Sample
	63	
Age¹		
24-34 years	6	10%
35-44 years	16	25%
45-54 years	25	40%
55-64 years	14	22%
Gender		
Female	35	56%
Male	28	44%
Ethnicity¹		
Caucasian	47	75%
Black/African American	8	13%
Hispanic	6	10%
Highest Level of Education		
High School/Bachelor's	14	22%
Graduate Studies	47	75%
Other	2	3%
Field of Education		
Criminal Justice	4	6%
Psychology	8	13%
Sociology	2	3%
Social Work	20	32%
Other	29	46%
Work Setting		
Community Treatment Program	41	65%
Community Supervision	3	5%

(continued)

	N	% of Sample
Juvenile Confinement	2	3%
Prison	8	13%
Other	9	14%

Note. Demographic categories were defined by the preexisting data. Age was represented categorically within the data set and thus a mean and standard deviation could not be rendered. Also, the database did not allow for the recording of “other” fields of education. ¹Two participants were missing data for age and ethnicity.

Table 3

Demographic Information of Sites

	N	% of Sample	
	63		
Licensing/Accreditation			
Yes	48	76%	
No	15	24%	
Licensing/Accreditation Board			% of Lisc./Accred.
American Correctional Association (ACA)	8	13%	17%
Commission on the Accreditation of Rehabilitation Facilities (CARF)	4	6%	8%
Joint Commission on the Accreditation of Health Care Organizations (JCAHO)	12	19%	25%
Utilization Review Accreditation Commission (URAC)	1	2%	2%
National Committee for Quality Assurance	1	2%	2%
Federal Agency	2	3%	4%
State Agency	34	54%	71%
Other	7	11%	15%

(continued)

	N	% of Sample
Program Strengths		
Male	20	32%
Female	7	11%
Pregnant	6	10%
Youth/Adolescent	54	86%
Spanish Speaking	9	14%
African American	12	19%
Dual-Diagnosis	20	32%
Heroin Addiction	8	13%
Sexual Offenses	4	6%
HIV/AIDS	7	11%
Homeless	7	11%

Note. Programs were able to endorse multiple licensure/accreditation agencies and multiple populations with which they specialized in treating.

CHAPTER III

Results

Hypothesis 1: Representation of Risk > Need > Responsivity

When examining the data, few sites engaged in the use of risk or need assessment measures. Approximately 16% of sites used some sort of risk assessment tool.

Approximately 10% of sites utilized a need assessment tool, and 96% engaged in a treatment plan review. Fifty-seven sites (90%) supplemented their treatment planning and/or need assessment with a substance use measure. An overwhelming majority of sites endorsed using most, if not all, of the components identified by Andrews and Bonta (2010) for effective general responsivity practices. Again, this resulted in responsivity for this study being defined by the degree to sites endorsed only *specific* responsivity practices. For these practices, 49% of sites provided individualized treatment for all offenders, 21% individualized treatment for most offenders, and 15% provided such services for some of their offenders. Fifty-nine percent offered a mental health assessment screener, many of which included the Beck Depression Inventory (BDI) and the Structured Clinical Interview (SCI). For descriptive information on the dispersion of sites that had practices to reflect each principle of RNR, see Table 4 (next page).

Table 4

Representation of the Risk, Need, and Responsivity Principles

	N	% of Sample
	63	
Risk¹		
Use of the YLS/CMI or SAVRY	1	2%
Use of Other Empirically Tested Measures	9	14%
“Homegrown”/Organization-Created Measures	0	0%
No Risk Assessment	45	71%
Need²		
No Need Assessment or Treatment Plan Review	0	0%
Treatment Plan Review or Need Assessment	6	10%
Treatment Plan Review	5	
Need Assessment	1	
Treatment Plan Review and Substance Assessment	49	77%
Need Assessment and Substance Assessment	1	2%
Treatment Plan, Need Assessment, Substance Assessment	7	11%
Responsivity		
General Responsivity		
Cognitive Approaches	63	100%
Behavioral Management Approaches	63	100%
Social Skill Development	61	97%
Family Counseling	59	94%
Individual Drug Counseling	60	95%
Role Playing	59	94%
Specific Responsivity		
All Offenders have Individualized Treatment	31	49%
Most Offenders have Individualized Treatment	13	21%

(continued)

	N	% of Sample
About Half of Offenders have Individualized Treatment	3	5%
Some Offenders have Individualized Treatment	10	15%
Activities for All Offenders are the Same	6	10%
Utilized a Mental Health Assessment Tool ³	37	59%

Note. Sites could endorse multiple general responsivity approaches. ¹The single site that utilized the YLS/CMI or SAVRY utilized the SAVRY. Of those sites that utilized other various empirically tested risk measures, 5 chose the LSI-R, 3 used the LSI-R and the WNR, and one utilized the JI-R. ²Of the need assessments utilized, the single site that only utilized a need assessment used both the LSI-R and the WNR. The site that used a need and substance use assessment utilized the LSI-R and WNR. The sites that used a need assessment, a substance use assessment, and engaged in treatment planning, one used the LSI-R and WNR, and 6 used only the LSI-R. ³Of the mental health assessments utilized, 26 sites utilized the BDI, 9 sites used the SCI, 6 sites used the Symptom Checklist-90-R, and 9 sites used other measures.

Spearman-Brown correlations were also run on each of the RNR principles as they related to the organizational variables in this study. Correlation coefficients are provided in Table 5. Overall, each principle was largely unrelated to the organizational variables; however, need scores and responsivity scores were moderately correlated with the privatization of the treatment sites ($r_s = 0.27, p = 0.034$ and $r_s = -0.25, p = 0.049$, respectively).

