Risk-need-responsivity model: Contrasting criminogenic and noncriminogenic needs in high and low risk juvenile offenders

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ABSTRACT

The Risk-Need-Responsivity (RNR) offender rehabilitation model contends high risk offenders benefit more from intervention programs than low risk offenders (risk principle), and interventions are more effective if they target criminogenic needs (need principle) and engage offenders. A field study was undertaken in order to assess the relation between the risk of recidivism (high and low) and criminogenic and noncriminogenic needs in juvenile offenders. 101 juvenile offenders classified as either of high or low recidivism risk on the Youth level of Service/Case Management Inventory (YLS/CMI) were evaluated in terms of school failure, behavioural disorders, psychological adjustment, and social skills. The results showed higher rates of school failure and behavioural disorders (criminogenic needs) in high risk than in low risk juvenile offenders, and higher rates in low risk offenders than in the general population. As for psychological adjustment and social skills (noncriminogenic needs), the results revealed higher deficits in high risk than in low risk juvenile offenders, and no differences between low risk offenders and the general population. The theoretical and practical implications of the results are discussed.

1. Introduction

Problems associated in the literature to maladjustment, the risk of maladjustment, and ongoing maladjustment (Amato, 2001; American Psychiatric Association [APA], 2013; Cottle, Lee, & Heilbrun, 2001; Seijo, Fariña, Corras, Novo, & Arce, 2016) include internalizing (i.e., psychological adjustment); externalising symptoms (i.e., behavioural disorders, school failure); and social competence (i.e., poor social skills). These domains fall under the domain of dynamic factors i.e., they can be modified and are responsive to intervention. Thus, both internalizing and externalising symptoms and social competence (needs) should be the target of juvenile offender rehabilitation programs. The Risk-Need-Responsivity [RNR] model, which has become the most predominant offender rehabilitation model worldwide (Andrews & Bonta, 2010), distinguishes between criminogenic and noncriminogenic needs on the basis that the former have a direct impact on recidivism rates whereas the latter do not. Hence, intervention models should target criminogenic needs given that noncriminogenic needs fail to reduce recidivism rates. For example, Andrews and Bonta (2010) highlight that raising self-esteem (noncriminogenic need) may promote self-confidence and self-satisfaction, but does not in itself reduce recidivism rates.

The RNR offender rehabilitation model, initially intended for community-based interventions and later extended to interventions in other institutions, is regarded as the best empirically supported model and is underpinned by a robust theoretical framework (Andrews & Dowden, 2006; Hanson, Bourgon, Helmus, & Hodgson, 2009; Hanson & Morton-Bourgon, 2005; Koehler, Lösel, Akoensi, & Humphreys, 2013; Landenberger & Lipsey, 2005; Lipsey & Cullen, 2007). However, the model is subject to certain limitations that should be borne in mind. First, the model lacks internal consistency, fertility, explanatory depth, and external validity, but these limitations are not inexorable and the model can be reconstructed to overcome these shortcomings (Ward, Melser, & Yates, 2007).

Second, the measure of the efficacy of the intervention is not appropriate i.e., recidivism alone is not a reliable measure of the efficacy of the intervention owing to the different measures employed (i.e., police records, convictions, victim self-reports, victimization/self-report surveys), giving rise to inconsistent measures, and overestimated official records of recidivism and intervention outcomes (Arias, Arce, & Vilariño, 2013; Cala, Trigo, & Saavedra, 2016; Novo, Herbón, & Amado, 2016). Indeed, most recidivism goes unreported and thus undetected. Moreover, the most frequent measure of recidivism, i.e., official records, require a considerable lapse in time before recidivism is detected. Thus, the efficacy of an intervention is substantially overrated, leading to the model being poorly evaluated.

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Third, the assumption of a clinical treatment model for offenders who are not real clinical patients is intrinsically flawed. This assumption entails a double internal inconsistency underpinning the model: clinical intervention models for offender rehabilitation tend to measure efficacy in terms of modifying cognition (cognitive distortions) and not recidivism, which contradicts the responsivity principle. Succinctly, the main aim is to implicate the offender in the intervention, but labelling offenders patients and designating them clinical cases endorses false treatment adherence and progress, and in turn recidivism (i.e., the principle underlying clinical models is that offenders are not responsible for their acts due to their illness).

Fourth, disregarding noncriminogenic needs is regarded to be a major weakness undermining interventions, and several studies have linked noncriminogenic needs to recidivism (Maruna, 2004). Though noncriminogenic needs may not account for recidivism, they do act as inhibitors of recidivism (Novo, Fariña, Seijo, & Arce, 2012), and should be targeted by interventions. Furthermore, psychological adjustment is regarded to be an indirect and uncontaminated indicator of the efficacy of an intervention. Besides being a measure of the intervention, it also serves to control the lack of treatment adherence or false progress i.e., malingering, which proceeds differential diagnosis in forensic settings, particularly in antisocial and psychopathic populations (American Psychiatric Association, 2013).

