RNR Treatment Support Plan for Health Providers

GUIDE

Introduction

The Risk-Need-Responsivity (RNR) model provides a criminal justice framework through which the MISSION-Criminal Justice (CJ) services can be used to better meet the needs of individuals with mental illness and substance use co-occurring disorders (also known as co-occurring disorders (CODs)) who are in the criminal justice system. The concept of RNR is considered a best practice for professionals working with individuals in criminal justice settings and has been shown to effectively reduce recidivism. Criminal justice research has shown that non-adherence to the RNR principles in program and supervision planning and service delivery is not only ineffective but can also be detrimental to offender outcomes. For more information on the RNR framework, refer to the MISSION-CJ manual (Appendix C and Appendix H). Prior to completing this tool, please watch the RNR webinar from Debra Pinals, M.D.

The following treatment support planning tool was designed to help MISSION Case Managers (CMs) understand and adopt RNR assessment and planning into their clinical practice and development of treatment support plans. While screening and assessment identify the client's need for substance use; mental health; and other treatment and support services, the treatment support plan is where the information gathered is used to put treatment into practice. A RNR structured treatment support plan is a map specifying where clients are in recovery from substance use and criminality, where they need to be, and how they can best use available resources (personal, program-based, or criminal justice) to get there. The treatment support plan also serves as a basis of shared understanding between the client, MISSION team, other treatment providers, and criminal justice partners, such as Judges or Probation Officers.

How and When to Use the RNR Treatment Support Plan

The CM should complete the RNR Treatment Support Plan at the beginning of initiating treatment (generally within the first 3 sessions) for all MISSION clients. The plan can be used as a way to synthesize information attained from multiple sources including a client interview (i.e., MISSION baseline assessment), collateral sources (i.e., probation officer), treatment providers, and client records. The RNR Treatment Support Plan does not replace, but complements, your agency's established screening and assessment process and documentation. The RNR Treatment Support Plan should be reviewed and updated with progress monthly.

A critical component of this plan is the inclusion of available risk-needs screening and assessment results. At enrollment, the CM should identify whether there has been a formalized risk-needs screening and assessment through the criminal justice referring parties. There are several versions, and criminal justice agencies may use any number of validated or home-grown tools (validated risk-needs measures include Level of Service Inventory-Revised (LSI-R), Ohio Risk Assessment System (ORAS), Correctional Offender Management Profile for Alternative Sanctions (COMPAS), etc.). When available, these should be reviewed with the criminal justice personnel who have conducted or have access to these assessments to help the CM inform behavioral health treatment planning. CMs may ask trained probation officers to complete a risk-needs screening and assessment with current clients if the assessment is not available anywhere else. CMs may administer validated risk-needs assessment tools themselves in circumstances where they are appropriately trained and authorized to do so. Risk-needs assessment results should be summarized within the treatment plan. If there are no formal risk-needs

assessments available and the CM is not trained in risk-need assessment, the CM should determine whether a risk-needs assessment was done in a prior criminal justice setting that could be reviewed to understand past risk domain assessment and/or confer with clinical supervisors or clinicians working with the client to help understand risk domains for a particular client.

RNR and Behavioral Health Treatment Support Planning

Behavioral health treatment planning has a long and deep history in the field of mental health and substance use providers. What makes this RNR and Behavioral Health Treatment planning unique is that the RNR principles are layered onto Behavioral Health treatment planning so that reducing recidivism and criminal justice involvement becomes part of the treatment and recovery goals. Such planning is a critical component of the MISSION-CJ approach and serves as the foundation for the overarching treatment, and can be examined across all points of the Sequential Intercept model (i.e., the system that identifies intercept points between behavioral health clients and the justice system) where the client may intersect, such as with police, courts, correctional facilities, and community supervising entities.