Table 5

Correlations between RNR Principles and Organizational Variables

	Private Funding	Non-Justice Engagement	Support for New Programs	Mgmt. Commitment to Quality	Training Opportunities	Perceived Organizational Need
Risk Score	0.15 0.272	0.13 0.343	0.03 0.821	-0.09 0.523	0.12 0.387	0.06 0.648
Need Score	0.27 0.034*	0.21 0.094	-0.01 0.975	-0.15 0.251	0.12 0.357	0.11 0.396
Responsivity Score	-0.25 0.049*	0.20 0.112	0.16 0.232	0.22 0.105	0.16 0.212	-0.16 0.209

Note. * $p < 0.05$

To determine if significant differences existed in the degree to which programs' treatment practices represented principles of RNR, an omnibus Friedman Test was utilized. There was a statistically significant difference in the degree to which programs preexisting treatment practices followed each of the RNR principles, $X^2(2) = 19.891, p < 0.01$. Wilcoxon Signed-Rank Tests further indicated that significant differences existed between risk and need practices. Specifically, sites reported need assessment practices that were significantly more representative of RNR-based practice than they did with risk assessment ($Z = -4.02, p < 0.01$). Forty-nine sites indicated stronger need assessment practices than risk. There was no significant difference between the strength of the risk and responsivity practices ($Z = -0.03, p = 0.973$). Thirty-three sites reported stronger responsivity procedures than they did risk procedures and 22 sites reported stronger risk procedures. There was also no significant difference between the strength of need and

responsivity practices ($Z = -0.21, p = 0.836$). Thirty-nine sites endorsed stronger responsivity representation and 24 sites endorsed stronger need representation.

Hypothesis 2: Incorporation of Organizational Variables

Negative binomial regressions were performed to ascertain if organizational variables may predict representation of RNR principles in programs' treatment practices. See Table 6 for descriptive statistics pertaining to the organizational variables, and Table 7 for regression coefficients. No organizational variables significantly predicted whether or not a site would have stronger or weaker representation of the risk principle, or need principle.

Table 6

Descriptive Statistics Pertaining to Organizational Variables

	N	% of Sample
Privatization of Treatment Site ¹		
Yes	39	62%
No	22	35%
	M	SD
Non-Justice Engagement	3.73	1.39
Support for New Programs	3.83	0.68
Managerial Commitment to Quality	3.85	0.71
Training Opportunities	3.83	0.61
Perceived Organizational Need	3.26	0.45

Note. All organizational variables, except the variable Privatization, are on scales of 0-5, with 0 indicating low levels of that variable and 5 indicating high levels of that variable. ¹Two sites had missing data regarding the privatization of their facility.

Table 7

Negative Binomial Logistic Regression Coefficients for Organizational Variables on RNR Representation

	Estimate	S.E.	Est./S.E.	<i>p</i>
Risk				
Private Funding	-0.10	0.08	-1.17	0.241
Non-Justice Engagement	0.00	0.01	0.00	1.000
Support for New Programming	0.02	0.06	0.32	0.753
Managerial Commitment to Quality	0.17	0.12	1.40	0.163
Training Opportunities	0.02	0.06	0.25	0.800
Perceived Organizational Needs	-0.19	0.15	-1.23	0.219
Need				
Private Funding	0.06	0.10	0.63	0.527
Non-Justice Engagement	0.05	0.04	1.67	0.095
Support for New Programming	0.02	0.06	0.32	0.748
Managerial Commitment to Quality	-0.03	0.05	-0.67	0.503
Training Opportunities	0.07	0.04	1.51	0.131
Perceived Organizational Needs	-0.02	0.10	-0.22	0.829
Responsivity				
Private Funding	-0.32	0.15	-2.10	0.040*
Non-Justice Engagement	0.09	0.05	1.69	0.091
Support for New Programming	0.12	0.09	1.34	0.181
Managerial Commitment to Quality	0.18	0.10	1.93	0.053
Training Opportunities	0.09	0.08	1.12	0.263
Perceived Organizational Needs	-0.13	0.11	-1.20	0.230
Total RNR				
Private Funding	-0.06	0.06	-1.09	0.277
Non-Justice Engagement	0.05	0.03	2.02	0.044*

(continued)

	Estimate	S.E.	Est./S.E.	<i>p</i>
Support for New Programming	0.05	0.04	1.30	0.195
Managerial Commitment to Quality	0.06	0.04	1.53	0.127
Training Opportunities	0.06	0.03	1.92	0.055
Perceived Organizational Needs	-0.04	0.04	-0.91	0.362

Note. * $p < 0.05$

When examining if any organizational variables predicted the extensiveness of the responsiveness principle, privatization of the organization was found to be a significant predictor ($b = -0.32$, standard error [SE] = 0.15, *pseudo z* = -2.10, $p = 0.040$). The direction of the relationship indicated that higher levels of privatization lead to lower representation of the responsiveness principle in preexisting treatment practices. The impact of management commitment to quality treatment services on responsiveness representation was also approaching significance ($b = 0.18$, standard error [SE] = 0.10, *pseudo z* = 1.93, $p = 0.053$).

Consideration for the impact of organizational variables on the representation of the RNR model in its entirety, showed engagement with non-justice-related organizations to be the only significant predictor ($b = -0.05$, standard error [SE] = 0.03, *pseudo z* = 2.02, $p = 0.044$). The direction of the relationship indicated that more non-justice organizations connected to a treatment program, the more that program possessed characteristics of overall RNR adherence. The relationship between having more training opportunities and having higher representation of the RNR principle was approaching significance ($b = 0.06$, standard error [SE] = 0.03, *pseudo z* = 1.92, $p = 0.055$).

