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Developing an Intervention to Reduce Criminal Recidivism During Reentry:

A Prototypical Model

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DRAFT (1-30-17)

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Abstract

Reentry--the process of returning to the community following incarceration--has received increasing attention in recent years, given the importance in promoting responsible living and decreasing the violence and criminal recidivism risk that can result from certain interventions and support. This article reviews the literature in the area of risk-reducing assessment and intervention services for individuals returning to the community following incarceration in federal prison. There is good empirical support for the specific assessment and interventions that could be effectively applied toward this end. The article further describes the Reentry Project, a university- and community-based program developed in partnership with a federal reentry court, that now offers such services. Using the available evidence, the Reentry Project experience, the challenges that have arisen and the approaches to addressing these challenges, this article offers a prototype for a community-based project seeking to provide effective risk-reducing services to justice-involved clients.

Developing an Intervention to Reduce Criminal Recidivism During Reentry:

A Prototypical Model

The process of returning to the community following incarceration has received increasing attention in recent years, given the value of promoting responsible living and decreasing criminal recidivism risk that can result from certain interventions and support. This is part of a larger focus on reducing recidivism through promoting rehabilitative alternatives to standard prosecution and incarceration across steps in the criminal justice system ranging from first contact to reentry (see, e.g., the Sequential Intercept Model; Griffin, Heilbrun, Mulvey, DeMatteo, & Schubert, 2015). It encompasses the growth of specialized interventions such as problem-solving courts, which generally operate at the pre- or post-adjudication stage as an alternative to incarceration, with considerable evidence for the effectiveness of drug courts and mental health courts in particular (Heilbrun et al., 2012). It includes attention to the reentry process itself, with additional structure (Brooks Holliday, Heilbrun, & Fretz, 2012) and criminogenically-oriented approaches (e.g., “firm but fair” attitudes on the part of probation officers; Eno, Louden, Manchak, O’Connor, & Skeem, 2015) providing evidence for improving the performance of individuals undergoing reentry. It has also included the establishment of problem-solving courts with jurisdiction over individuals going through reentry. These developments suggest that our criminal justice system is moving toward the implementation of specialized services delivered to individuals returning to the community from incarceration.

But such developments also raise important questions about what services will be delivered, to whom, with what goals, and in what ways. One of the core questions for mental health professionals providing services to justice-involved clients concerns whether such services should target behavioral health symptoms or criminogenic risk factors. Is the overarching goal to improve an individual’s behavioral health or reduce the risk of criminal reoffending? The impact of mental health treatment on offending risk reduction has been debated theoretically and empirically (Van Dorn, Desmarais, Petrila, Haynes, & Singh, 2013; Prins, Skeem, & Link, 2015), with some suggesting that the treatment of justice-involved individuals should prioritize offending risk reduction by targeting both behavioral health and non-behavioral health risk factors for crime (Heilbrun, DeMatteo, King, Thornewill, & Phillips, 2016).

The question of whether the participating individuals are part of a selected population (e.g., with severe mental illness, with substance abuse) or included in the broader general population of those returning to the community following incarceration is also important. The specific services would need to be more specialized for certain selected populations. However, there is good evidence that a theory of correctional classification and change, such as Risk-Need-Responsivity (RNR; Andrews, Bonta, & Wormith, 2011) can play a foundational role in providing services to justice-involved populations that are highly specialized, such as those with severe mental illness (Skeem, Steadman, & Manchak, 2015). For a plan to develop reentry services to individuals who are part of a general correctional population, however, an organizing theory such as RNR would be particularly applicable.

The evidence relevant to more specific Cognitive Behavioral Therapy (CBT)-based interventions in this context has recently been reviewed (Heilbrun, et al., 2016). This review examined effective specific elements in psychological interventions to reduce risk of reoffending while also examining the empirical evidence that these treatments more broadly reduce recidivism.

CBT interventions focus on understanding offenders’ learned distorted thinking while aiming to restructure these thought processes that may lead to criminal behavior (Lipsey, Landenberger, & Wilson, 2007). Elements of these interventions can include cognitive skills training, cognitive restructuring, anger management, and supplementary techniques to accomplish this goal (Heilbrun et al., 2016). Some specific programs in these areas include Reasoning and Rehabilitation (R&R) (Ross & Fabiano, 1985), Aggression Replacement Training (Goldstein & Glick, 1987), Thinking for a Change (T4C) (Bush et al., 1997), and the Cognitive Interventions Program (CIP) (National Institute of Corrections, 1996). More generally, problem solving interventions target positive versus negative orientations to problems, and problem solving styles (D’Zurilla & Nezu, 2001). Evidence suggests that no single “name brand” intervention is distinguishable from the others in it risk-reducing effectiveness. Rather, the shared aspects of these interventions may combine within different interventions to reduce reoffending risk, with a small but significant treatment effect for moderate and high risk cases (Heilbrun et al., 2016).

