- **Steven Diehl**

  00:00:37

  Hello, everyone. It's now 2 Pm. Eastern time. You've joined the Justice and Mental health collaboration program field, wide Webinar, on understanding the expanded risk need responsibility, model supervision, programming and dosage

- to allow for additional sign in past the hour. We're going to be starting this webinar in a few minutes. Thanks.
- Alright, Looks like it's slowing down for people coming in. So i'm gonna get started. Good afternoon and thank you for joining today's justice and mental health collaboration program field wide. Webinar, on understanding the expanded risk, need responsivity, model supervision, programming and dosage.
- My name is Steven Deal, and i'm a senior policy analyst here at the Council, State Government's Justice Center. I'll be moderating today's Webinar, which is hosted by the Us. Department of Justice, Bureau of Justice, Assistance, and the Council of State Governments Justice Center
- next slide.
- and to just give you an overview of today's Webinar. First, we'll do introductions of our speakers.
- You'll hear a presentation about the overarching principles of the R. Andr model, including the 18 components of the expanded model and guidelines for accurate, fair, and transparent on our assessment, and towards the end of the Webinar we'll have some time for questions and answers
- at any time during the Webinar. You can ask a question by clicking on the Q. A. Button on the bottom of the screen and entering your question.
- This includes both technical and content related questions. We'll try to reply to technical questions in the chat as we go for the content, related questions. We'll keep a running list and address them at the end of the Webinar. We'll do our best to get through as many questions as possible, and if you encounter
- technical or audio problems during this Webinar, please click on that link that we shared within the chat
- is understand that there are some technical issues we may not be able to resolve, but we are recording the Webinar, and we'll post it along with the Powerpoint slides on our website within one to 2 weeks.
- Next slide.
- Today's presenters are David, a. Diamora who is a senior policy Adviser with the Council, State Government's Justice Center.
- Myself and Maria Fryer. Justice Systems and Mental Health Policy Advisors Substance, Abuse and Mental Health Bureau of Justice, Assistance with the Us. Department of Justice
- and the next slide I am going to kick to her.

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  **Maria Fryer**

  00:05:22

Great

- Thank you, Stephen. Welcome everyone today to this Webinar. We're really happy to have you just a little bit about the office of Justice pro justice programs, and where the Burea of Justice Assistance
- s in this office, and you can see the Bureau of Justice. Assistance is located within the office of Justice Programs we call Ojp
- and Ojp provides a wide range of services to the Criminal justice community and the form of Grants training, technical assistance and research. And you can see within the Ojp we have Bj. A. Our sister organization that collects statistical information, Vjs.
- Nij. The National Institute of Justice.
- the office for Victims of Crime, Ojdp, that works with juvenile justice and delinquency, prevention and then the smart office
- next one.
- So a little bit about Bj. A. In our mission which is to provide leadership and services and grant administration and criminal justice, policy, development to support state, local and tribal justice strategies to achieve safer communities.
- Dja works with communities, governments and nonprofit organizations to reduce crime, recidivism and unnecessary confinement and promote a safe and fair criminal justice system.
- Specifically, Bja provides funding to support law enforcement, combat, violent and drug-related crime and combat victimization
- through the development and implementation of policy services and sound grant management. Bja strengthens the nation's criminal justice system and restores security and community
- next slide.
- So this is our director, Carlton Moore. He was appointed by President Biden in February of 2,022
- and Director Moore leads the Bj a programmatic and policy efforts on providing a wide range of resources, including the training and technical assistance I mentioned to law enforcement, courts, corrections, treatment reentry.
- justice, information, sharing community-based partners.
- and he does travel quite a bit around the country to speak to states and tribes and local communities, and to talk about our partnership, and how we're through our grants and technical assistance, improving safety and reducing recidivism
- next one.
- So the 5 major strategic focus areas
- on the Ibja. On this slide you can read more about the 5 primary strategic focus areas, many of which relate directly to the work in direct programs that Bja ministers
- and these include a strategic focus on building trust and ensuring effective criminal justice systems, reducing recidivism, as I mentioned.
- and unnecessary attacks, with the criminal justice system as well as utilization of evidence-based strategies.
- increasing program effectiveness and ensuring organizational excellence.
- Next up

- and again, these are the 4 areas that Bja focuses on with our collaborative partners, such as the Council of State Government Justice Center.

**Unknown Speaker**

00:08:51

Okay.

**Unknown Speaker**

00:08:54

Okay. So many

**Maria Fryer**

00:08:55

kick it back over to CST: Thank you so much for being with us today, and we hope to see you in future. Webinars. Thank you.

**Steven Diehl**

00:09:05

Thank you, Maria. I'm going to give some background on the Council State Governments Justice Center. The Justice Center is a national nonprofit, nonpartisan organization that combines the power of Membership association representing State officials and all 3 branches of government

- with policy with the expertise of a policy and research team focus on assisting others to attain measurable results. Our staff develops research, driven strategies to increase public safety and strengthen communities.
- Next slide.
- How we work is bringing people together and driving the criminal justice field forward with original research, building momentum for policy, change and providing expert assistance to the field.

- Next slide.
- Lower our goals.
- Oh, sorry! Can you jump back? One is, Thank you.
- Lower our goals for breaking the cycle of incarceration, advancing health, opportunity and equity
- and using data to improve safety and justice in the field.
- Next slide
- the Council of State Government's Justice Center is committed to advancing racial equity internally and through our work with states, local communities and tribal nations.
- and next slide
- the Justice of Mental Health collaboration program, or Jm. Hcp, as we call it, was established in 2,005, and it's funding the training today for the field at large. Some of the attendees in this training may currently have a jam Hcp. Award, or may have received one previously.
- Next slide
- we're back to our presentation outline. So for our presentation I'm. Going to turn it over to David. A

**David D'Amora**

00:11:00

thanks, Steven. Hi, everybody, and good morning for those of you on the West coast. Good afternoon to the rest of you. I'm. Pleased to be able to chat with you this afternoon, and to talk about the risk, need responsibility, model.

- and risk a need assessment, and what we're going to do during this conversation is basically to talk about the 18 components of the expanded on our model on our has been around for a good 30 years now, and
- most people know R. Andr as in risk need responsibility, and they don't actually know the other components that are wrapped around all of that in terms of the expanded model. So we're going to go through all of these different areas
- when we get to the part of structural assessment in terms of assessing R. Andr. etc. We are going to take a slight detour, talk a bit more in depth specifically about risk, and needs assessment, and what the issues are around that.
- and then we will come back and complete the afternoon's. Conversation with program, delivery and self practices and organizational skills.

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Next slide, please.

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**David D'Amora**

00:12:13

There are 3 overarching principles in the risk need responsibility, model.

- The first one is respect for the person in the normative and the normative context. The second is the psychological theory that underpins it.
- and the third is general enhancement of crime. Prevention services next slide, please.
- So, looking first of all at the issue of respect for the person and the normative context. Services under this model are to be delivered with respect for the person.
- including respect for personal autonomy, being humane, ethical, just, legal and otherwise normative.
- It's important to understand this principle in the R. Andr model, particularly for those of us who work in or have worked in the behavioral health field.
- There have been times in the behavioral health field where there's been concerns about the R. And R. Model with it, being seen only as a criminal justice model, or being seen as a model that doesn't take into account the the needs for respect for personal autonomy, for
- humanity. But, in fact, when the model is done correctly, when there is fidelity to the model, those those needs, those issues are indeed met in our cornerstone of the model itself.
- Secondly, some norms may vary with the agencies or the particular settings within which the services are delivered. For example, agencies that are working with youth may be expected to show exceptional attention to education issues, and child protection Agencies working with women may be particularly expected to know trauma, informed treatment more so than perhaps other agencies might be expected to know that, and we could. We could sort of go on and on about a lot of different areas.
- And so it's important to understand that it's not a one. Size fits all, and that there are different knowledge components that are necessary within the model. And then, thirdly, mental health agencies in particular may attend to issues of personal well being. In in other words.
- one of the big arguments historically, was
- Well, R. Andr. Talks about criminogenic factors, and it talks about people that have high risk or needs that are criminogenic. But it ignores the other important components that actually isn't what the model was designed to do. What the model said was that intensity of treatment to deal with criminogenic factors is related to the degree of risk, and we'll come back to that.
- It never suggested that if people, for example, need housing or have food insecure or have significant mental health or substance use that are not. That's not related to the crime Substance use issues that they shouldn't be given access to those programs, or they shouldn't be given the supports
- it's giving the right support to the right people at the right time.