CHAPTER IV

Discussion

There is currently question as to whether or not the Risk-Need-Responsivity model may be truly effective for use in juvenile settings. This is largely because adults, whom the model was initially created for, do not possess the same developmental treatment considerations as adolescents. Thus, consideration for other risk and need factors, or alternatives to current responsivity practices, may be indicated for justice-involved youths. Ultimately, research in this area is still sparse relative to the strength of RNR research applied to adult offenders. Hoge (2001) emphasized the importance of determining what is already available within the justice system (and beyond) before seeking to make alterations to treatment practices. This study wished to take Hoge's advice, and first examine the prevalence of Risk-Need-Responsivity principles and overall RNR practice in juvenile justice treatment programs.

It was first hypothesized that the risk principle would be the most represented in current practice, characterized by the utilization of "central eight" risk assessments such as the YLS/CMI (Hoge & Andrews, 2006) or the SAVRY (Borum, Bartel, & Forth, 2006). Also, that the need principle would be the second most represented through the use of substance use assessments, revisions of treatment plans, and the utilization of "central eight" need assessments. Finally, it was hypothesized that the responsivity principle would be the least represented, defined as the ability for sites to provide individualized treatment and utilizing effective psychotherapy principles originally outlined by Andrews and Bonta (2010). After examining the prevalence of each principle, the hypotheses were not supported. Contrary to what was initially suspected,

responsivity was the most represented principle among the sites used in this study. Risk was present significantly less than the need principle, but there were no significant differences between the risk and responsivity, or need and responsivity principles.

Explanations for these findings could come from a few different sources. First, while researchers indicate the utilization of risk assessment to be on the rise within justice-involved treatment facilities (VanBenschoten et al., 2016), aspects of the need principle (substance use assessments and treatment plan reviews) may have already been a component of these programs, and therefore would naturally be more common (Steadman, 1992). This may also explain why there were no significant differences between need representation and responsivity practices. For this study, need was defined primarily by treatment plan reviews and substance use assessments, and responsivity practices were defined by providing individualized treatment and mental health assessment. These practices may have already been considered commonplace in delivering mental health services before they were considered important components to the RNR model.

When exploring the null differences between risk and responsivity variables, the dispersion of the data between both principles may explain the findings. More specifically, a large number of sites did not utilize a risk measure, and a large number of sites also either provided individualized treatment plans to all or most of their offenders. Because the data were so heavily weighted to the provision of no risk assessment and provision of individualized treatment, little variability existed within these two principles, which may have impacted the degree to which statistical differences could have been found.

When considering the effect organizational variables had on RNR representation, the hypotheses that they would most impact representation of the responsivity principle were partially supported. There were no organizational variables that predicted that risk or need representation among the programs surveyed. These results may be due to the circumscribed manner in which the risk and need variables were defined. With regard to the responsivity principle, only the privatization of services was indicative of lower representation of this principle. This was a puzzling finding as the privatization of a treatment organization may spark images of abundant training and services for offenders, disconnected from the “red tape” stereotypically expected to exist in government-funded programs. However, some researchers provide that privatization may not actually provide enhanced efficiency or validity in treatment (Steen & Duran, 2010) and that privatization may erode the responsibility to effective treatment. This is to say, when a treatment program is government-funded, there may be more systems of evaluating the utility of the programs to ensure that the programs are effective (Beaulaurier, 2001). Management commitment to the quality of services was approaching significance for the impact it had on responsivity representation. This may have been due to the fact that widespread, effective treatment practices (regardless of what they are) first begin with organizational and management support. With supervisory staff committing to practices of providing individualized treatment and mental health screenings, such activities are likely to become habit for the organization and increase skill sets of practitioners tasked with delivering treatment and assessments (Carlson, Goscha, & Rapp, 2016). Non-significant findings regarding perceived organizational need and training opportunities may reflect the fact that this study was not an adherence study, or an exploration into the

revision of current treatment practices. Thus, these variables, which have otherwise been found to be significant in studies examining the degree to which new treatment programs may persist and prosper, may not serve as predictors for programs that are not in flux.

When examining organizational predictors of total RNR representation, involvement with non-justice organizations was found to be the only significant predictor, and provision of training opportunities was approaching significance. In the Henderson et al. (2007) study, these were also significant predictors of evidence-based practice adherence, at least within the juvenile substance use treatment programs utilized in their study. Henderson et al.'s findings can be considered applicable to the present study, as the substance use treatment program sample used in the Henderson et al. study also incorporated measures of mental health practices and comprehensive treatment approaches as well. Specifically, non-justice organization involvement is likely to have little impact on risk or need assessment on their own as those principles again are mostly limited to the utilization of screening and assessment measures, and would be more dependent on support from internal employees, such as management or staff (Garner et al., 2012). Its impact on RNR-based practice as a whole may instead be related to the creation of a more overall supportive environment for treatment, rather than punitive sanctions, and would better reflect the rehabilitative mission of RNR.

Findings of this study suggest that current treatment programs may be engaging in practices more representative of the RNR need and responsivity principles specifically than any other RNR component. This is a positive finding as it may paint a more optimistic picture than some previous studies citing that responsivity and effective treatment are hard to come by (Gebo et al., 2006; Mark et al., 2006; Shook & Sari, 2007).

However, it must be noted that the components of need and responsivity-based practice that treatment sites endorsed the most (treatment planning, substance use assessment, offering individualized treatment, etc.) were those that are usually common among general treatment programs to begin with, and may not be the most indicative of RNR-based treatment. For example, few of the sites that scored highly on need representation did so because they actually incorporated need assessments. In the present sample, 71% of sites did not use risk assessment measures at all. One site utilized the SAVRY, and a few other sites used other measures, primarily the Level of Service Inventory-Revised (Andrews & Bonta, 1995). While the LSI-R is a well-validated measure of risk and need, the YLS/CMI is a risk/need measure designed from the LSI-R for specific utilization on a juvenile justice population (Hoge & Andrews, 2006). Also, 8 sites (13%) engaged in some form of need assessment. This too is concerning as assessment of risk and need are supposed to specifically guide the selection of treatment within the responsivity principle. Also, if research has indicated that need assessment be reassessed more frequently in a juvenile justice population to guide proper treatment (Mulvey et al., 2016), it posts a puzzling discrepancy in the current data where such a small number of sites endorse engagement in need assessment, and a high number of sites conduct treatment plan reviews. This would indicate that if RNR-related changes or improvements were to be made to treatment sites, emphasis should be placed on the consistent assessment of risk and need, using the suggested appropriate measures, to directly inform treatment and treatment reviews.

