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Mini Review

Treatment of High-Risk High-Need Sexual Offenders: The Integrated Risk Need Responsivity Model (RNR-I)

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Abstract

The present article briefly describes the Integrated Risk-Need-Responsivity (RNR-I) Model developed by our team [1,2]. This model provides a contemporary perspective regarding the earlier RNR Model developed by Andrews & Bonta (1998, 2010) [3,4]. The original RNR Model did not account for research that has emerged over the last few decades indicating that a history of serious mental illness represents a risk factor for sexual offence recidivism among convicted sexual offenders. As well, issues associated with complex trauma were not incorporated into the original RNR model. Research in support of the RNR-I Model will be discussed as will case examples that illustrate some of the issues raised by the model.

INTRODUCTION

The very influential Risk-Need-Responsivity (RNR) Model introduced by Andrews & Bonta (1998, 2010) [3,4] has received a great deal of empirical support in the literature. Although a comprehensive review of this model is beyond the scope of this [5,6] a brief summary is necessary. Andrews & Bonta (1998, 2010) [3,4] suggest that offender assessment and treatment be based on the RNR principles. In specific, they argue that risk of recidivism should be assessed by means of actuarial instruments and that treatment efforts should be directed towards higher risk clients. With reference to need these authors are referring to criminogenic needs, that is, domains that have been associated with recidivism in the empirical literature. These authors describe the "Big 8" criminogenic needs; 1.History of antisocial behavior, 2.criminal personality, 3. criminal associates, 4.criminal attitudes, 5.substance abuse, 6.problematic circumstances at home (marital/family), 7.problematic circumstances at school or work, and 8.few if any positive leisure activities. By responsivity Andrews & Bonta (1998, 2010) [3,4] imply that treatment should be delivered in a manner that is consistent with the learning style of offenders. Typically these approaches should be concrete and cognitive-behavioural in orientatio. Although issues associated with motivational interviewing are raised by Andrews & Bonta (2010) [4] the responsivity aspect of the model has received comparatively little attention by proponents of the RNR perspective.

Recently, we have proposed that a newer approach be adopted by clinicians working with moderate and high-risk groups of offenders. We have called this new approach the integrated RNR model (RNR-I) [1,2]. One of the core assumptions of this model is that both issues associated with criminogenic need (the Big 8) and serious mental illness (SMI) need to be incorporated into the contemporary management of moderate to high-risk groups of offenders. We have also argued that, given the frequent histories of physical, emotional, and sexual abuse among such groups of offenders issues associated with what has been called complex trauma [7] need to be included in any comprehensive model of offender treatment.

With reference to mental illness, our team have demonstrated in a variety of studies that more serious forms of mental illness are related to increased rates of recidivism. Using a sample of high-risk sexual offenders, observed that neither a paraphilic diagnosis (i.e., sexual deviation) alone nor a diagnosis of personality disorder significantly increased risk of recidivism [8]; however, those offenders with both a personality disorder and a paraphilic diagnosis were twice as likely to recidivate sexually (9.6% vs. 20.6% respectively, N=188). More recently, we have shown [9] that, after controlling for actuarially assessed risk among a group of high-risk sexual offenders, only having had a history of psychiatric impairment significantly added to the prediction of recidivism. A number of psychometric scales related to such factors as deviant sexual interests failed to substantially increase prediction after accounting for actuarially assessed risk.

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These data are in keeping with the conclusions of a number of authors who have commented on the over representation of mentally ill persons in the criminal justice system and the fact that the criminal justice system is increasingly becoming the primary institutional contact for mentally ill persons [10-12]. A variety of meta-analytic data also demonstrates that serious mental illness may either be directly related to recidivism among offender populations [13] or indirectly related to recidivism via the impact of such factors have on program attrition [14]. Unfortunately, to date there have been few programs that have been shown to be effective at reducing rates of recidivism that have incorporated factors associated with both complex mental health histories and more traditional criminogenic needs.

Our team has conducted a number of outcome studies which have demonstrated that this more comprehensive approach to treatment is associated with significant reductions in recidivism [2,5,6]. At the Regional Treatment Sex Offender Treatment Program (RTCSOTP) we have incorporated individual and group based approaches that address both traditional criminogenic needs and issues associated with SMI. With reference to SMI, treatment targets may include such diverse topics as symptom management, management of negative emotionality and the role that chronic mental illness may play in the development of longstanding patterns of criminal behavior. Further, an emphasis is placed on helping clients understand how a variety of factors may interact in their lives to result in one or more criminal offences.

Clients attending our programs are counselled that they must learn strategies to address both internal and external high-risk situations. Internal high-risk situations consist of thoughts or feelings that, if present, may increase a client's risk of recidivism. Deviant fantasies in the case of sexual offenders, anger and loneliness may all be considered internal high risk situations for some of the clients with whom we work for example. These issues may also be associated with the presence of external high-risk situations. External high-risk situations include persons, places or situations that may represent an increased risk of recidivism. For example, when clients have a history of alcohol use that is associated with criminal behavior their going to a bar may constitute an external high-risk situation.

Of course, clients may be more likely to be tempted to drink when feeling lonely or depressed. In this way both internal and external risk factors work in a synergistic fashion. Internal high-risk situations do not always precede external high-risk situations, however. Clients may, for example, have a drink and then come to believe that they cannot control their intake of alcohol. This may result in feelings of depression or anxiety. Such feelings are typically associated with an increased likelihood of relapse to ongoing drinking behavior.

Although contemporary treatment programs that use cognitive-behavioural strategies have been shown to reduce rates of recidivism, effect sizes associated with these programs tend to be small to, at best, moderate. We believe that approaches such as the RNR-I may represent a way forward where further reductions in recidivism may be observed. Such approaches require a multi-modal approach where professionals from a variety of disciplines are involved in the assessment and treatment process.

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