 Given the absence of a single intervention as clearly superior, it would seem that a community-based program providing reentry services to a general population of individuals should include multiple elements that are empirically supported. Such elements might include improving cognitive functions (Gendreau & Andrews, 1990), cognitive restructuring, “moral reconation,” and cognitive skills (Wilson, Gallagher, & MacKenzie., 2000), behavioral techniques (Pearson et al., 2002), and anger control, and interpersonal problem solving (Landenberger & Lipsey, 2005).

Structuring such interventions can be usefully guided by RNR. The first principle of the RNR model is risk, which focuses on matching the level of intervention intensity to the offender risk level. Those with higher measured risk levels are treated longer and more intensively (Andrews, et al., 2011), with recidivism reduced (and resources allocated) more effectively when this principle is observed (Bonta & Andrews, 2007). A standardized measure of reoffense risk, such as the Level of Service/Case Management Inventory (LS/CMI; Andrews et al., 2004), should be administered to obtain a meaningful measurement of risk level. The LS/CMI measures areas of risk and strength based on empirically-supported risk/need factors: history of antisocial behavior, antisocial personality pattern, antisocial cognition, antisocial associates, family/marital circumstances, school/work, leisure/recreation, and substance abuse (Andrews, Bonta, & Wormith, 2006). The LS/CMI has a mean predictive criterion validity including correlations with general recidivism (.41) and violent recidivism (.29), higher than most of the measure’s predecessors (Andrews, et al., 2006).

The second RNR principle is need. This principle guides the matching of intervention with identified areas of criminogenic need (Andrews et al., 2006; Bonta & Andrews, 2007). Hence, identifying each risk factor and targeting the associated need through intervention is a primary aspect of service delivery planning.

The third principle is responsivity, which guides the intervention in (a) using approaches that are empirically supported (*general responsivity*), and (b) employing interventions that are a good fit for the individual’s capacities and limitations (*specific responsivity*) (Andrews & Bonta, 2010). Practical barriers and personal limitations may need to be addressed before therapists can effectively target specific criminogenic needs.

Implementing community-based reentry interventions should be based on criminal justice risk and crimnogenic needs that are associated with reoffending behaviors (Wooditch, Tang, & Taxman, 2013). However, there is limited research on how offenders’ needs change over time, and how these changes affect recidivism rates. One study found that the criminogenic needs of parolees change significantly over six months (Schlager & Pacheco, 2011). Another study, conducted over a two-year period, found that probationers who increased in total LSI-R score were 67% more likely to be reconvicted than those who decreased their LSI-R total (Raynor, 2007). Neither study addressed the question of which dynamic needs are most important to fostering positive outcomes and reducing recidivism, but additional evidence indicates that participation in treatment can facilitate changes in criminogenic needs, which is associated with reduction in criminal offending overall (Wooditch et al., 2013). More specifically, individual participation in a brief, structured reentry program addressing four criminogenic needs (education/employment, procriminal attitudes/orientation, family/marital, and antisocial pattern) resulted in lower overall risk level and the reduction in risk level for each criminogenic need (Brooks Holliday et al., 2012).

Several studies have indicated that RNR-consistent approaches have a favorable impact on recidivism (Andrews et al., 1990; Dowden & Andrews, 1999; Vieira, Skilling, & Peterson-Badali, 2009). According to one meta-analysis (Andrews et al., 1990), the effect size for the appropriate type of treatment (.30) was greater than criminal sanctions (-.07), unsuitable services (-.06), or unspecified services (.13). The RNR model has a stronger impact on recidivism than do other approaches focusing on broader needs (Dowden & Andrews, 1999). The eight risk factors described by the RNR model provide a structure that is reasonably accurate in both appraising risk and identifying intervention targets (Grieger & Hosser, 2014).

Although limitations of the RNR model have been discussed (Polaschek, 2012), numerous studies have reported that its rehabilitative approaches are more effective in risk-reduction than are punitive measures (Lowenkamp, Latessa, & Smith, 2006; Vieira et al., 2009). The Correctional Program Assessment Inventory (CPAI) and associated correctional program integrity are correlated with the client’s success in rehabilitation programs (Lowenkamp et al., 2006). Targeting individuals’ needs and providing care that extends to companions can result in more positive outcomes for the client, while less attention to responsivity can reduce the effectiveness of the treatment (Lowenkamp et al., 2006). In addition, matching specific interventions to individuals’ needs has resulted in more positive outcomes (Vieira et al., 2009). Program effectiveness has also been shown to be associated with treatment providers’ implementation of the RNR principles (Andrews et al., 1990; Vieira et al., 2009). The incorporation of all three principles--risk, need, and responsivity—is thus important in developing a successful treatment plan for justice-involved individuals (Listwan, Cullen, & Latessa, 2006).