To address the change in how responsivity was operationalized, it is important to note that just because sites endorsed most, if not all, of the effective treatment strategies

delineated by Andrews and Bonta (2010), does not mean that one can assume responsivity was represented above and beyond the other two principles. The therapeutic techniques suggested by the general responsivity principle, that the sites endorsed, may or may not be actively utilized to address criminogenic risk and need factors (Campbell et al., 2015). For example, the use of cognitive and/or behavioral techniques are indicated in responsivity, but are indicated in the specific treatment of risk and need factors such as criminogenic thinking and negative peer/family relationships. However, cognitive and/or behavioral techniques can also be used for other issues, such as anxiety, depression, low self-esteem, and other presenting issues unrelated to criminogenic risk or need. It also cannot be assumed that just by endorsing the use of these techniques, that they are being used accurately or effectively. This could have caused the sites within this study to report the use of general responsivity techniques above and beyond what they are initially intended for, thus inflating the degree to which responsivity is represented in treatment programs (Campbell et al., 2015).

Limitations

Despite the importance of the above findings, this study does possess some limitations worthy of note. First, this study was constructed using pre-existing data from a pre-existing survey. This limited the ways in which risk, need, and responsivity principles could be operationalized. For example, an important component within the RNR model is the explicit matching of appropriate treatment to the appropriate level of risk that an offender possesses (Andrews & Bonta, 2010). For as important as that matching is to RNR, no question related to that practice was included in the survey or the data that were available. Data was also obtained for this study between the years 2002

and 2008. While treatment practices of juvenile offenders have not changed substantially since the data was obtained, the age of the data should be noted as juvenile justice reform began in the late 1990s and is still considered an active process.

Another limitation to this study was the relatively small number of sites that were included. Sixty-four sites endorsed serving only juveniles, an additional 59 sites endorsed serving adults *and* juveniles. However, because data collection did not allow for directors at these sites to report on their adult population and juvenile populations independently, the additional 59 sites could not be utilized because the data provided could have been representing both juvenile and adult populations at the same time. Therefore, the regression analyses were underpowered.

For data analysis, the first set of hypotheses determining the prevalence of each RNR principle was conducted using z-scores to normalize distribution for post-hoc analyses. This means that the principles of risk, need, and responsivity, and their relationships to one another, were based solely on how each site compares to the other sites in the study, and not how each site performed in their representation of “best case scenario” RNR representation. Similarly, data coding of specifically the responsivity principle was made one-dimensional, meaning it only accounted for which of the therapeutic modalities were endorsed overall (yes/no). The frequency with which each site used the modalities included (e.g. “most of the time,” “some of the time,” etc.) were not incorporated into data analysis.

Finally, the literature surrounding RNR in juvenile justice settings should be taken into consideration. At present time, while the RNR model is considered an ideal guide for treatment in a juvenile population, the model is still fairly understudied. Variations in

opinion exist regarding whether the “central eight” risk and need factors apply, do not apply, or somewhat apply to juveniles. Research also suggests that need assessments be given more frequently with juveniles than adults, but gives no indication as to how often. Some changes in effective treatment modalities for the responsivity principle are also under debate. All of this is to say, the current study examined the presentation of the RNR model in juveniles, as it is currently understood within the available research literature. This does not necessarily mean that the operationalization of these principles for this study represent the penultimate guidelines for this model, for this population.

CHAPTER V

Conclusion

Current findings provide an interesting picture for the degree to which RNR principles have naturally occurred and been represented in juvenile justice treatment programs. While principles of risk and need may intuitively be most easily represented as they only require the provision of assessment measures and treatment plan reviews, findings showed the opposite. Responsivity was essentially the most represented principle within the data, which may be explained by the longer-standing history of therapeutic modalities and manualized treatments. Only a few of the organizational variables were found to be predictive of current representation of RNR principles. This was likely because the study sampled pre-existing treatment programs that were not currently in the process of changing in treatment practices.

Currently, no study exists within the literature base that examines the representation of RNR-based practice already occurring within functioning treatment programs. Knowing what is currently available through these treatment sites is an important first step to consider when looking to alter treatment practices based on upcoming literature on RNR applicability to juveniles. Major concerns raised by the findings of this study were the relatively scarce use of risk and need measures by programs, especially because such assessments are supposed to guide the provision of responsivity services. It is also worth keeping in mind that some researchers have also noted that sites may be engaging in empirically-supported treatment practices but are using them to target symptoms other than criminogenic risk and need factors.

It is suggested by this researcher that future studies should first seek to solidify how to best alter the RNR model to fit a juvenile justice population. Meta-analytic studies of each principle should be used to determine what changes or caveats (if any) need to be applied to the original, adult-focused model. Then and only then, should the translatability of the model be undertaken and controlled trials be completed.

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VITA

DANA L. FORMON, M.A.