**Unknown Speaker**

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Next slide, please.

**David D'Amora**

00:15:11

Second principle has to do with psychological theory, which basically says that the programs need to be based on solid psychology, not pop psychology, not the flavor of the week, not a lot of quite frankly silly programs that we often see that take root in the criminal justice system.

- And so fundamentally, what it talks about is general personality and cognitive social learning, which is one of the reasons why we talk about code programming. And so there are 2 issues here. One is the issue of cognitive programming and lots of folks. If If if folks have a high criminogenic need.
- Cognitive programming is something is part of what needs to be given to them. And cognitive programming means things like thinking for a change, or it might mean something like reasoning and rehabilitation or decision points. There are a number of those programs that are out there that Don't necessarily require a clinician to provide that programming, and they were designed as such.
- In addition to that, there's cognitive behavioral treatment, and many of the individuals that we work with, of course, do need some type of mental health or substance use treatment.
- And, generally speaking, for this set of clients, the cognitive, the cognitive forms of treatment tend to be the most successful in terms of looking at outcomes.
- And then, thirdly, we don't want to forget about the issue of crime. Prevention. There needs to be general enhancement. We we certainly do want to have a do want to have a reduction of victimization. That's a legitimate objective of service agencies which include both agencies within the judicial legal system, and outside of the judicial legal system. There, I I would argue, there's nobody that works in any human service whose goal is to not worry about crime. Prevention.
- We all want to make sure that the people that we're working with are as healthy as possible, and by definition, if they're as healthy as possible. The the likelihood of them committing crime drops dramatically
- next slide, please.
- So we'll talk now in terms of an overview of the chromogenic risk data, responsibility model. and go through those different components that I was just mentioning at the beginning.
- So next slide, please.

- So, first of all, let's just talk about the thing that most of us probably have heard. If we've been in the field for a while, which is the the middle part of that right risk need, and a responsibility
- risk in this model is the probability of an event occurring
- to be clear. Risk does not mean harmfulness or seriousness of the event.
- or violence or dangerousness. It means the probability of some type of recidivism. Maybe the probability of being arrested for a new crime, or convicted for a new crime, or possibly being returned to custody for a technical violation of violation that is not the result of new crime.
- and the idea behind the risk construct is that you want to match the level of service to the person's risk to reoffend. You want to provide those folks at moderate or high risk of reoffending with the cognitive programming that I was mentioning.
- And you want to keep low risk folks out of those services. First of all, we can't lower their risk anymore if they're already low risk. Second of all, mixing them with folks who have a less pro-social thinking and behaviors bad plan. We're not going to increase their strength. We're actually going to increase their risk, to offend or re offend by connecting them with others who are more likely to do so, and it's a waste of resources
- as well as an inappropriate use of the criminal legal system to respond to an issue. They may need mental health services. They may need some other services. Nobody's saying, Don't do that. But what we don't want to to do is have an intensity of services designed to lower criminogenic risk
- for those individuals who do not have a moderate or high level of criminogenic risk.
- One of my several so boxes that I will go on as we're talking is that one of the problems that has happened in our work
- is that we have over the course of the decades gotten a bit lazy, and we talk about risk.
- and we conflate risk with dangerousness, and we conflate risk with how rigid we need to be with individuals that wasn't what the construct was about. The construct of risk had to do with what's the intensity of service that is needed?
- Yes, supervision is one component. But supervision by itself does not, cannot, will not lower the risk of somebody's recidivism.
- The supervision is what we utilize hopefully when we do it well. What we utilize to have sort of a a temporary set of guardrails around someone, while they may not be able to make good decisions themselves.
- and the services that we then provide are those services to help them develop the ability to make pro-social or positive or good decisions themselves as opposed to somebody on the outside, saying, I'm going to make sure you behave, which fundamentally is not affected, and certainly by itself
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**Unknown Speaker**

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is not effective.

**David D'Amora**

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Next slide, please.

- The second has to do with criminogenic need. A criminogenic need also does not mean a risk of violence or a dangerousness, or factors that are historical and unchangeable.

**Unknown Speaker**

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There.

**David D'Amora**

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There are factors related to violence, and there are assessments related to violence, but the R. Andr. Model wasn't specifically developed to focus on violence. It was looking at what the potential for any new crime or new issue that would come up might be

- in addition. What it then looks at are what they call criminogenic needs, which is the dynamic factors of the dynamic characteristics that are associated with a person's risk of reoffending, and they include a number of different things that will go through in just a moment. But it is important to understand that
- when we are working with individuals who have these particular criminogenic needs. We have to respond to those, because if we don't, no matter what else we respond to, we will not lower their risk.
- Now there are times where we need to respond to other issues in order for them to benefit from the response to lower their criminogenic need. And again we'll come back to that
- next slide, please.
- Responsibility is the most important and sadly least understood component of the risk need responsibility, Model
- responsibility can be clinical syndrome. It can be impairments. It can be social service needs. They don't typically cause crime. They're there's not a direct relationship, a causal relationship, but they can certainly interfere with the individual

rehabilitation. If I don't know where I'm going to sleep tonight, i'm probably not going to be very good at getting my homework done. If I am starving. I probably am not going to be focusing on what are my cognitive distortions.

- So they are very important and and genuine issues, and needs that will have to be met. They fall under this bucket, if you will, of responsibility, and it includes, as I already mentioned.
- homelessness or serious or persistent mental illness, drug or alcohol cravings, withdrawal, ptsd traumatic grain, injury, and and many others.
- The concept of Mac of responsibility is to maximize the individual's ability to learn from a habilitative intervention
- by providing a cognitive behavioral program or intervention and tailoring that intervention to the person's learning style to their motivation, to their abilities and to their strengths. One of the other
- things that you see in terms of the failure to to, if have fidelity to the R. Andr. Model is that many programs want people
- to treat who already have decided that they need all of the help that they need.
- And so basically 60 of the work is already done in reality for the types of clients that we work with, given where they are in their lives. Given what the issues are, part of our job is actually engaging them and and working with them to increase their motivation for change.
- Now there are 2 components to responsibility.
- One is general, which is the use of cognitive social learning methods, as I've mentioned, to influence behavior.
- and the other is specific, and we've gotten pretty good at the general over the last 30 on years or so 40 years now we've gotten pretty good at that. We know it's cognitive programming. We know there's a variety of types of cognitive behavioral treatment that make a difference. We we we're really good at that. I mean. Generally speaking, we know what those things are.
- We have not done so well at specific responsibility. We have not done the well modifying strategies in accordance with the strengths and the motivations, and the readiness to change of the individuals or their particular personality issues or their mental status and learning ability. They're learning style.
- There's specific circumstances, cultural differences, racial and ethnic differences, demographics of individual cases. We've not done a good job about that. One of the
- one of the failures of a lot of what we've developed is that they've been developed by middle class, white folks.
- and you know not to pick on middle class white folks exactly. But the reality of it is that when you, when that's who's developing that. And you don't adapt to those things appropriately for folks who aren't in that same grouping.
- Then you aren't, giving people the things that they need, or giving them the things that will work the most effectively for them. And it is one of the things that it's only in the last decade we've begun to understand. It took us
- way too many years to figure that out, and we are still in the early. In my view, we are still in the early stages of making those adaptations and those changes. There are some very exciting things happening, but you do not see it consistently happening throughout the country. Yet
- next slide, please.