Fifth, the literature has clearly underscored that the needs or deficits of offenders vary according to the risk level, with the relation between needs or deficits and risk escalating with the level of development, that is, deficits and needs gradually increase with development (Arce, Seijo, Fariña, & Mohamed-Mohand, 2010; Hawley, 2003; Maughan, Pickles, Rowe, Costello, & Angold, 2000). Notwithstanding, though it may be logical to assume that varying levels of risk require different degrees of treatment, the RNR model claims intervention is more efficacious in high risk offenders. This assertion is based on the findings of meta-analytical reviews that do not substantiate this view (not all of the studies arrive at the same conclusion; Hanson et al., 2009). This claim is also dubious since low risk offender interventions do not implement the same treatments as high risk offender interventions i.e., treatment is adapted to meet the criminogenic needs, characteristics, and learning styles of offenders (principle of responsivity). Thus, high risk offenders undergo intensive treatment, whereas low risk offenders are exposed to minor or no intervention at all (Hanson et al., 2009). Furthermore, there is no reliable classification of the level of risk. The offender's criminal record is the standard classification criteria for distinguishing between first time offenders and reoffenders (Andrews & Dowden, 2006; Dowden, 1998; Hanson et al., 2009), but in many cases the distinction is based on inferring from descriptions of participants in primary studies or according to the degree of the intervention (low intensity is classified as low risk, and high intensity as high risk), or on the basis of the recidivism rates of comparison groups (Landenberger & Lipsey, 2005). Moreover, descriptors are often imprecise and subsequent classifications are unreliable leading to offenders being arbitrarily assigned to a low risk level if they are not designated to a high risk level. Thus, all offenders in a given intervention are allocated to the same risk level and assumed to share the same needs and risk level in the same study (Andrews & Dowden, 2006), which is highly improbable. Moreover, the comparison of the results obtained in the intervention in terms of the recidivism rates of high and low risk offenders with control groups, without considering the different recidivism base rates in each condition, magnifies the results for high risk offenders and minimizes them for low risk offenders. In short, data analysis designs and classifications inflate the intervention outcomes applied to high risk offenders (Hanson et al., 2009). Paradoxically, this appears to overlook that (high risk) reoffenders were in the past first time (low risk) offenders, which leads to the follow-up question as to whether we should wait until first time offenders become reoffenders before we intervene as the former are classified low risk (one of the interpretations of the risk principle is recommending intervention only in high

risk cases) or because offenders do not exhibit sufficient deficits or needs (being first time offenders) for treatment to be effective. Moreover, most meta-analyses endorsing the risk principle, save a few (Hanson et al., 2009), do no support this viewpoint. Indeed, the meta-analyses appear to confuse the fact that the effect is significant in high risk offenders but not so in low risk offenders with the effect being significantly higher in high risk groups. The statistical data available (Koehler et al., 2013; Schmucker & Lösel, 2015), do not confirm this superiority (95% confidence interval for the average effect sizes of the high and low risk offender interventions overlapped, meaning intervention efficacy between both groups was comparable). In addition to the previously mentioned lack of predictor reliability, the results were not accurate as the reviewed meta-analyses did not inform about the control of predictor and criterion unreliability as well as the sampling error i.e., the effects are not true effect sizes (Hunter & Schmidt, 2015). Nevertheless, if the meta-analytical reviews are valid, one may conclude that intervention is significant in high risk offenders, but not so in low risk offenders (but this does not imply that it is significantly higher than in low risk offenders), and the intervention with low risk offenders (little or no intervention) is ineffective, which underscores the need for greater precision through the efficacious adjustment of the principle of responsivity. To conclude the intervention is efficacious with high risk offenders and inefficacious with low risk offenders is not only contra natura [high risk offenders (reoffenders) at one time in the past were low risk offenders i.e., primary]; meanwhile, there is no reliable evidence supporting such a claim. Hence, this conclusion is unfounded.

As for the adherence of rehabilitation interventions to the set of RNR principles, the evidence available is subject to the same shortcoming. Though the mean effects of the meta-analyses were significant for the RNR principles, there were no differences between the mean effect sizes (overlapping mean confidence intervals) according to the level of adherence (none, one, two, and three principles), or the level of adherence (low, medium, high) to assess the principles of the model. Thus, the type of treatment administered, in particular in behavioural, cognitive behavioural, and multisystemic therapy, explains the same efficacy as the RNR (Hanson et al., 2009; Koehler et al., 2013). The high correlation between treatment type and the classification of studies on high adherence to the RNR model led Koehler et al. to underscore that both factors may be mutually confused. Nevertheless, adjusting interventions to meet the needs of offenders (need principle) is unquestionable i.e., interventions failing to target the needs of offenders simply lack substance. However, limiting interventions to criminogenic needs (i.e., history of antisocial behavior, antisocial personality pattern, antisocial cognition, antisocial associates, family/marital circumstances, school/work, leisure/recreation, substance abuse), and disregarding noncriminogenic needs (e.g., negation, little empathy for the victim, psychological adjustment, deficits in social skills; Hanson & Morton-Bourgon, 2004, 2005) may be a form of reductionism that undermines the efficacy of an intervention i.e., though they may not be the underlying causes of recidivism, they may serve as protective factors against recidivism. As for adjusting the intervention to the offender's learning abilities (responsivity principle), its validity is so evident that no evidence is required to support this issue. Hence, the RNR model rather than an intervention model appears to be a model of favourable conditions for an efficacious rehabilitation intervention (high correlation between treatment type and intervention efficacy).

Bearing this in mind, a field study was undertaken to assess the relation between the risk of criminal recidivism (high and low) and criminogenic or noncriminogenic needs in juvenile offenders by evaluating one of the fundamental strengths of the RNR model i.e., the relation between criminogenic needs and risk, and one of the reported weaknesses i.e., the relation between noncriminogenic needs and risk that are not targeted in the intervention.