Department of Psychology and Philosophy, Sam Houston State University
 DanaLeighFormon@shsu.edu

EDUCATION

- Present** **Doctor of Philosophy, Clinical Psychology with Forensic Emphasis**
 Sam Houston State University – Huntsville, TX
Dissertation: *Know where you are to guide where you're going: A survey of Risk- Need-Responsivity treatment practices in juvenile correctional programs*
Chair: Craig E. Henderson, Ph.D.
- August 2015** **Master of Science, Clinical Psychology** (Received: August 2015)
 Sam Houston State University – Huntsville, TX
Thesis: *Nothing will work unless you do: Studying employment outcomes of offenders and non-offenders*
Chair: Adam T. Schmidt, Ph.D.
- May 2013** **Bachelor of Science, Psychology** (Summa Cum Laude)
 Drexel University – Philadelphia, PA
Thesis: *The social impacts of being an offender with a mental illness*
Chair: David DeMatteo, Ph.D.
- May 2010** **Bachelor of Fine Arts, Dance** (Cum Laude)
 Southeast Missouri State University – Cape Girardeau, MO

CLINICAL & PRACTICA

- June 2017 - Present** **Montgomery County Adult Probation**
 Psychology Practicum Intern – Conroe, TX
Setting: Montgomery County Jail/Mental Health Court and adult probation department
Population: Ethnically diverse, adult, male and females with pathology surrounding substance abuse, trauma, persistent severe mental illness, mood/anxiety disorders, personality disorders, and adjustment disorders
Responsibilities:
- Individual therapy (to include treatment planning and crisis assessment)

- Performing a wide variety of assessments that are court-ordered or referred by community supervision officers
- Lead an open format, substance abuse group for court-mandated probationers

Modalities: Motivational Interviewing, Dialectical Behavior Therapy, Cognitive-Behavioral Therapy, parenting skills, supportive counseling
Supervisor: Darryl Johnson, Ph.D.

**August 2016
– Current**

TEAM Forensic Services LLC, Sex Offender Treatment Program

Student Clinician and Co-Therapist – Livingston, Conroe, & Huntsville, TX

Setting: Rural, primarily low-income, private practice offices

Population: Ethnically diverse, adult, male and female populations on probation and parole for sexual offenses

Responsibilities:

- Co-facilitated bi-monthly, mandated, manualized group treatment with a Licensed Sex Offender Treatment Provider (2 male groups, 1 female group)
- Provided individual psychotherapy for group members whose needs extended beyond the group context (authored intake reports and treatment plans)
- Participated in external social support and chaperon training meetings
- Consulted with probation officers on group members' progress

Modalities: Cognitive-Behavioral Therapy, Dialectical Behavior Therapy, supportive counseling, grief counseling

Supervisor: Holly Miller, Ph.D., LSOTP

**August 2016
– September
2017**

Texas A&M Telehealth Counseling Clinic

Student Practicum Clinician – College Station, TX

Setting: Located on Texas A&M campus, we serviced several small counties with limited access mental health care through a telepsychology platform (video and phone)

Population: Rural/underserved, low-income, ethnically diverse adults with mood and anxiety disorders, personality disorders, trauma-related disorders, and adjustment disorders

Responsibilities:

- Provided 8-week, in-person, group therapy mindfulness protocols for meditation for depression/trauma/anxiety
- Individual psychotherapy (including suicide risk assessment, treatment planning)
- Authored intake and termination reports, formulated case conceptualizations and diagnoses, corresponded and provided progress summary reports for clients' disability services
- Participated in clinical case conferences

Modalities: Dialectical Behavior Therapy, Cognitive-Behavioral Therapy, STAIR-NST, supportive counseling, grief counseling, also included use of smartphone applications to facilitate treatment goals

Supervisors: Carly McCord, Ph.D. & Meredith Williamson, Ph.D.

- August 2015 – December 2016** **Dr. Angie Hays, Private Practice**
 Psychology Practicum Intern – Conroe, TX
Setting: Private practice setting in-person and over a telepsychology platform
Population: Ethnically diverse, adults and children of mixed incomes, and a veteran population; clients suffered from persistent and serious mental illness, trauma and adjustment-related disorders, mood and anxiety disorders, personality disorders, chronic pain
Responsibilities:
- Conducted evaluations for the Department of Disability Services (disability for mental health reasons and mental health related to chronic pain)
 - Assisted in ADHD, Autism Spectrum, and gifted/”twice exceptional” evaluations
 - Conducted disability service evaluations for military veterans through a telepsychology platform
- Supervisor: Angie P. Hays, Ph.D.
-
- October 2015** **Jorge G. Varela, Private Contractor, Texas Department of Criminal Justice**
 Student Forensic Evaluator – Huntsville, TX
Setting: State correctional facility
Population: African American, adult, male offender convicted of several sexual offenses
Responsibilities:
- Participated in a behavioral abnormality and risk assessment of an inmate considered for civil commitment as a Sexually Violent Predator
 - Assisted with administration, scoring, and interpretation of actuarial risk assessment and psychopathy measures
 - Formulated case conceptualization and diagnoses, and assisted with written report
- Supervisor: Jorge G. Varela, Ph.D.
-
- August 2015 – Present** **Psychological Services Center**
 Student Forensic Evaluator – Huntsville, TX
Setting: Detention centers or outpatient clinic, primarily rural counties
Population: Ethnically diverse, adult and adolescent, justice-involved
Responsibilities:
- Conducted court-ordered or probation-referred psychodiagnostic evaluations of justice-involved youth and adults referred from mental health court
 - Conducted court-ordered, pre-trial evaluations under the direct supervision of a board-certified forensic examiner
 - *Adult:* Competency to Stand Trial, Mental State at the Time of the Offense
 - *Juvenile:* Fitness to Proceed, Criminal Responsibility
 - Authored reports describing evaluation, providing psycholegal opinions, and providing treatment recommendations

Supervisors: Darryl Johnson, Ph.D.; Wendy Elliott, Ph.D.; Mary Alice Conroy, Ph.D., ABPP