Although it is unlikely that the treatment support plan will be completed in the first session, it is suggested that the CM begin to introduce the idea of treatment support planning and prioritization of goals during the orientation session. The direction of the treatment support plan will follow logically from discussion of the client's goals, available support, personal strengths, potential obstacles to recovery, and criminogenic needs as well as factors that may help improve responsivity to treatments. As noted above, the RNR treatment support planning tool helps the MISSION-CJ team integrate into their treatment planning the perspective of reduced criminal recidivism to the treatment goals and incorporate information related to criminogenic risk, needs and responsivity factors. In the MISSION-CJ approach, treatment support plans are reviewed at least monthly with the client, and the treatment plan is fine-tuned when necessary to reflect both goals achieved and new goals and objectives. A copy of the complete and signed RNR treatment support plan should be kept in the client's file. The treatment support plan should be used to guide clinical supervision discussion; treatment and support services decisions; and case presentations. The following is a sample RNR treatment support plan:

RNR Treatment Support Plan

(THIS TOOL SHOULD BE/CAN BE COMPLETED BY PROVIDERS AND CORRECTIONAL SUPERVISORS WITH APPROPRIATE CLIENT CONSENT)

Client Name: John Doe **D.O.B.: 1992** **Age: 24** **Client Record Number: 1234**

Program Name: MISSION Prison Reentry and Peer Support

Date of Completion: 11/21/16

Current Legal Status:

☐ Community supervision (if checked, list supervisor and supervising agency): _____

Name of probation ☐ or parole ☒ supervisor: **Officer Tom Dawes**

☐ Specialty court involvement

☐ Pending charges

☒ Incarcerated

If incarcerated, current facility: **Urban County Sheriff Department**

☐ Other (explain): _____

Person(s) Primarily Responsible for Completing this Guide in Addition to Client:

1. **Mary Smith, MISSION CM**

2.

Risk Assessment Data Source:

Risk/Needs Screening/Assessment Utilized (Check one)

☐ LSI-R: SV ☐ LSI-R ☐ LS/CMI ☒ COMPAS

☐ RANT ☐ ORAS ☐ No formal Risk Tool available

Date of risk/needs assessment if completed: **10/16/16**

Source of risk/needs assessment (community corrections, correctional setting): **correctional facility pre-release**

Risk Information:

Risk Type	Risk Scores (Range)
Risk of re-offending	**9 (1-10)**
Risk of failure to appear	**10 (1-10)**
Risk of violence	**10 (1-10)**

Risk Domains:

Criminogenic Risks	Rating by instrument
Antisocial Behaviors[1]	☒ High ☐ Medium ☐ Low
Antisocial Personality Patterns	☒ High ☐ Medium ☐ Low
Antisocial Cognitions	☒ High ☐ Medium ☐ Low
Antisocial Peers	☒ High ☐ Medium ☐ Low
Family/Marital Relationships	☒ High ☐ Medium ☐ Low
Employment/Education	☐ High ☒ Medium ☐ Low
Leisure and Recreation	☐ High ☒ Medium ☐ Low
Substance Use	☒ High ☐ Medium ☐ Low

[1] Italicized four risk factors are considered most closely associated with criminal recidivism

**Summary risk/needs score sheet to be attached to this assessment

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Substance Use Background and Factors: Brief Synopsis of Current and Past Use (type, quantity, frequency):

Does the client have a substance use diagnosis? Yes ☒ No ☐

If yes, what is the diagnosis? **Alcohol Use Disorder, Severe**

Was a toxicology screen completed? Yes ☒ No ☐

If yes, date completed and results: **11/10/16, Positive for THC**

Addiction Severity Index rating (include scale used): **Version 6 of the Addiction Severity Index (ASI-6)**

Number of lifetime detoxification programs entered: **3**

Number of lifetime residential treatment programs entered: **0**

Number of Naloxone or other rescues: **0**

Current cravings rating (1-10): **5**

Current use of Medicated Assisted Treatment (MAT): Yes ☐ No ☒

If yes, what type? _____

Past use of MAT: Yes ☐ No ☒

If yes, what type? _____

Gambling or other addictions: Yes ☐ No ☒

Mental Health Background and Symptom Rating (include scale, such as BASIS, used):

Does the client have a mental health diagnosis? Yes ☒ No ☐

If yes, what is the DSM diagnosis? **Conduct Disorder and ADHD, combined (diagnosed at 13), Mood disorder, Not Elsewhere Classified, PTSD, Alcohol Use Disorder, Severe and Cannabis Use Disorder, Severe**

How were diagnoses gathered? (Check all that apply)

☐ Objective measures ☒ Clinical interview ☒ Chart review ☒ Self-report

Current Behavioral Observations of Note:

The client presents as an average weight individual on a medium frame. His appearance seemed slightly younger than his stated age. He was dressed in a disheveled manner. He showed some difficulties in comprehending questions he was asked. Although, he was cooperative and adequate rapport seemed to be established, he demonstrated difficulty turn-taking during our conversation and often interrupted the counselor. His speech was pressured, loud and rapid. Additionally he was fidgeting-often tapping the table with his finger. He generally had difficulty staying on topic and was easily distracted by the environment- gazing out the window and becoming very tangential at times. The client apologized several times and reported that his "ADD" impacts his turn taking ability, speech and ability to sit still and stay on topic. He did request one break during the baseline assessment because he said it would help him with his focus. He displayed full and normal affect and it was generally congruent with the content of his self report except when client displayed laughter when discussing his trauma experiences.

Current mental health treatment: **Attending anger management group offered in jail; Attending treatment in RSAT but mostly to earn good time to get out and return to same situation**

Psychotherapy (type, frequency): **Weekly group counseling**

Type (CBT, Criminogenic Specific, etc.): **CBT**

Psychopharmacological assistance (name of medication, dosage): **Fluoxetine for anxiety associated with trauma**

Psychiatric hospitalizations and intensive treatment interventions: **1 psychiatric hospitalization for self harming behaviors at age 18 (cut self on face)**

Number of prior inpatient psychiatric hospitalizations ever: **1 (see above hospitalization description)**

Number of prior inpatient psychiatric hospitalizations in last year: **0**

Number of prior crisis unit stabilizations in last year: **0**

Number of prior emergency psychiatric visits in last year: **0**

Suicide/Self-Injury History:

Number of episodes as suicide attempts: **0**

Frequency of self-injury: **At least monthly from ages 13-18**

Most serious self-injury regardless of intent**: Carved a large symbol into his face with a knife at age 18**

Self-described information regarding suicidal thoughts, ideas, plans, or intent (consider further suicide assessments): **No current or past**

Last suicide and/or self-injury attempt: **Age 18**

Violence History:

Number of episodes (approximate daily, weekly, monthly, yearly, rarely): **Repetitive domestic violence charges (at least 2 incidents a year starting at age 19 years old) with long terms. Fighting during school years**

Most serious episode: **Broke girlfriend's nose last year**

Self-rated irritability/temper (scale 1-10, 10 being worst) (consider Navaco Anger scale): **8**

Medical Background and Treatment (type, frequency):

Does the client have a medical diagnosis? Yes ☐ No ☒

If yes, what is the diagnosis? _____

Number of prior medical hospitalizations ever: **1, Beaten badly as a teen. Jumped by a group of boys, reports a concussion**

Number of prior medical hospitalizations in last year: **0**

Number of prior emergency medical visits in last year: **0**

Please list any current medications for medical issues: **None**

Race/Ethnicity (self-described by client):

Ethnicity: ☒ Hispanic ☐ Non-Hispanic

Race (check all that apply): ☒ White ☐ Black or African American ☐ Asian
☐ American Indian ☐ Alaska Native ☐ Native Hawaiian or other Pacific Islander

Self-described specific cultural system that should be considered: **Client strongly identifies as Nuyorican, "New York" and "Puerto Rican." He is bi-lingual and mostly communicates with his friends and extended family in Spanish. He immigrated to mainland US from Puerto Rico at the age of 11. He reports being "Catholic" and that religion is a big part of this culture. He has tattoos with religious figures and sayings.**

Trauma Factors:

Posttraumatic Stress Disorder checklist (PCL) Rating (specify which PCL was used and whether Civilian or Military version): **PCL-C Score: 47**

Other trauma inventory data if available (i.e. Trauma Screening Questionnaire): **None**

Self-description of trauma responsivity factors (how does your trauma history impact you today?): **Client reported being traumatized by a fight that occurred in his teens where he was severely beaten by a group of boys he "considered" friends/fellow gang members. He reported that it is hard to trust others, make friends and that he often becomes fearful when he sees a group of boys or men. He also was physically abused by some of his Mother's past boyfriends. He reported several beatings in his childhood where he was injured (i.e. "gash" on head).**

Data from Other Assessments:

Motivational factors (section E on MISSION Assessments): **Reports high motivation driven by desire to earn good time and get an early release**