- So what about those major risk factors? What we historically called the Central 8? We now sort of. They're still called the central Central a, but in reality it's kind of the Big 7, and that's because the eighth one, or the number 1, one is a static factor. It has to do with criminal history
- has to do with issues around number of arrests, number of convictions, types of offenses, couple of things about that. This is one of those areas where concern valid concern is a reason about.
- Are we overestimating risk of some individuals because they are more likely to be arrested by virtue of nothing other than the color of their skin. And so that's a very valid issue which will come back to when we talk about risking age assessment.

**Unknown Speaker**

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But one of the reasons why it's in the separate or in the left hand box here

**David D'Amora**

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is that we can't do anything about that. Okay.

- if we want to look at that it may help make some determination about an initial level of intensity of service. But after that
- it's meaningless. Now let me sound odd. What I mean by that is for those of us who are supervising those individuals for those of us who are treating those individuals, whether that's through cognitive programming, mental health substance use whatever it is that we're providing
- the things that we can impact our
- are not the static factors. The things that we can impact are the dynamic factors on the right and dynamic risk factors. Isn't is the original way of talking about need, and that's essentially what needs are. They're changeable factors that when they exist, increase the potential for the individual
- participating, being engaged in further crime, or failing on supervision by effectively working with those we lower those risks, and what you see here are several of them anti social personality pattern being the first one to be clear.
- it is anti social personality, pattern, not antisocial personality disorder. Some people certainly have a diagnosis disorder.
- but many people have an anti social personality pattern who don't have a diagnosable disorder. So so it's. It's not necessarily a quote clinical diagnosis, but it is a pattern of behavior that is antisocial in nature, and a style of thinking that is anti social in nature. And the sort of silly example is.

- if you give someone with an anti social personality pattern, a problem to solve this solution will almost always be criminal or anti-social in nature. That doesn't matter. What the problem is that's what their first thought goes to that sort of thing.
- The other factors include pro criminal attitudes, meaning supporting of crime, pro criminal associates, friends who are involved in crime, friends or associates involved substance, use disorder, family and marital stressors for school or work performance and few leisure or recreation activities. Now a couple of things.
- First of all, when the top 3 exist.
- If we focus on the bottom 4 and ignore the top 3. We won't lower it so that the argument of well substance use treatment will solve. The problem
- is absolutely true for somebody who is low Criminogenic risk and doesn't have the top 3 factors.
- But if they have the top 3 factors, we have to deal with those as well as the substance use issue. And this is true for family and marital school, and work, leisure and recreation. If we just deal with the bottom. For when somebody has the top 3,
- that's a problem.
- Second Second comment.
- One of there been a number of studies out there saying that folks who have
- mental health issues
- are more likely to have as many or more criminogenic risk factors than those who do not.
- That has that has led to some misunderstanding of what the intent of that those studies were. It is true that when you look at a sample of folks, you see that. But what you see is that those folks
- are more likely to have more of the bottom 4 factors, not the top 3.
- They're not more generally criminal. They have more of the things that we know. The folks who have significant mental health and substance use issues have right family and marital stresses, families, entire families who are tired of them. Perhaps you know marital or in intimate relationships that have fallen apart
- problems in school and work, whether that's completing those things or keeping a job and difficulties in terms of being involved in any type of leisure social kinds of things with other appropriate folks. So it, while it is true, on the one hand that
- when we look at the data it is likely that there will be more of some of these things. It's really important to understand that the more is not the more criminal thinking stuff. But the more what we might argue is sort of social support kinds of things that you see there

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**Unknown Speaker**

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next slide, please.

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**David D'Amora**

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So

- when we're focusing on dynamic needs to create positive behavior change, what? What do we do? Well, what you see in the right or the the the need, meaning what it is that we do, and on the left you see the factors. These are hardly the only things, but these are the typical examples from Bona and Andrew's work that they've done over the years
- and so with an anti-social personality pattern. You're building self management skills you're teaching anger, management, good decision, theory, etc., with the pro criminal attitudes. You're working with cognitive distortions, countering the rationalizations and excuses with pro-social attitudes you want to build a more pro-social identity

**Unknown Speaker**

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with the pro criminal associates you want to replace with pro-social friends and associates.

**David D'Amora**

00:31:33

Once again a comment.

- We went too far with this in in some cases, and we we've begun to understand that what I mean by that is, we now know that some of the most powerful people to pier with people who are having difficulties are peers. P. E. Rs.
- Those individuals who have had lived experience, and who actually can understand and help these individuals, these folks in ways that perhaps some of this cannot. And obviously you want to make sure that there are folks who are doing well in their own life that they are not currently involved in any type of criminal behavior. They don't have criminal thinking. But the idea that this person should never be around anybody else who's ever been convicted of something makes no sense, and that wasn't the original intent.
- The original intent again, going back many years, had to do with. Look, if you're hanging around with a whole bunch of other people that are committing crime, that's probably a bad plan, and you're gonna more likely to commit crime. So we

don't want you to do that. We want you to hang around with people who don't commit crime.

- There are people who have a prior criminal history who no longer commit crime and can be an incredibly effective in helping these folks
- substance use disorder, obviously either reducing use or enhancing and or enhancing alternatives to using substances, Family and marital stressors might have to do with parenting might have to do with a needs in terms of intimacy, development, capacity to care for others

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**Unknown Speaker**

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for school or work. Performance

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**David D'Amora**

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again, enhancing work, study skills, nurturing interpersonal relationships, friendships at school or work and encouraging for a leisure and recreation activities, encouraging participation in pro-social activities, hobbies, and sports

- Again, these are hardly all of the kinds of things that one can do. But These are a lot of those sort of core or basic things. And when we look at a lot of the cognitive programming that is out there
- for folks again. Thank you for a change. Using a rehabilitation, etc. They all to different degrees, have components of all of these areas to help sort of teach folks about them and help them really move from what the dynamic risk. Fact is, on the left to getting their needs met that are on the right
- next slide, please.
- So now we talk about the issue of risk and needs assessment, and
- whenever I talk about this I always talk about risk and needs assessment. This is another thing we've got lazy about. We all talk about risk assessment. There are things that are only risk assessment. Those exist.
- But the vast majority of what we do when I say, we, those of us that are working with people on the community in particular, we are doing a risk, and needs assessment, not just a risk assessment by shortcutting it and just talking about risk assessment, we are giving the most attention to what is it? Ultimately the less important piece of it
- is, the most important piece really is needs. I would argue that there might be a point in time when we should just drop the word risk altogether and just talk about needs assessment

- and understanding that one of those needs might have to do with the level of risk, but that we need to change the thinking about it. We're going to get lazy. We need to get lazy and call them needs assessments and not just call them risk assessments.
- So
- in terms of this, 4 steps, first of all, assessing risk needed responsibility.
- using structured and validated instruments to assess criminogenic risk, criminogenic need and the responsibility factors.
- secondly, identifying strength. Again, something early on we did not do a very good job within our early tools. Newer tools are really looking at these issues.
- assessing personal strengths and integrating those into the interventions those might have to do with family. It might have to do with particular skill sets it might have to do with particular types of education. Again, a variety of different possibilities in terms of what those strengths might be
- breath or or how? Why do we look at this assessing specific
- risk? Need responsibility factors. but also the other human service needs that maybe barriers to pro social change.
- But, My, but we still have to maintain a focus on the R. And our factors. Again, if those factors exist, we need to respond to them. But we Don't doesn't mean we ignore other basic human needs that people might have.
- Interestingly, some of the work out of Canada shows that
- when you look at dosage which will come back to a little while. But some of the we got to Canada shows that when you look at dosage they're combining dosage of the criminogenic risk programming and the human service programming. And they're finding that when even when they're combining that they're getting the the better outcomes, in other words, they didn't need all the dosage specifically to deal with criminogenic risk factors.
- And then, lastly, professional discretion, which means deviating from the principles for specified. Reasons and there are.
- There are some reasons that people deviate. Some of them may have to do with the what the capacity of the individual is with the supports are that they have. Some of it may have to do with what the degree of violence that was involved in a particular behavior, that even if they quote are low risk
- or relatively low need, there may still be an initial period of
- more intense oversight and involvement, because, even though there's much less of a likelihood that they will do something that's something that they do is much more likely to result in something very devastating in terms of another person, public safety, etc.
- Next slide, please.
- These are just some of the common risk and need assessment tools, the the compass, correctional, offender management, profiling for alternative sanctions.
- the pick, row. The Federal Post conviction, risk, assessment tool, the I Orange inventory of offender risk needs and strengths. Ls Cmi Level of service case management, inventory actually revised now, and the LSI are level service, inventory, revised offender, profile index offenders, screening tool, a screening tool as opposed to full risk risk and needs assessment, offender risk assessment system. The O Ras out of Ohio.