August 2014
– Present

Psychological Services Center

Student Clinician – Huntsville, TX

Setting: Community mental health, primarily rural, low-income

Population: Ethnically diverse, adult, adolescents, and child; diagnoses of persistent serious mental illness, personality disorders, mood and anxiety disorders, trauma-related pathology, family and academic stress

Responsibilities:

- Conducted intake evaluations, treatment planning sessions, and delivered individual psychotherapy
- Conducted comprehensive psychodiagnostic and psychoeducational evaluations
- Attended and participated in group supervision and clinical case presentations

Modalities: Dialectical Behavior Therapy (adult and adolescent protocols), Cognitive-Behavioral Therapy, Emotion-Focused Therapy, supportive counseling, grief counseling

Supervisors: Jorge G. Varela, Ph.D.; Adam T. Schmidt, Ph.D.; Craig E. Henderson, Ph.D.; David V. Nelson, Ph.D., ABPP, Wendy Elliott, Ph.D.; Darryl Johnson, Ph.D.

September 2012 –
March 2013

Undergraduate Recreational Therapy & Psychotherapist Intern

Albert Einstein Medical Center & Belmont Behavioral Hospital – Philadelphia, PA

Setting: Urban inpatient/acute care hospital and behavioral healthcare campus

Population: Ethnically diverse adults and adolescents with persistent serious mental illness, mood and anxiety disorders, and eating disorders

Responsibilities:

- Provided daily recreational therapy to inpatient adults and adolescents
- Assisted in group activities lead by music, art, and horticultural therapists
- Participated in treatment team meetings and case conferences

Supervisors: Virginia Reed, M.A.

SUPERVISORY EXPERIENCE

August 2015
– Current

Capstone Practicum Course Peer Supervisor

Sam Houston State University – Huntsville, TX

Setting/Population: Junior doctoral student clinicians conducting psychotherapy and psychoeducational evaluations in a community mental health clinic; clients were low-income, rural, culturally diverse adults with mood and anxiety disorders, learning disorders, and family and academic stress

Responsibilities:

- Co-facilitated supervision sessions with a licensed staff psychologist
- Reviewed therapy and assessment session videos with supervisees
- Reviewed and provided feedback on clinical documentation, integrated reports, and case presentation materials for the Capstone comprehensive exam

Supervisors: Craig E. Henderson, Ph.D. & Darryl Johnson, Ph.D.

**January
2017 – May
2017**

Psychotherapy Course Peer Supervisor

Sam Houston State University – Huntsville, TX

Setting/Population: First-year doctoral students learning psychotherapy modalities and theoretical orientations; students would practice mock therapeutic interventions on classmates and meet with peer supervisors for feedback

Responsibilities:

- Facilitated supervision sessions with students enrolled in Psychotherapy course
- Tape review of mock sessions, and provided feedback on therapeutic techniques

Supervisor: Craig Henderson, Ph.D.

TEACHING EXPERIENCE

**January
2017 – May
2017**

Developmental Psychology – Graduate Teaching Assistant/Instructor

Sam Houston State University – Huntsville, TX

Undergraduate Course (PSYC 3374)

Responsibilities:

- Designed course syllabus and course material
- Designed and graded course projects, quizzes, and exams

Department Chair: Christopher Wilson, Ph.D.

**January
2015 – May
2016**

Introduction to Psychology – Graduate Teaching Assistant/Instructor

Sam Houston State University – Huntsville, TX

Undergraduate Course (PSYC 1301)

Responsibilities:

- Designed course syllabus and course material
- Designed and graded course projects, quizzes, and exams

Department Chair: Christopher Wilson, Ph.D.

**May 2015 –
August 2015**

Abnormal Psychology – Graduate Teaching Assistant

Sam Houston State University – Huntsville, TX

Undergraduate Course (PSYC 3331)

Responsibilities:

- Assisted in constructing syllabus, course material, and class projects
- Assisted in grading course projects and student presentations
- Managed online course page and materials

- Provided guest lecture on *Substance Use Disorders and the DSM-5* and facilitated related classroom discussion

Course Instructor: Adam T. Schmidt, Ph.D.

**November
2013 –
September
2015**

Special Topics Lecturer & Guest Lecturer

Undergraduate Courses

Sam Houston State University – Huntsville, TX

Responsibilities:

- Prepared lectures for the following courses on the following topics:
 - Introduction to Criminal Justice – *Mental Health and the Criminal Justice System* (Special Topics Lecturer; September, 2015)
 - Introduction to Psychology – *Motivation and Emotion* (Guest Lecturer; March 2015)
 - Introduction to Psychology – *Gross Neuroanatomy* (Guest Lecturer; January 2015)
 - Introduction to Psychology – *Neurons, Synapses, and Axons! Oh My! Studying the Small Bits of the Brain and Nervous System* (Guest Lecturer, January 2015)
 - Victims and Violence Special Topics Course – *Punishment Options and Alternatives for Offenders* (Special Topics Lecturer; November 2014)
 - Introduction to Psychology – *Social Psychology Experiments that Rocked the World* (Guest Lecturer; November, 2014; October, 2014; March, 2014; November, 2013)

RESEARCH

**January
2017 -
Present**

Know Where You Are to Guide Where You're Going: A Survey of Risk-Need-Responsivity Treatment Practices in Juvenile Correctional Programs
(Principle Investigator)

Sam Houston State University – Huntsville, TX

Dissertation Chair: Craig E. Henderson, Ph.D.

- Designed project exploring the degree to which juvenile substance abuse treatment programs adhered to a Risk-Needs-Responsivity framework and adhered to empirically-supported treatment protocols
- Obtained data from the National Institute on Drug Abuse's Criminal Justice Drug Abuse Treatment Studies (CJ-DATS) cooperative

**May 2016 –
Present**

Graduate Research Assistant

Sam Houston State University – Huntsville, TX

Supervisor: Craig E. Henderson, Ph.D.