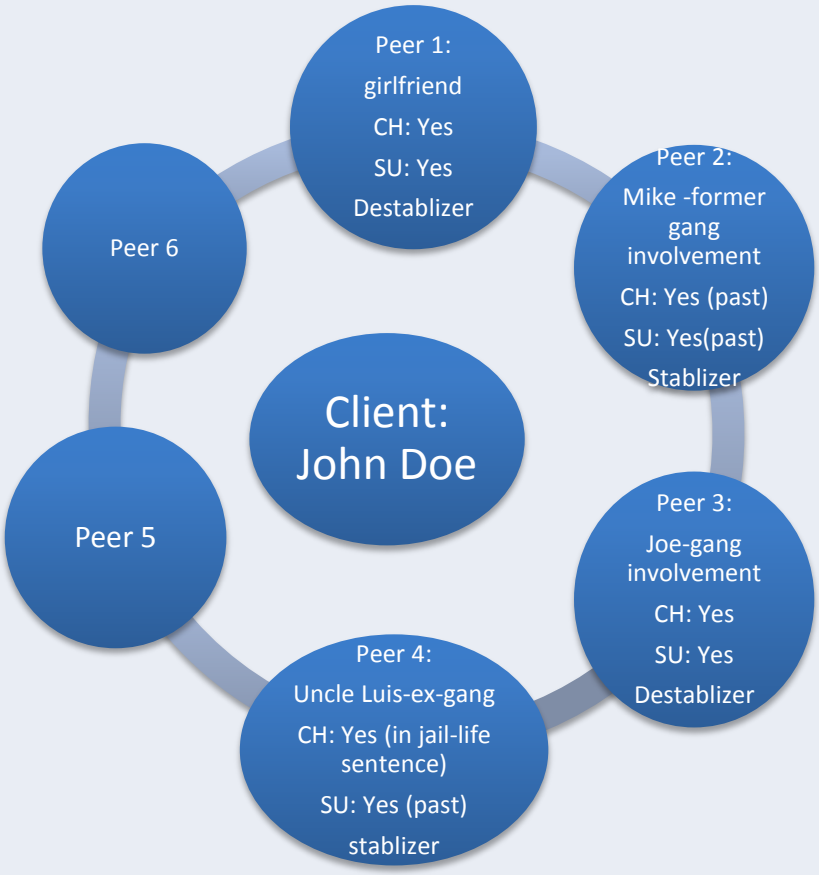
Perceived coercion factors (section E on MISSION Assessments): **Does not report feeling coerced to participate in pre- or post-release services**

Perceived self-determination toward recovery description: **Presents with low self-determination toward recovery post-release. Reports significant concerns about being able to manage environmental and relational triggers post release**

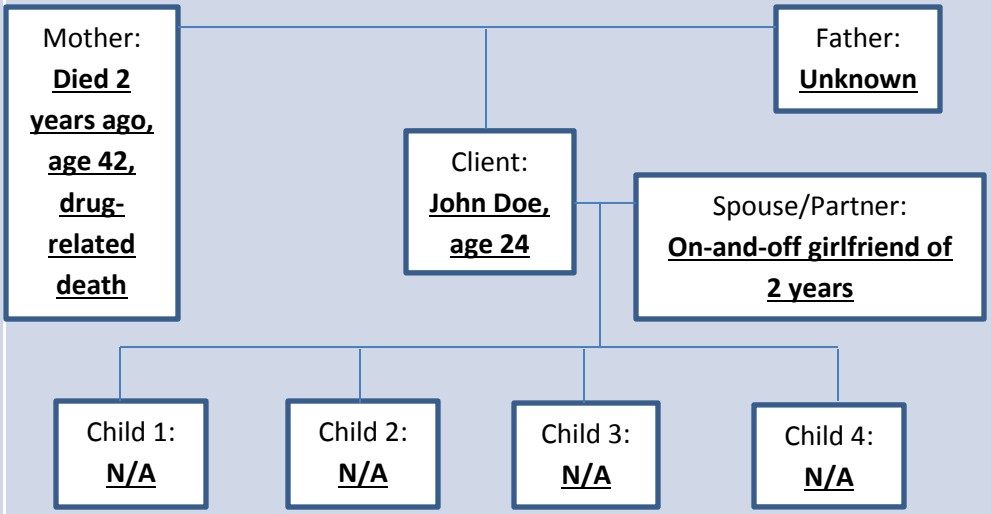
Psycho-social Summary: (brief summary of client's substance use/mental health disorder and/or RNR needs and history)