- and it's been re revalidated in different states. Texas uses the T Ras Indiana uses the Iras. So different States have taken the the fundamentals of the Ohio risk assessment system and then validated them in their own States for use
- You risk it needs triage, the risk, prediction, index.
- static risk and offender needs a guide or the strong, and those constantly risk and need assessment scale.
- While I personally have my favorites, as most people do, and there are some that I do not like for a number of reasons, that the reality is this, that when we sort of look at it all. At the end of the day.
- All the tools that are in use tend to have reasonable predictive accuracy
- between about point 6, 5, which is good to point 7, 5, which is really good with with 0 being bad, and 1 point o being perfection
- to be clear clinical assessment of of these kinds of issues, typically isn't about point 5, which is equal to chance. So the tools make this perfect. No, but it increases our accuracy in a lot of ways, and one of the things that the tools actually help do help do, excuse me, is limit our own personal bias that every one of us has some set of biases about other folks. It's just the way that it is
- what I do say when I look at these tools, or when I talk to folks about tools is Don't go for the super expensive ones where you're spending all your money, keeping them updated.
- go for the tools that are reasonably cost effective. Go for the tools that you can get trained on, and that they might be a training cost. But you're not paying 1 million in some cases millions of dollars a year to for upkeep in terms of those tools.
- We can use that money for better things. And again, there is no one perfect tool, and there are, currently, they're probably currently about 30,
- highly recommended tools.
- Having said that there are over 400 in use in the United States.
- It's silly. We we have way too many different tools that we're using across the country that that really does not make a lot of sense. That's for another day next slide.
- So I want to talk a little bit about the Justice Centers national guidelines for our and our assessments, and this fits into the section of the expanded R. And our model about assessing for risk and need, because this has become a very big issue, and again understandably so. Several years ago. Some concerns were, I. I'm sorry next slide, please.
- Thank you. Several years ago some concerns were raised about risk and needs assessment increasing the disproportionality and disparity in the criminal justice system. A number of news articles and number of politicians that have spoken about it, and and those concerns are valid. And and they're we. We need to be very careful and real and thinking about it.
- I will suggest that the concerns our we're targeting the wrong thing.
- and that it was they were targeting risk and need assessment tools that weren't necessarily
- unpredictable. They were very predicted.
- They were still showing disparity, because the system within which they are predicting is disparate. There's disproportionality.
- and so and i'll come back to that.
- So before we get into that.

- let's talk a little about some of the common terms that are used. The first one is the come. The the of disproportionality
- to the racial or ethnic group is over representative on people experiencing a certain outcome
- compared to the groups representation in the overall population. For example, one state that i'm. Working in the population of people of color. It makes up 3 of the State, and but it makes up 37% of the jail population
- There's a problem there right that's disproportionate.
- Then there's disparity differences in treatment, opportunity, or experience, for one racial or ethnic group relative to another group. We also know it wasn't criminal justice, but we also an article or many of son Article this morning about If you are black and pregnant in the United States, access to to medical care is substandard
- across the country, and that would be a disparity that we're talking about. What about in terms of criminal justice. It would be the likelihood of being accepted into treatment, programming, and the likelihood of of successfully completing that treatment. Programming
- bias would be an inappropriate consideration of race or ethnicity in deciding with whom and how to intervene. This is a very real problem with risk and need to assessment, because what we see is that when we do a lot of studies about the implementation of the tool is that the person who is making the decisions
- will make different decisions based on the race of the individual being assessed, even when the risk level is the same.

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**Unknown Speaker**

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And so

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**David D'Amora**

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if someone is black or hispanic and the risk level is low or low, moderate, and somebody is white, and the risk level is lower, low, moderate they we. We see situations where there's much more intervention, and and in increased supervision

- for those people of color than for that person who is white, and we see it happen at a lower level of risk, and then we see it consistently happen all the way through. That is an implementation problem, not a tool problem.
- And then there's profiling. The use of race or ethnicity is grounds for suspecting someone of having committed an offense. We all know about that in terms of traffic stops, for example, and many other things. I mentioned all of these things because couple of things first of all

- risk and needs assessment. Tools
- do not increase these. If you follow certain
- objectives and rules that i'll talk about; and, secondly, they can't solve these problems by themselves either
- risk and needs assessment. Tools can't fix a system
- that is problematic.
- They can act as a canary in the coal mine in terms of looking at what's happening in a system, and we'll talk a little bit about that as we move forward as well.
- Next slide, please.
- So numbers along. Can't really tell us why we see disproportionality. There's many, many causes. So there are differences in the first of all potential explanation for differences in offending rates by populations. One risk of criminal involvement, maybe related to educational and economic opportunities.
- Risk of criminal involvement may may be related to the neighborhood.
- There may be something related to enforcement priorities, gangs, gun violence, high risk drug transactions, public order issues or deployment patterns, public how police are deployed in terms of public housing or hotspot, policing or high. Excuse me, high impact zone policing.
- And then, of course, the issue of systemic bias, the differential treatment across criminal justice system, actors and agencies, and that starts at the very entrance into the system, and carries itself all the way through.
- and then differential resources to navigate the criminal justice system, which is, you know, among other things, means whether or not I have money for a really good lawyer, right? Whether or not I can afford private care as opposed to whatever the community car is that's involved in that. I don't mean that as an insult on community care. But what you see.
- So our people that use a private care, people that use private care when those private care folks make recommendations, and they have a high price lawyer that are carrying those recommendations through. Interestingly, you see a difference in impact when people are listening to those things

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**Unknown Speaker**

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next slide, please.

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**David D'Amora**

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So what about bias and risk needed responsibility? Well, again, we have to distinguish where the problem lies. Does the test over rate risk, and we need to make sure it does not. Just to be clear

- is it accurate meaning? It is predictively accurate. But cultural factors are indeed the cause of the higher risk, and some examples of that would be the aboriginal population in Canada.
- in the United States, African, American, Latino, Hispanic populations.
- you know australia the aboriginal population, and in France Sub-saharan africans and so there are clear cultural factors
- Sometimes risk is a measure
- of the world that the person lives in as opposed to a measure of internal factors about the individual, and we have to be better at thinking about how to distinguish between those 2 things next slide, please.
- And so, because of that, we at Bja's request a few years ago we started working on developing some national guidelines for accurate.
- fair, and transparent risk, and needs assessments in order to really work on these issues of disparity, of disproportionality, of bias.
- And so there's 4 components in terms of the the work for areas of buckets, if you will, in terms of these guidelines. One is the accuracy, addictive accuracy; the second is fairness. There is transparency, and the fourth is communication and use, which has to do with implementation. And so we'll go through each of these a bit
- Next slide, please.
- So first of all, what do we mean by accuracy? It refers to the degree to which assessment results predict the recidivism outcomes they were designed to predict
- as indicated by the observed rate and severity of the criminal behavior, as well as the ability to identify individuals at greater and lesser risk of recidivism.
- It also involves considering whether the post-conviction risk and these assessment instruments are completed, and used as intended
- to inform case, decisions, and planning within facilities and in the community. Our guidelines, by the way, are specifically for the for use.
- post-conviction.
- and not not for pretrial just to make that point.
- And, secondly, this: this piece of used as intended is very important.
- One of the big problems that we see in the implementation is that people will say I made this decision because of the result of the risk assessment tool, when, in fact, the risk assessment tool was never designed to be an aid for that particular decision. So it's used as sort of an excuse for a decision that may be more rigid or or more problematic than it should be.
- Next slide, please.
- There are several guidelines under accuracy, and let me just tell you there are 13 overall guidelines.
- We're going to i'm going to mention them.
- Each one of these guidelines have many sub components. The document that goes along with this in terms of really looking at this, in an in-depth way is on our website. It's 50 odd pages long. We obviously are going to go through all of that today, but it is easily accessible for you, and I will also mention something else

**Unknown Speaker**

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about the this project, as we get to the end.