Research:

- *A Longitudinal Exploration of Life and Training Stress on Recovery* – Co-Principal Investigator (September 2016 – Present)

- *A Descriptive Analysis of the Psychological Functioning of Professional Ironman Triathletes* – Principal Investigator (May 2016 – September 2016)

April 2016 – Present **Graduate Research Assistant**
 Center for Research and Training at Pirelli Clinical and Forensic Psychology – Verona, NJ
Supervisor: Gianni Pirelli, Ph.D.
Research:

- Aiding to develop measures of firearms competency and knowledge
- Aims to assess professionals' ability and willingness to conduct mental health evaluations for firearms permits

September 2013 – May 2016 **Graduate Research Assistant**
 Sam Houston State University – Huntsville, TX
Supervisor: Adam T. Schmidt, Ph.D.
Research:

- *Behavioral Genetic Evidence in the Criminal Justice System: A Case Law Review* – Research Mentor and Co-Principal Investigator (August 2015 – December 2015)
- *Studying the Impacts of Affective Priming on Transient Personality Change* – Principal Investigator (August 2015 – January 2016)
- *Examining Risk and Resilience Factors in Children of Families with an Incarcerated Parent* – Co-Principal Investigator (October 2013 – January 2016)

September 2014 – May 2015 ***Nothing Will Work Unless You Do: Studying Employment Outcomes of Offenders and Non-Offenders* (Principle Investigator)**
 Sam Houston State University – Huntsville, TX
Thesis Chair: Adam T. Schmidt, Ph.D.

- Designed a study to examine differences between offender and non-offender graduates of a vocational training program
- Facilitated data acquisition from data source, created study database out of existing data, oversaw data coding and created data dictionary for research assistants
- Obtained data from the Work Faith Connection in Houston, TX

January 2012 – June 2013 **Undergraduate Research Assistant**
 Drexel University – Philadelphia, PA
Supervisor: David DeMatteo, Ph.D.
Research:

- *The Role and Reliability of the Psychopathy Checklist-Revised in U.S. Sexually Violent Predator Evaluations: A Case Law Survey* – Undergraduate Research Assistant (August 2015 – December 2015)
- Also assisted graduate students within the lab with various thesis, dissertation, and research projects (literature reviews, coding, etc.)
- Co-reviewed publications submitted for peer review to *Law & Human Behavior*, under direct supervision of Dr. David DeMatteo

PUBLICATIONS

- Published** **Formon, D. L.**, Schmidt, A. T., & Henderson, C. (in press). Examining employment outcomes of offender and non-offender vocational program graduates. *International Journal of Offender Therapy and Comparative Criminology*. doi: 10.1177/0306624X17735041
- DeMatteo, D., Edens, J. F., Galloway, M., Cox, J., Smith, S.T., & **Formon, D.** (2014). The role and reliability of the Psychopathy Checklist-Revised in U.S. sexually violent predator evaluations: A case law survey. *Law and Human Behavior*, 38(3), 248-255. doi: 10.1037/lhb0000059
- Formon, D.** (2012). Bruises, costumes, auditions, and quick changes – Dancers as a subculture? *The 33rd*. Philadelphia, PA: Drexel Publishing Group.
- In Preparation** Schmidt, A. T., Biekman, B. A., Wilde, E. A., Chu, Z., Hanten, G., **Formon, D. L.**, & Levin, H. S. *Diffusion tensor imaging correlates of resilience following adolescent traumatic brain injury*.

CONFERENCE PRESENTATIONS

- Formon, D. L.**, Yenne, E., & Schmidt, A. T. (2017, August). *Child and caregiver perceptions of prison stigma: A pilot study of children with incarcerated parents*. Paper presented at the APA Annual Conference. Washington, D.C.
- Hill, L., **Formon, D. L.**, Maloney, K., Schmidt, A. T. (2017, March). *The influence of trauma exposure on the development of externalizing and internalizing psychopathology in children of incarcerated parents*. Poster presented at the AP-LS Annual Conference, Seattle, WA.
- Beene, L., Schmidt, A. T., **Formon, D. L.** (2017, March). *Behavioral genetic evidence in the criminal justice system: A case law review*. Poster presented at the AP-LS Annual Conference, Seattle, WA.
- Kempker, S., **Formon, D. L.**, Bernhard, P. A., Bate, B. P., & Schmidt, A. T. (2016, April). *The Michael Brown affect: Impacts of race-related arrest footage on personality*. Poster presented at the meeting of the Southwestern Psychological Association, Dallas, TX.
- Formon, D. L.**, Bernhard, P. A., Kempker, S., Bate, B.P., & Schmidt, A. T. (2016, March). *Freaking out! The role of affective arousal in objective personality assessment: Implications for forensic assessment*. Poster session presented at the AP-LS Annual Conference. Atlanta, GA.

Formon, D. L., & Maloney, K. (2016, March). *Stigma, mental illness, and perception of gun violence*. Poster session presented at the AP-LS Annual Conference. Atlanta, GA.

Formon, D. L., Schmidt, A. T., Marshall, K., & Camins, J. S. (2015, August). *Dollars-and-cents differences in ex-offender employment outcomes*. Poster session to be presented at the APA Annual Conference. Toronto, Ontario.

Formon, D. L., Schmidt, A. T., Maloney, K., Schiafo, M., Schrantz, K. (2015, August). *Job hunting efforts in offender and non-offender completers of a community-based employment program*. Poster session to be presented at the APA Annual Conference. Toronto, Ontario.

