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

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A B S T R A C T

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

1. Introduction

Problems associated in the literature to maladjustment, the risk of maladjustment, and ongoing maladjustment (Amato, 2001; American Psychiatric Association [APA], 2013; Cottle, Lee, & Heilbrun, 2001; Seijo, Fariña, Corras, Novo, & Arce, 2016) include internalizing (i.e., psychological adjustment); externalising symptoms (i.e., behavioural disorders, school failure); and social competence (i.e., poor social skills). These domains fall under the domain of dynamic factors i.e., problems associated in the literature to maladjustment, the risk of maladjustment, and ongoing maladjustment (Amato, 2001; American Psychiatric Association [APA], 2013; Cottle, Lee, & Heilbrun, 2001; Seijo, Fariña, Corras, Novo, & Arce, 2016) include internalizing (i.e., psychological adjustment); externalising symptoms (i.e., behavioural disorders, school failure); and social competence (i.e., poor social skills). 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Third, the assumption of a clinical treatment model for offenders who are not real clinical patients is intrinsically flawed. This assumption entails a double internal inconsistency underpinning the model: clinical intervention models for offender rehabilitation tend to measure efficacy in terms of modifying cognition (cognitive distortions) and not recidivism, which contradicts the responsivity principle. Succinctly, the main aim is to implicate the offender in the intervention, but labelling offenders patients and designating them clinical cases endorses false treatment adherence and progress, and in turn recidivism (i.e., the principle underlying clinical models is that offenders are not responsible for their acts due to their illness).

Fourth, disregarding noncriminogenic needs is regarded to be a major weakness undermining interventions, and several studies have linked noncriminogenic needs to recidivism (Maruna, 2004). Though noncriminogenic needs may not account for recidivism, they do act as inhibitors of recidivism (Novo, Fariña, Seijo, & Arce, 2012), and should be targeted by interventions. Furthermore, psychological adjustment is noncriminogenic needs may not account for recidivism, they do act as protective factors i.e., though they may not be efficacious in terms of modifying cognition (cognitive distortions) and not recidivism, which contradicts the responsivity principle. Succeedingly, the RNR principles, there were no differences between the mean effect sizes (overlapping mean confidence intervals) according to the level of adherence (none, one, two, and three principles), or the level of adherence (low, medium, high) to assess the principles of the model. Thus, the type of treatment administered, in particular in behavioural, cognitive behavioural, and multisystemic therapy, explains the same efficacy as the RNR (Hanson et al., 2009; Koehler et al., 2013). The high correlation between treatment type and the classification of studies on high adherence to the RNR model led Koehler et al. to underscore that both factors may be mutually confused. Nevertheless, adjusting interventions to meet the needs of offenders (need principle) is unquestionable i.e., interventions failing to target the needs of offenders simply lack substance. However, limiting interventions to criminogenic needs (i.e., history of antisocial behavior, antisocial personality pattern, antisocial cognition, antisocial associates, family/marital circumstances, school/work, leisure/recreation, substance abuse), and disregarding noncriminogenic needs (e.g., negation, little empathy for the victim, psychological adjustment, deficits in social skills; Hanson & Morton-Bourgon, 2004, 2005) may be a form of reductionism that undermines the efficacy of an intervention i.e., though they may not be the underlying causes of recidivism, they may serve as protective factors against recidivism. As for adjusting the intervention to the offender’s learning abilities (responsivity principle), its validity is so evident that no evidence is required to support this issue. Hence, the RNR model rather than an intervention model appears to be a model of favourable conditions for an efficacious rehabilitation intervention (high correlation between treatment type and intervention efficacy).

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