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**David D'Amora**

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So the accuracy guidelines say that first of all we need to conduct a local evaluation of the post conviction tool to ensure that it's suitable for the agency's population, that you can always do that upfront. Sometimes you have to have it in place for a couple of years Before you can do that you have to get the samples and places a number of things that you could do so. Sometimes we take a quote off the shelf tool.

- utilize it for, say, 2 years or so, and then we begin the evaluation. Excuse me. The validation process
- needs to be minimum performance standards or post conviction risk, and needs assessments that are completed in the field. According to statistical standards. In other words, it has to have that a. You see that predictive accuracy that I was mentioning of between at least point 6, 5, and preferably around point 6, 8 to point 7, 5.
- Use a continuous quality improvement or Cqi process to ensure successful implementation of the instrument.
- and use a multi-step approach to a sense risk in these over time. In other words, it's not a one and done we need to be looking at this
- routinely, if you will, and there's different. Just different tools have different suggestions about what that timeframe should be. But it's it's never a one and done
- next slide, please.
- So what about the issue of fairness? Fairness is the degree to which the results have the same meanings and applications across groups
- that might be defined by race, ethnicity, gender, or other characteristics, such as mental illness. For example.
- fairness should be considered in the development of the tool, in the validation of the tool, and in the implementation of the tool
- fairness has to be front and center from the very beginning of the development of the tool all the way through the implementation, and where you see it particularly fall down again, unfortunately, is in at the implementation stage.
- Next slide, please
- one of the guidelines here in terms of fairness. Well, the first one is: Examine the results of the post-conviction risk, and needs assessment instrument for predictive bias and disparate impact across groups. Again, remember the earlier definitions that are in this presentation in terms of a disparity and bias.
- Secondly, apply the risk and needs instrument results to individual cases in keeping with the R. Andr. Principles. In other words.

- your case plan where that is a supervision case, plan, or a clinical case, plan should fall within the r andr principle right, whatever those print, whichever ones are relevant, if you will, to a particular situation.
- Thirdly, or a number 7 adopt agency-wide strategies to minimize the potential that local implementation of the tool promotes disparities. And this is
- one of those examples that I was mentioning. I won't mention the State.
- but another state that I was working in. It was a it was a unified system, meaning the Doc was statewide, and it proved probation both within Doc. But there were 2 subgroups. Meeting was a northern and southern region.
- and when we looked at the results of the northern and southern region we found tremendous disparity in terms of risk levels.
- and we started looking at what was going on here, and the disparity in terms of the risk levels
- had to do with the implementation of the tool, not with the tool itself, and certainly not with the people that were being evaluated, but with how the tools were being used differently, and in one
- of these 2 areas they were basically massively overrating the risk and need level of the individuals. So it became a it became a cultural problem of the Northern regions. Parole and probation agents compared to the Southern regions for all and probation agents.
- Next slide, please.
- Transparency that refers to how the information about the content, structure and application of these instruments is disseminated to stakeholders. It's relevant both the development and implementation of risk and needs assessment instruments.
- and it requires a pro active communication strategy. Couple of things about this. Well, i'll come back to that next slide, please.
- Here are some of the guidelines here, one providing system stakeholders with relevant information on the development, intended use and validation of the post conviction and risk and needs assessment instrument.
- There there are some developers who say I can't let you know what's under the hood.
- and they'll say things like Well, if I let you know what's under the hood. then people will be able to fool the test. My response to that is twofold one. It's usually the developers that have
- a fiscal
- relationship to the tool that are saying that so that's part of it. And the second issue is, if, in fact, my knowing what's what's being measured
- is going to distort the measurement that it's not a very good tool to begin with, and when you look at what tools measure the assumption that they are measuring something that's just coming out of somebody's mouth, saying something is inaccurate.
- And so it's a little like me getting the medical test and not being allowed to ask, what is that medical test, showing, and how is it been developed? Makes no sense at all.
- 9 develop a written policy that guides the local use of the post-conviction risk, and these assessment instrument
- and 10 communicate the strengths and limitations of post-conviction, risk and needs assessment instruments to the general public. These are not magic bullets.
- They all have certain strengths. They all have limitations. They are not the only answer, the only solution, or, for that matter, the only assessment that should often

be done right. We should also be looking at in many instances mental health, screen substance use screens, slash full assessments.

- We need to be looking at issues of assessing again for things like food and security housing issues, other kinds of education issues there are. There are many other areas that in addition to this, we need to look at, even when a tool has some of those components in it.
- it's not typically to the degree that it gives us the full assessment.
- And so we shouldn't make believe that they are the end, all, be all. They are a necessary, absolutely necessary, but not sufficient assessment component of the work that we do with people that are in the criminal legal system.

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**Unknown Speaker**

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Next slide, please

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**David D'Amora**

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communication and use the manner in which individual assessment results are communicated.

- and how they're used can greatly affect their impact on decision making.
- and consequently their effectiveness. And that is in several ways One.
- if all I do is talk to an advocacy group who are advocates for folks who have been hurt.
- and simply say, Well, he's low risk, and that's all it's saying.
- Well, they're like you're excusing this individual. Well, that's not what the point is. We need to be explaining to them what those issues are, what we're going to do. What doesn't make sense to do, why it doesn't make sense. Why, we're concerned about community safety. And why, if we do, certain things will actually decrease community safety.
- or we're talking to the client himself or herself, and we just look at him and go your high risk.
- Hmm.
- What does that mean? What are we going to do as opposed to what are the what are the top? 3 or 4 needs that we're seeing here? How can we help Massachusetts? Does some really nice work with this.
- I I only mentioned States when I have something good to say as opposed to the concern. Massachusetts does some really nice things with this, and where they really work jointly with the client. After the assessment results are back they explain

it to them. We sit down with them, and they say so. Here's the Here's the top 3 or 4, which one do you want to work on? First

- let's. Let's decide how we want to move this Forward now? Are there ever exceptions? That, of course, if there's an immediate community safety risk the maybe a violence risk, then obviously they're going to have to make some decisions. But, generally speaking, the majority of the time. That's not the case
- until they're literally engaging the individual, and they're engaging that individual in a way that says, I want to work with you with the results of this, to help you move forward to help you be successful as opposed to. Oh, my goodness, I need to watch you so closely, because you are high risk.
- Improper communication of the results can undermine efforts to promote accuracy, fairness.
- and transparency. And we're using these instruments, and they need to be a key consideration in their implementation. Even good tools can be misused, and we need to really be on top of this particular area to sure that they are used. Well.

**Unknown Speaker**

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next slide, please.

**David D'Amora**

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Some additional communication and use guidelines anchor. The communication of the assessment results. Again, in the R. Andr. Principles. As a example, I actually just gave in terms of Massachusetts.

**Unknown Speaker**

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contextualize the results of the risk, and needs assessment instruments. In other words.