Maloney, K. M., **Formon, D. L., Schmidt, A. T., Hanten, G. R., & Levin, H. S.** (2015, August). *Pre-Injury Disruptive Behavior Disorders Attenuate Executive Functioning Post-Traumatic Brain Injury*. Poster session to be presented at the APA Annual Conference. Toronto, Ontario.

Formon, D. L., Schmidt, A. T., Marshall, K., & Camins, J. S. (2015, February). *Dollars-and-cents differences in ex-offender employment outcomes*. Paper presented at Sam Houston State University 18th Annual Graduate Research Exchange. Huntsville, TX.

Formon, D. L., & DeMatteo, D. (2014, March). *The social consequences of being an offender with a mental illness*. Poster session presented at the AP-LS Annual Conference. New Orleans, LA.

Bitting, B., Boccaccini, M., **Formon, D. L., Gardner, B., & Vera, L.** (2014, March). *Validity of the Personality Assessment Inventory (PAI) coefficients of fit among offenders*. Poster session presented at the AP-LS Annual Conference. New Orleans, LA.

Formon, D. L., & DeMatteo, D. (2013, April). *The social consequences of being an offender with a mental illness*. Poster session presented at Drexel University Research Day. Philadelphia, PA.

Galloway, M. P, **Formon, D. L., & DeMatteo, D.** (2013, March). *A national survey of self-defense statutes: Stand Your Ground and the implications for battered women*. Poster session presented at the 2013 AP-LS Annual Conference. Portland, Oregon.

Formon, D. L., Grauman, J., & Parrott, P. (2012, April). *Stigma measurement to behavioral vignettes among college psychology majors*. Poster session presented at Drexel University College of Arts and Sciences Research Day. Philadelphia, PA.

PROFESSIONAL SERVICE & LEADERSHIP

May 2015 – August 2017 – **Communications Officer**
American Psychology-Law Society Student Committee

Responsibilities:

- Managing social media pages and posting daily material

- Assisting in student committee programming during the American Psychology-Law Society annual conventions
- Assisting in the creation of “Student Survival Guide” for annual conventions
- Organizing and designing r-shirts for student committee 5k fun run
- Writing for student committee column in American Psychology-Law Society newsletters

**May 2016 –
May 2017**

Student Co-Extern

Sam Houston Area Psychological Association

Responsibilities:

- Organized, advertised, and attended monthly meetings and professional development presentations/discussions
- Recorded and maintained business meeting minutes and other society documentation
- Acted as liaison between society members and society executive council
- Participated in conference workshop presentations on at the annual meeting of the Texas Psychological Association
- Engaged in outreach to community psychologists

**September
2014 –
September
2015**

Graduate Student Mentor

Psi Chi – Sam Houston State University

Responsibilities:

- Mentored Graduate School Admissions Committee
- Mentored Research Committee

**August 2014
– July 2015**

Student Representative

Clinical Psychology Doctoral Program – Sam Houston State University

Responsibilities:

- Attended weekly faculty meetings and recorded and communicated faculty and program business to student body
- Acted as liaison between students and faculty regarding faculty and program news and concerns and suggestions for program improvement
- Organized, administered, and communicated annual program review feedback from students to faculty and vice versa
- Coordinated and planned interview weekend for candidates for admission to the doctoral program

AWARDS

April 2017

Outstanding Graduate Student Award Nominee
Sam Houston State University, Office of Graduate Studies

November 2015	Outstanding Teaching Assistant Award Nominee Sam Houston State University, Office of Graduate Studies
May 2015	AP-LS Student Research Travel Award (\$500) Sam Houston State University, College of Humanities and Social Sciences
April 2015	Most Impactful Research, SHSU Graduate Research Exchange Sam Houston State University, College of Humanities and Social Sciences
August 2013	AP-LS Undergraduate Paper Award – First Place (\$250) Drexel University, College of Arts and Sciences
June 2012	Drexel Publishing Group Essay Contest – First Place (Social Sciences Category) Drexel University, Department of English and Philosophy

SEMINARS & TRAININGS

July 2017	<i>Motivational Interviewing: Clinical Training Workshop</i> Joseph Mignogna, Ph.D.
February 2017	<i>Privacy Rights: A Psychological Perspective</i> Megan Mooney, Ph.D.
November 2016	Working with International Students Annie Matthew, Psy.D.
October 2016	<i>Sunset Commission and Licensing boards: Ethical and Professional Issues</i> David White, CAE
September 2016	<i>An Overview of Psychiatric Medications, Indications, & Potential Side Effects</i> Barry Gritz, M.D.
April 2016	<i>Advancing Recidivism Reduction Efforts: The Risk-Need-Responsivity Simulation Tool</i> Faye Taxman, Ph.D.
March 2016	<i>The Role of Forensic Psychologists in Child Custody Issues</i> John Zervopoulos, J.D., Ph.D., ABPP
February 2016	<i>Caring for Our Veteran's Mental Health and the V.A.</i> Joseph Mignogna, Ph.D.
April 2015	<i>Callous-Unemotional Traits and Conduct Disorder: Implications for Understanding, Diagnosing, and Treating Antisocial Youth</i> Paul J. Frick, Ph.D.

August 2014 *Monthly Seminars on Clinical Supervision*
– **May 2015** Mary Alice Conroy, Ph.D., ABPP & Jorge G. Varela, Ph.D.

Specialty Coursework: Neuropsychology, Psychopharmacology, Group Therapy, Forensic Assessment I, Forensic Assessment II, Law and Social Psychology, Mental Health Law

PROFESSIONAL AFFILIATIONS

American Psychological Association – APAGS Student Member
American Psychology-Law Society – Member

GRANT WRITING EXPERIENCE

Perceptions of Blame and Stigmatization Toward Parents of Children with Mental Health Issues
Violet and Cyril Franks Scholarship (\$5,000)