John is a 24-year old Hispanic male. Client's mother died of a drug over dose 1 year ago and he does not know his father. He has an on and off girlfriend of 2 years. He has been arrested for repetitive domestic violence and robbery charges, totaling 10 arrests. He has been using substances since age 12 when he started drinking alcohol and began gang involved. His drug use quickly progressed. He reported "trying every drug in the book" from 12-23 and drinking heavily throughout this time. He became "hooked" on heroin at age 22. He was a daily user and used multiple times a day. He is currently serving a two-year sentence on armed robbery related to trying to get money to support heroin habit. His initial adjustment to incarceration was poor and he received several initial disciplinary issues due to fighting with fellow inmates. He has now been incarcerated for 1-year months and has "settled in." He has "banked" a lot of good time and will be released early. He is currently attending treatment in RSAT and reports that he consistently attends because it helps him collect good time and will lead to early release. He reports wanting to stay sober post release, but has serious "doubts" due to environmental and relational triggers he will face when released. Client agreed to participate in MISSION-CJ pre and post release services. Client's RNR assessment indicates that he is a high risk, therefore he CM/PSS team will work together with the community justice partners in coordination and the CM/PSS will continually review progress and treatment plan.

Criminogenic Risk Data:

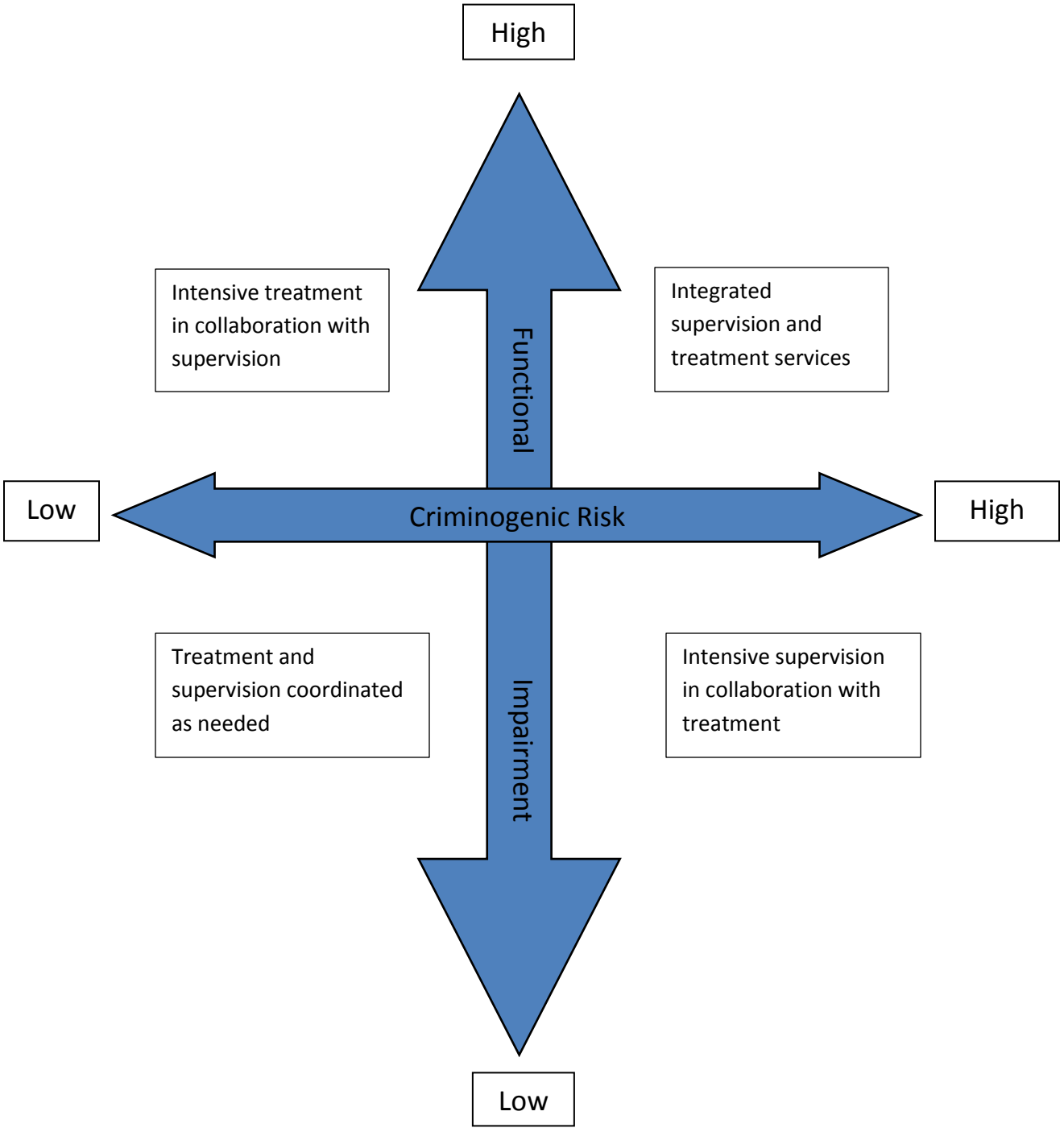
Criminogenic Risks	For Any Medium/High Scores
Antisocial Behaviors[2]	**Examples: Repetitive domestic violence and robbery charges, 10 arrests, Serving a two year sentence on armed robbery related to trying to get money to support heroin habit**
Antisocial Personality Patterns	**Examples: displays impulsive, adventurous pleasure seeking such drag racing on busy streets**
Antisocial Cognitions	**Examples: Risk thinking: "I could get away with it. No one will know"**
Antisocial Peers	Peer Descriptions: In each circle place peer initials, criminal history (CH) yes/no, substance use (SU) yes/no, stabilizer or destabilizer **Has "very few friends but many acquaintances." Most, if not all, acquaintances are gang involved, have a criminal history, use and/or sell drugs** 