**David D'Amora**

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Don't, just sort of throw out the lingo. Make sure you're speaking in a language that people understand, and they contextualize it in the sense of this is what we need to do. This is where we need to go. This is how it can be, how it can help as opposed to just you this year this year this. So i'm going to give you program a programming program

- again. You know our 50 odd page document. We have a lot of content under each one of these items, far more in depth than than what I can do in the time that we have today.
- and then 13 develop a template for communicating individual results of post-conviction risk, and each assessment instruments to all the relevant stakeholders, including the person being assessed and that's really important. It's not fair.
- It's really not fair to
- the supervising officer when it is the supervising officer that is doing this to expect him or her to on their own develop how they're going to do this
- we we need. We need to really develop a template that says, here's how we do this in this agency or in this organization, if we're doing it in a community agency, and how we how we're doing it in this probation or role agency, if that's what we're doing now, so that that
- it is consistent across that it is, it is consistent and doesn't change from officer to officer, that when an officer or a clinician changes from one to another, because sometimes there's turnover, for whatever reason that the way that person talks to the clients probation are probably isn't suddenly different, using a different language, and it confuses the client. So again, lots

**Unknown Speaker**

01:00:36

of of ways to really make sure that we're developing that

**David D'Amora**

01:00:39

one of the things that I

- often say to agencies around this is that if you have a commons department, this is the time to call them in, and really let them help you develop this component of what it is that you need to be doing
- next slices

- I mentioned dosage earlier. There's not a lot of studies on dosage to be fair, but there are several out there now, and the
- findings from each of them pretty similar the main difference that we've seen.
- I I sort of alluded to earlier in Canada and in England.
- when they count or the United Kingdom they count dosage. They count both criminogenic risk programming, cognitive programming
- designed to lower criminogenic risk and human service programming, mental health substance use other programming. So they've combined those in terms of meeting the dosage numbers
- in the Us. The tendency is to stick with Co. The cognitive programs I have been suggesting lately. We should rethink that in terms of what we now know about the impacts of these other areas on folks lives.

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**Unknown Speaker**

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But fundamentally, what it says is if somebody is very low in terms of their risk.

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**David D'Amora**

01:01:56

And this is a 4 level model. Some people use a 3 level model. Some people use a 5 level model, arguably 5 level gives us the best disaggregation of individuals of folks. But for those folks that are low minimal, I mean really just

- let me put it this way. Leaving them alone is a really good idea, this very level we can do that won't actually be harmful. So we should leave them alone. And again, we're talking about intervention specifically related to criminal behavior, criminal activism, likelihood. If somebody is very low but has a mental health need, we should be referring them to mental health treatment or to whatever other need they have. What we shouldn't then be doing

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**Unknown Speaker**

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is violating them. If they don't go.

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**David D'Amora**

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they get to decide just like the average citizen gets to decide whether they are going to go to that treatment, or avail themselves, or whatever the service is.

- We don't.
- We don't punish them for not doing something that might help them; but that, in fact, is not related to the likelihood of new crime, just to the likelihood of their life, not being as good as it could be. Okay.
- then, we talk about folks in terms of moderate risk, and that's where you would see folks typically once a week or so 3 to 6 months, about a 100 h, and and they broken it out in these different ways, because depending on whether it's outpatient or residential or incarcerated.
- I don't know how you how many times you can meet. What you can do, you know, changes pretty dramatically, so they've broken them out in these different ways. But for moderate we're talking about roughly a 100 h
- Studies actually say 50 to 100 when we're talking about moderate high risk. We're talking about 6 to 9 months, typically about 200 h or so. Again, studies
- they tend to say 1, 25 to 200. So These are the upper levels of these things, and then for high twice a week, or possibly residential and residential, might mean while you're incarcerated 9 to 18 months in terms of programming might be 300 h for the very, very high. It might be more than 300 h.
- 1 point about this, though, when it talks about 9 to 18 months in terms of intensity or residential. There is not a good rationale for keeping people incarcerated to complete treatment.
- and unfortunately, there's a number of States that do that and that doesn't make sense. They it makes sense to make sure you've got a solid basic treatment going on. But to to deny somebody who is eligible for release release
- just because they haven't completed programming yet, and i'm not talking about people who refuse to be involved. I'm talking about. No, I've been working. I've been working for 10 months, and now i'm eligible. But you're telling me that because I have another 6 months to complete this programming I can't leave.
- That is not a good idea that should be continued in the community, so they can continue the programming. But you do so once they're back in the community
- next slide, please.
- And so, as we look back to then finishing up the the 18 areas when we talk about the Ro model. This includes treatment staff practices which includes relationship and structuring skills.
- Relationship Skills include warmth, respect, and being collaborative. By the way, those relationship skills are not specifically for clinical staff.
- Those relationship skills are for supervising officers. Those relationship skills are for people providing the cognitive programming, whether that's in a prison or in a in the community if they're not clinicians.
- Structuring skills includes modeling, reinforcement, skill, building, skill, building, problem, solving, cognitive, restructuring, and other validated structuring strategies and that issue of modeling.

- So first of all, reinforcement
- needs to be much more positive reinforcement than negative reinforcement, and we often talk about it needs to be a 4 to one. The the research on that is somewhat limited. But what we do know is that there needs to be more positive reinforcement and negative reinforcement in terms of
- folks changing, and the modeling piece is really important. Right? If you, if you model a do as I say, and not as I do as an officer, as a supervisor, as a program person. They all you're teaching. The person is that when they're out from under your thumb they can be mean to.
- I also have seen this sometimes in treatment programming. I've seen it particularly in specialized programming. What we're talking about. Problem, sexual behavior, interpersonal violence. I've often not often is unfair. I have seen many times
- that the providers themselves are really modeling very, very bad behavior, very abusive behavior toward those individuals which, needless to say, does not change how they're doing. I've also seen but many very good programs. That model excellent, appropriate behavior for the individuals they're working with
- skill. Building is important.
- There's some people who have the theory that these folks actually know what they're supposed to do. It's all deep inside. And so the problem is, they don't do it.
- It's kind of silly thinking. Actually, they don't know what they need to do. They did not learn those skills. They did not wake up one day after having a wonderful, perfect life and suddenly decide, I'm going to do something that turns everything upside down.
- They are folks who typically, for a very long period of time, have either not developed certain things or have had things happening to them that have led them to this point in time. They do not have what they need.
- Our job is to help them get or develop what they need. That's what we need to be doing. We are helping. Fill them, if you will, with skill sets
- they are not going to discover it deep down, that is to be blunt again. Sort of another middle class here. You know it's all in there. No folks. It's not always in there, and there's good reasons why it's not in there, and and it's not necessarily because of something always bad. I use the way bad, and air quotes about them. It has to do with what opportunities they did not have to get those things to knowledge
- and then problem solving, cognitive, restructuring, very obvious. Again, components of that work next slide, please.
- What about the organizational components of the treatment programs. When we're talking about setting and management. Well, community-based programming of all sorts should it here to our let me rephrase that that are dealing with these clients, should it here to R. Andr. Because they are more effective.
- The services are more effective when they're delivered in the community. That's not to say that we shouldn't provide services when they are incarcerated, or if they are in a residential setting, there are times when they have to be in those services those should be seen
- if you have nothing in the community, and the person is incarcerated, and they get that. That is absolutely a fine thing to do.
- If you have services in the community, the ideal is, get them. If they are incarcerated, or in a residential setting of some other type, the ideal. We get them started while they are inside, and then finish it up when they are on the outside, and, by the way, finish up on the outside doesn't mean, make them do the same

thing all over again. There needs to be a continuum, whatever they've gotten for the base while they are inside wherever inside is, should then be built upon. When they get to the outside

- in terms of continuity of services, there needs to be ongoing services from. If there have been again in a facility of any type, needs to be ongoing services and monitoring of progress as they move from inside to outside.
- managers should really be selecting and training staff according to their interpersonal facilitation. Skills provide clinical supervision according to R. And and sure that there are organizational mechanisms to maintain the monitoring evaluation and integrity of assessments and programs.
- I back before I I've been with the Justice Center for about 13 years, now
- crowded that I worked in the field for about 35 years, and, among other things, oversaw a number of clinical programs, always at the intersection of behavioral health and criminal justice, various types of programming, and we did a lot of different kinds of work, both in terms of traditional
- cognitive programming, like reasoning and rehabilitation, cognitive behavioral therapy, motivational interviewing and engagement about a third of my staff, including those who were clinical, could not do motivational engagement to save their lives. They They just weren't wired to do it.
- And so part of what we needed to do is to really think about what were the different strengths and skill sets of our staff. And who did we have doing different things.
- so that we weren't basically
- either creating a bad situation for the client or making the clinician miserable, if you will, and I've done a lot of training and probation, and for all supervisors over the course of my career as well. And the same holds true. There you need. You need to. Really. One think a lot better, a lot more about what skills we want when we hire. And then, secondly, because not. Everybody is good at everything. We need to decide how to best place folks

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**Unknown Speaker**

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dependent on their which skills they are best at.

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**David D'Amora**

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And then, lastly, community linkages. The agency where the program is housed should maintain positive relationships with other agencies and organizations

- we're not talking about breaking any hipaa rules to see if our 42 rules, but a lot of times, you see programs

- right. I I don't. I don't have a nice way to say a lot of times. You see programs hide behind those as a way to not communicate at all that is unfair to the clients, and obviously a client has control over what is communicated; but.
- generally speaking, they are in much better shape when we are working collaboratively with whatever the other organizations are that are involved in that person's life, it lessens the likelihood of them falling through the gaps or their cracks, if you will, and it lessons the likelihood that one of the organizations will do something that
- that negatively interferes with what the other organization or agency is trying to do next Slide, please.
- ignoring assessment results in ignoring R. And r
- results, or can result in over supervision and over programming
- multiple studies across the country. They've shown that supervision staff practices are often misaligned with the research on risk meeting responsibility and associated with agency trainings.
- The problem is not that the officers use the assessment to make case planning decisions, but that they ignore, override the results which leads to overriding the potential for recidivism over responding to client needs through over supervision.
- over programming.
- focusing on the wrong needs or making unnecessary program referrals. An Anger management is one of those common things that so many people get sent to that. There's often not a real connection between what that program has to offer for that particular individual, and what that individual needs. And there are other similar examples. You see, this happens sometimes with substance, use or courts, order, substance, use treatment when once they get to the substance. Use program. The assessment says that really doesn't fit here. It doesn't make sense.
- During the assessment results creates greater disparity and responses compared to following the recommendations of a correctly validated tool that is used on the intended population
- for the intended reason that the tool was developed.
- Next slide, please.
- and that leads us to questions and answers. I appreciate all of you who have listened, and the 137 of you that are still here. And so if there are any questions Ethan or Steve, or anybody wants to to let me know and try to answer them.

**Steven Diehl**

01:13:41

Thanks, David. You know, if you want to go, I think the next slide there perfect, and we'll begin the question. Answer and portion of the Webinar again. Please type your questions for the panelists using the Q. A. Button, and we'll respond to as many as we can in the time that's remaining.

- David. I'm gonna throw you the first couple that have come in here.
- and I'm going to try and

- group the juvenile ones together to start that way. We're not bounce back and forth. So one person asked if the information
- in the R. Andr. Assessments is there any information that's different between the youth, Justice R. And R. Versus an adult

**David D'Amora**

01:14:25

in terms of the overarching model.

- No, and in terms of the overarching model, it would be the same model, in fact.
- in terms of the original validation of the model. Many of the individuals in the original sample size were individuals who were who began their involvement when they were adolescents. Having said that the tools are different and some of the specific things the tools look at are different when you're assessing a juvenile versus an adult, and to be fair. All of the tools that I was showing you were specifically focused in terms of adults.
- The juvenile tools tend to
- juvenile tools have done a much better job of not getting caught up on the risk idea and really focusing on the need area and what those needs are. And there's a number of this 3 or 4 really good tools out there. There's a there's probably about
- 15 to 20 tools out there with this 3 or 4 that I think, have pretty solid research behind them. If whoever asked that is interested, I am happy to put you in contact with colleague of mine. I live in Connecticut. Not Not that any of you know that, but I live in Connecticut. I would put you. I put you in contact with a colleague of mine who's developed one of the better tools. That's that's utilized with juveniles as well as send you a couple of other connections, and you can
- you can email any of the team, and they'll forward it to me. And i'm happy to get that information to you.

**Steven Diehl**

01:15:59

Thanks, David, and that came in from an anonymous person. So if they want to send us their contact information, we can push that over. I'm. Following up Dave with another question about intervention dosage, and is that the same for juveniles and adults?

**David D'Amora**

01:16:15

But those dosage studies are on adults specifically. And so the answer to that would be No. And I would actually argue that, particularly when you get to the right side of that chart where you get to that 200 300 h, 200 300 h in the life of a 40 year old, is very different than 200 to 300 h. In the life of a 13 or 15 year old. We need to be careful in that

- over respond to juveniles. And so those studies were not the the the samples in those studies were not with juvenile. So you want. You want to be very careful about that. I've seen a lot of situations where they put juveniles in treatment for like 2 years, 3 years.
- and i'm not talking about mental health needs or whatever. Again, focusing on criminal legal issues. You know what we know is with brain development that things change as quickly as 6 months right when we're talking about adolescents right up to young adults. And so we we really need to be very
- we need we need. We need to be much more parcel, loading it in terms of dosage when we're talking about adults.

**Steven Diehl**

01:17:19

Thanks. David.

- Next question is coming in is, how can agencies ensure that prescript? Professional discretion does not encourage bias or gut reactions, particularly upon among the community supervision staff?

**David D'Amora**

01:17:34

Yeah. So the number of things. One is having coaches in place. 2 is having a. Q. A. Process that you're able to do routinely and routinely might be once yearly, whatever it might mean twice yearly depends. Some of it depends on the

- size of the agency. Sorry. But the
- first of all there should be a determination of what the override percentage should be. In other words, a lot of the tools to actually say. If you're more than a 10%, if you have more than 10% override of using this tool You, this tool is being misused.
- Other agencies have said anytime we have more than X percentage override happening. We're gonna start examining all of those overrides and figure out what the problem is. Because we're going to initially assume that the problem is probably an implementation problem, and not an issue that's related to the clients.

- That that. And so that's that's 2 and then 3.
- There are
- a number of dashboards out there that one can use that the different folks use around the country where they're able to sort of match in real time. And look at These are the results. For you know, Joe's, these are Joe's results. This is Jack's results, and
- you know Jill has a 5% override, and Joe has a 6% override, and Jack has a 22% override. We have a problem here. We better look at this and see what's going on. So the the in one. You can have policies the same.
- We there's an automatic triggering of checking things if we go over a certain percentage. And then, secondly, you do have to have an oversight model in place, whether that's coaching in Qa. Whether that's a dashboard model, you have to have something and not just leave people to their own devices, and to be clear
- that doesn't mean those people are purposely trying to do the wrong thing. The best of us, with the best of intention sometimes can make some pretty big mistakes about these things.

**Steven Diehl**

01:19:36

Thank you. David gonna slide in towards the dosage now that you were talking about one of the first

- one. So we just questions that came in was
- stating, If we're not to violate individuals, if they don't, attend mental health appointments.
- what if the individual's court order to attend mental health treatment. And what about the individual who self medicates, instead of using their medications?