[2] Italicized four risk factors are considered most closely associated with criminal recidivism

Criminogenic Risks	For Any Medium/High Scores
Family/Marital Relationships	
Employment/ Education	Current Activities: **Completed GED while incarcerated. Has no work experience**
Leisure and Recreation	Current Activities: **Prior to incarceration activities including hanging out with affiliated gang members at the bar or someone's house. Currently in the pod he enjoys playing cards, cooking in the cafeteria and attending therapy sessions with fellow inmates**
Substance Use	Current Use/Needs: **Has been abstinent since incarceration last year** **Used substances since age 12 when started with alcohol**

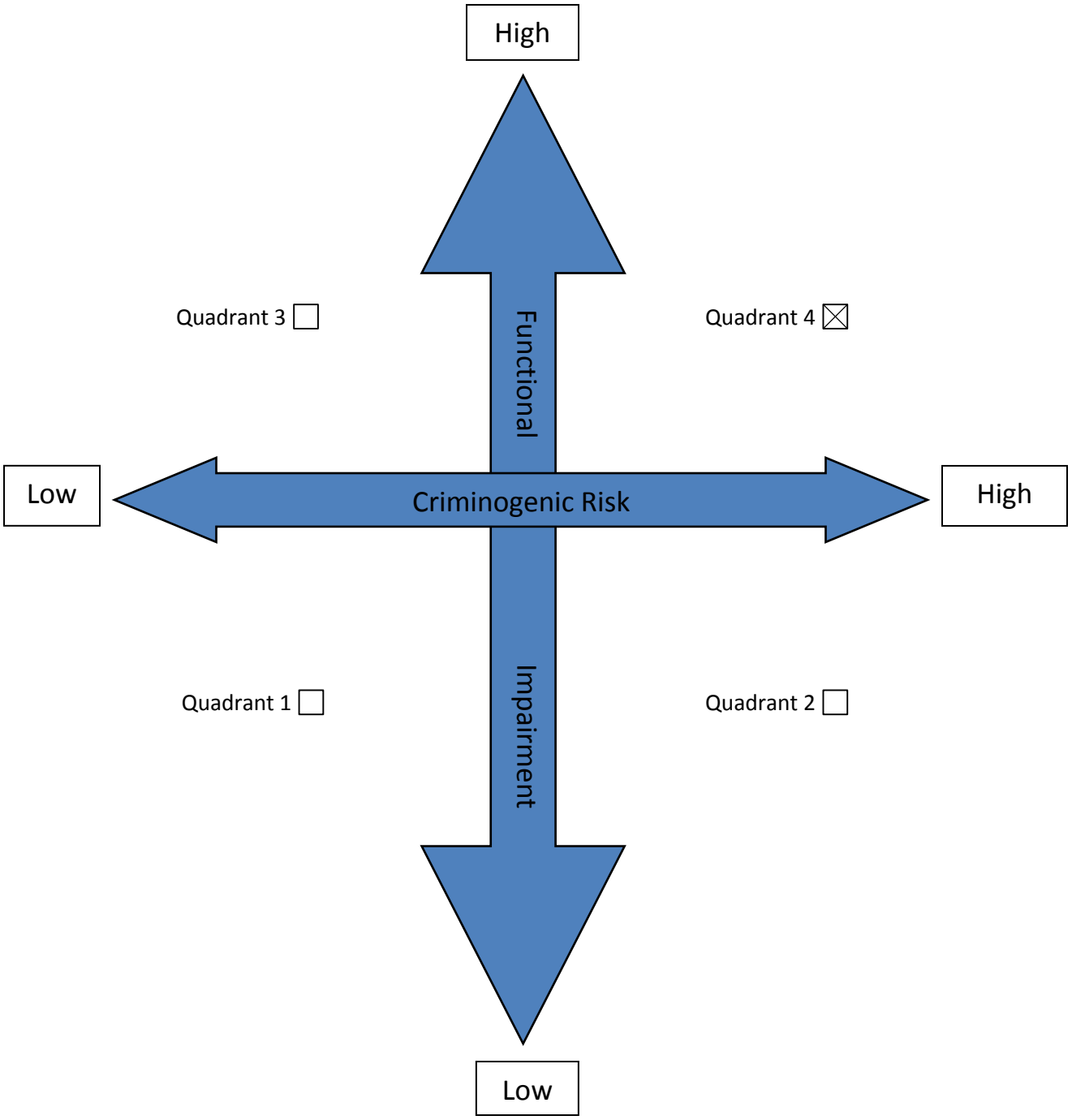
RNR Behavioral Health-Criminal Justice Framework (Complete framework on next page)

Identifying Strategies to Work with Target Population of Persons with Mental Illness by Criminogenic Need and Functional Impairment



Prins and Osher, Council of State Governments Justice Center, 2009

Client Data (Place Check in appropriate quadrant in Linkage grid to correspond to client needs):



Summary of Linkage Grid Above:

Client is in Quadrant 4, requiring high connection between behavioral health and criminal justice partners. Weekly contact between agencies to ensure coordination appears needed at least initially.

Client Strength and Resiliency Factors:

1. **Attending treatment in Residential Substance Abuse Treatment while incarcerated**
2. **Behavior Less volatile**
3. **Received GED rather quickly in jail**
4. **Able to be polite and laugh with staff without being superficial**
5. **Motivated to obtain employment**

RNR-Behavioral Health-Physical Health Treatment Plan:

Positive Resiliency Factors	Opportunities and Targeted Goals to Foster Strengths
1. **Attending treatment in RSAT** 2. **Behavior less volatile** 3. **Received GED** 4. **Able to laugh with staff** 5. **Motivated to obtain employment upon release**	1. **Motivational Interviewing to help move motivation rationale** 2. **Identify positive peer models that can model positive problem solving and management of anger further given client's current situation** 3. **Identify additional educational and training opportunities for client**