**David D'Amora**

01:20:04

So sort of a number of different issues that that

- let's unpack that a little bit. The first one is. There are many times when somebody is supervising an individual, or is a referral when there's a court order, and that does take some things out of our hands right when and if we have a judge that says
- this is what this person is gonna do. There are times when we have no choice but to follow that there are other times where we can go to the judge, and we can say, hey, Judge, we have additional information here, and we we get why this happened. But can we have a revision of the stipulation? I I work in a state that.
- fortunate that they don't have to go back to Court to do that. The the Probation Department has the leeway to do the assessment, make the decisions and the and

so the judge says you will follow, whatever the results of the assessment say that need to happen. So that's 1 2 the issue of

- So that's it. The court order.
- The second issue is the issue of self medicating. Well.
- again, we need to unpack that a little bit. There are they in the lowest risk category if they're in the lowest risk category. In my opinion, doesn't change.
- If they are in the higher risk categories. Well, now, you've got a bit of a problem, because there's a a direct relationship. The other question is, what does self medicating mean? Are they self medicating because they're smoking a lot of marijuana, and you live in a state where marijuana is not legal
- or they're self medicating in a state where what they're using is an illegal drug, which is means they're committing a new crime, which is a problem. And so you're probably in a situation where you need to really be reinforcing that person getting into programming, whatever that programming might be in this case
- right, perhaps substance, use treatment, or perhaps mental health treatment. So so part of that
- part of that. The answer to that question depends on whether or not they are in the lowest risk. Then, to begin with.
- whether or not. What they're self medicating with is another crime, and whether or not there's a relationship between that behavior and in other in general crime. In other words. Obviously, if somebody is committed to crime while using a substance, what I said earlier doesn't count right at that point, you have a direct integrated correlation between the use of that thing, that substance and the crime in order to lower the crime. You've got to deal with the substance. Use issue
- right.
- You're rarely going to get somebody in that scenario who falls in your lowest risk. Then you never say never! But that's really going to be the case. It's usually going to be at the very least in the next bin. That's going to suggest some type of intervention. So what I was really talking about was that lowest risk been no criminogenic factors
- not related to the crime, and they might have some needs.
- and we should certainly help them get those needs met. But but if it is a if it is a need that if they were not on supervision, we wouldn't be arresting them, for then we shouldn't be arresting them, technically violating them for doing that. Now again, as we move up in levels of risk that that dynamic changes.

**Steven Diehl**

01:23:09

Thanks, David

- sticking with dosage. There's a couple of questions. I'm. Going to try and combine here specifically dosage translating to probation, supervision versus the treatment.
- We have a couple of questions coming in about
- what what supervision levels for dosage are applying?

- Are we applying? If the probation is using Cvt. And then is there a difference in contact between office setting or community settings for probation.

**David D'Amora**

01:23:48

So here's what I think you're saying. The the question is, does supervision contact count as dosage?

- And the second question is, is there a difference if that happens in the Supervision Office versus in the community or versus a community agency

**Steven Diehl**

01:24:04

got it?

**David D'Amora**

01:24:06

Okay, so

**Unknown Speaker**

01:24:10

maybe

**David D'Amora**

01:24:11

it depends on what's going on in that contact if the supervision contact is? Hi, how are you? How's your wife doing? Did you go to work today? Did you keep your

curfew. And no, it really doesn't count. That's just to check the box kind of routine. If the supervision contact is something that is focusing on one of the identified needs and working with that individual about what that was like in terms of that we what that person did, chatting with that person about what happened in programming, essentially doing something that is, that is designed not to

- check the boxes about where they were, which you may need to do. I don't need to insult that you may have to fill out those things. But if that's all you do
- in some places, you know they've got 10 min. That's all they can do
- that doesn't count in other places. They have 30 min, or they have 35 min and they spend 5 min with the things that they need to do to keep records for, and they spend the balance of the time focusing on those things that are related to the, to the needs that the individual has. In that case yes, that would count toward the dosage. So whether it's the the difference between whether it happens in the probation office or role office, and the in a community program depends on what's occurring when that person is in the Supervision
- Office. If there, if you're using, carry guides. That would count right if you are using any of the kinds of programming.
- not necessarily doing a program, but using components from them. If you are doing motivational engagement kinds of things. If you, If, again, you are focusing on the specific areas, maybe the acute risk factors and making sure that they're doing well with those, and that can count toward dosage. But if it's a 10 min meet and greet.
- you know, did you? You made curfew, and you didn't do this, and didn't do that. That really doesn't count towards dos, because there's no outcome to that in terms of change, behavior, change on the part of the individual.

**Steven Diehl**

01:25:59

I think I answer both parts of that, Steve. Very well. I think you did, too, and that was very good information there, and 2 things one, Eunice, could you slide us back to page 40 in the slide?

- And while she does that, David, I have a different question. And for sex offenders. How does the dosage suggestion work? If a residential is 300 h? Are there other chronogenic needs picked up in those 300 h? Or are there other dosage hours on top of the 300

**Unknown Speaker**

01:26:42

you should.

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**David D'Amora**

01:26:43

should there be only is the 300 I should the 300 h, the only sex offender specific specific treatment. I think that that's the question the

- So let me start with. We tend to overtreat people with problem sexual behavior. We tend to assume that they are all higher risk. Yet when you look at recidivism data, and when you look at actual objective assessment data, they they are not so that sort of the good news.
- The second second issue is, Can other things be included in that 300 h?
- There should be other things included in that 300 h. And and, by the way, the at the highest level, when you look at the studies themselves, it actually says, 300 plus Again, this slide is sort of making it more discrete than in in truth, when you look at the data.
- when you look at the studies it, the way that it is, you know the moderate. The studies say 50 to 100
- a byward high, 201, 1 50 to 200, etc., and to be clear the studies and I'm thinking of Mcgrath. Particular work here, where he was looking at sex offense specific. He was clearly talking about a combination of in the facility and in the community. When you have
- somebody who has problem sexual behavior, that is, at a level that he, you know, typically be a he requires 300 or more hours of intervention. It would be very rare that there aren't other co-occurring problems, that individuals having, and so to focus only on the problem. Sexual behavior issues is probably missing some very key issues.
- And so that would be my my response. If you should never only focus on that. And then the second one is when you look at the actual studies it says, 300 plus. And so part of what you have to do
- to really assess what you're dealing with here right in terms of what this individual's needs are, and it is possible that somebody will have such a wide
- group of co-occurring needs that. Yeah, it might be $400 and a 100 of those. It might be a 100 of Those hours are not 6 offense specific, and they might need the 300.
- The studies are not that.
- How do I want to put this? Not that solid, that you you should just sort of take them
- without having some real thinking about. What are the particular needs of this individual? And what do I have to do in order to make sure, i'm meeting the needs of that individual. Again, when you look at the actual studies themselves at the high end, it says 300 plus which gives you some room, because, you know, people are different.

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**Steven Diehl**

01:29:25

Thanks, David. I want to jump back to this slide here. Someone asked if this risk level model showing

- is based off of a specific risk assessment tool.

**David D'Amora**

01:29:37

No, no.

- this is not based off of a tool. This is based off the what You see here the framework from an IC.
- Which is based on studies done by Diro Kroner, and let Tessa. I forgot his name out of Canada. England is another person who I should remember his name, because I know him, but i'm spacing on it, and I see, and and Mcgrath, and so there are several
- studies out there, and and this comes from the combination of those studies. It is not, does not come from a specific tool. There are not really
- tools, I I mean there's I saw in the chat somewhere. Somebody was using the George Mason tool, and that tool is built some of those things in. But but generally speaking, the the tools don't give a specific
- like. If I were using Ls Cmi. It doesn't, then say to me well, until you get, you know 72 h to this individual. It doesn't do that sort of thing. So this was developed from the the various studies that are out there as opposed to specifically from one tool.

**Steven Diehl**

01:30:44

Thanks again, David, you know. Could you slap us back over to the last slide? Please?

- Awesome. There are a handful of more questions still coming in. So
- I know we're at time, so I don't want to hold anybody over. I'm gonna ask if you want to send those questions in, and we can forward them over to David.
- There's the information there to contact Ethan Kelly, and he'll do his best to get that information to David, and then back at you. And if you would like to get your contact information over to David, you could do that as well, David. Thank you. Obviously, again, we really appreciate your participation. Your expertise in this area is unmatched, and all of your insights.
- And with that I believe we're going to wrap things up, and this program is being recorded, so it'll be available on our website.

- which is also listed there
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  **David D'Amora**

  01:31:35

  within the next one or 2 weeks. Thank you everybody for participating again. Thank you, David, for everything.

- Take care.