Criminogenic Risks	Needs	Targeted Goals for Intervention (include who and time line) (these should be measurable and achievable)[3]
****Targeted Goals for Intervention can be N/A for specific criminogenic risk categories if client has successfully reached and maintained goals in that category****		
Antisocial Behaviors[4]	**Reduce antisocial acts and criminal behaviors** **Reduce irritability contributing to behavior**	• **Upon Release Weekly 1:1 for monitoring by CM/PSS, encouragement, education (probation- 3 months)** • **CM will connect with probation by phone weekly to ensure coordination given client's risk level** • **Attend 1 DRT session per week (one additional dose per case manager and client as needed)** • **Discuss with client weekly observations of trauma awareness** • **Attend one prosocial activity (with peer; within two weeks)**
Antisocial Personality Patterns	**Reduce restless aggression**	• **CM will teach and practice (role-play to habit) anger control (DRT session) during two current month sessions** • **CM will teach and practice (role-play to habit) social skills (i.e., keeping out of fights) during two current month sessions** • **Peer will reinforce this learning via roleplay, review of related workbook exercises**
Antisocial Cognitions	**Reduce sense of mistrust and negative cognitions**	• **Peer support** • **Social structure in RSAT commitment meetings** • **CM will utilize DRT session focused on cognitive distortions and cognitive restructuring to address these thoughts**
Antisocial Peers	**Reduce interaction and time with negative peers (gang involved, current SUD and involvement in criminal behavior)**	• **Motivational Interviewing (MI) skills to increase desire to avoid antisocial peers** • **Increase time spent in prosocial structured & supervised activities by 50% (peer support specialist will identify activities and transport the client to these activities)**

[3] A manageable number of goals should be selected to avoid overwhelming the client and to allow for intensive case management and assertive outreach regarding these goals. The specific number of goals should be based on client capacity to handle multiple goals and staff ability to integrate direct service, support, case management, and assertive outreach around these goals.

[4] Italicized four risk factors are considered most closely associated with criminal recidivism

Family/Marital Relationships	**Family relations repair/resolution** **Recognize depression as impairing engagement**	• **Have client identify through lawyer parameters of any restraining order from girlfriend against him. Client will review this with PSS and CM in individual meetings** • **Have client evaluated for need for BIP (batterer intervention program)** • **Treat depression (medications, therapy and consult with prescriber and therapist monthly)**
Employment/ Education	**Reduce under employment**	• **CM and PSS will teach and practice (role-play to habit) social skills needed at work (i.e., getting ready for a difficult conversation, dealing with accusations, etc.) This will be done for this month every Monday morning when he has other appointments**
Leisure and Recreation	**Reduce levels of involvement in criminal leisure pursuits**	• **CM will use MI skills enhance motivation/desire to engage in prosocial activities** • **CM and PSS will identify and encourage participation to engage in prosocial activities** • **PSS will teach and practice (role-play to habit) skills needed to engage in these activities**
Substance Use	**Substance Use Treatment**	• **RSAT programming focused on addiction recovery** • **MISSION services focused on co-occurring disorder** • **AA post release**

Responsivity Factors	Needs	Interventions
Mental Health	**PTSD**	• **CM will assess further for PTSD symptom and will refer to a specialist for treatment of PTSD** • **CM and PSS will utilize the MISSION model to provide COD treatment and wrap around supports, integrating trauma informed consideration**
Ethnic/Cultural/ Spiritual	**Strongly identifies as Puerto Rican and reports that particular "saints" in his religion have protected him in really bad times/also mentioned utilizing prayer in difficult situation**	• **CM will explore spirituality as a support and prayer as a positive coping tool**
Linguistic	**Client reports feeling most comfortable in Spanish speaking social groups**	• **PSS will identify Spanish speakers AA meetings**
Housing	**Client is facing homelessness post release. A restraining order prevents him from living with his**	• **CM and PSS will identify a sober living house**

	GF	
Fiscal (this includes SSI/SSDI/TANF benefits)	**Client will have no funds post release** **Client has never had a bank account**	• **PSS will reach out to local church which provides donations (clothes, food) to reintegrating offenders** • **PSS will teach client how to set up an account and accompany him to the back (when ready) to set it up**
Trauma Reactivity	**High reactivity to neutral or ambiguous stimuli**	• **Determine need for PTSD treatment** • **Utilize a trauma informed approach in treatment as measured by utilization of formal screening of PTSD symptoms, referral for PTSD assessment and treatment if need indicated in screening**
Cognitive/ Intellectual	**Appears to function at average IQ level, but can be easily distracted due to ADHD**	• **CM and PSS will help client with organization skills** • **CM and PSS will help client schedule and attend an appointment to assess need for medications to manage ADHD symptoms**
Traumatic Brain Injury Sequelae	**Client reported a concussion at age 13. Also reported some head trauma from beatings received by Mother's boyfriend**	• **CM will refer for neuropsychological assessment to rule out any brain injury**
Other	**N/A**	• **N/A**

Preparer's Signature: **Mary Smith**

Client Signature: **John Doe**