**Description of Prototypical Project**

A community-based project providing psychological services to individuals returning following incarceration, focusing on reducing the risk of criminal recidivism, should have three components. The assessment phase should involve appraisal of overall risk, including risk factors and protective factors that can be addressed through intervention. The motivational enhancement phase should include a discussion of assessment findings, identification of differences between assessor and client views about risk and needs, and encouragement to participate in subsequent sessions. Finally, the intervention phase should provide work on building skills in areas relevant to reoffending risk and responsible living, particularly in the domains of need identified in the assessment.

In this context, faculty and doctoral students in a university-based clinical psychology training program sought to build a community-based program (the “Reentry Project”) that would offer such services on a *pro bono* basis to individuals returning from federal incarceration who were clients in the Structured Assistance to Reentry (STAR) program, a federal reentry court in the Philadelphia area. The Reentry Project is housed within the Drexel University Psychological Services Center (PSC). It has three phases of services.

**Assessment**. Following a referral from the STAR program, a participant is scheduled for a combined intake and assessment appointment. A number of specialized measures are administered during the assessment phase to appraise risk, needs, and treatment targets. Each was selected to address an important aspect of risk and needs among reentry clients that could further identify a treatment topic (including both intensity and content). These measures include the Novaco Anger Scale and Provocation Inventory (NAS-PI; Novaco, 2003), the Level of Service/Case Management Inventory (LS/CMI; Andrews, Bonta, & Wormith, 2000), the Wechsler Abbreviated Scale of Intelligence-Second Edition (WASI-II; Wechsler, 2011), the Psychological Inventory of Criminal Thinking Styles (PICTS; Walters, 1995), the Self-Appraisal of Risk and Needs (SARAN; King, 2016), the Corrections Victoria Treatment Readiness Questionnaire (CVTRQ; Casey, Day, Howells, & Ward, 2007), the Stressful Life Events Screening Questionnaire (SLESQ; Corcoran, Green, Goodman, & Krinsley, 2000; Goodman, Corcoran, Turner, Yuan, & Green, 1998), the Social Problem Solving Inventory-Revised: Short (SPSI-R:S; D’Zurilla, Nezu, Mayden-Olivares, 1990), and the Triarchic Psychopathy Measure (Tri-PM; Patrick, 2010).  Administration of these measures can be completed in approximately 2.5 hours. They yield information that is useful for informing decisions on the length of participation in the Reentry Project, the composition of therapy groups, and whether interventions will be delivered in a group (as they are for most individuals) or individual format. Individuals appraised at medium or high risk for reoffending are expected to complete Modules 1 and 2, whereas low risk individuals need only complete Module 1. Whenever possible, low risk individuals are not mixed with medium or high risk individuals in groups. Occasionally placing a low risk individual in sessions delivered individually has been one approach to avoid such mixed group composition.

**Motivational Enhancement**. After clients complete the assessment session(s), trainee clinicians score and interpret test results and provide feedback to clients. This feedback is based on the Short Motivational Programme, which was designed to increase offender’s motivation to change prior to release from prison (Corrections Department New Zealand, nd). It is intended to (1) facilitate clients’ linkage of the assessment results and the prescribed treatment modules; (2) prepare clients for interventions that will follow; and (3) motivate clients to participate meaningfully in treatment. It is also influenced to some extent by the literature on motivational interviewing (see, e.g., Hettema, Steele, & Miller, 2005), but is more directive. It links assessment with treatment planning by describing the concepts of risk and protective factors, and their relation to treatment needs. Clients are then informed about results reflecting their own risk level and treatment needs. To make the feedback more supportive and beneficial, the discussion begins by noting risk factors that are absent (e.g., low risk or strength areas), then proceeds to high risk and medium risk areas. Finally, clients derive treatment goals from the RNR model. For instance, if Family/Marital were a problem area, then one treatment goal might involve reducing conflict at home and spending more time with one’s children. Throughout the feedback session, a standardized form is used to assist in the review of important information. Clients receive a copy of this form to use throughout treatment. Feedback is delivered in a respectful, supportive manner intended to help clients to feel more comfortable and discuss their reactions more openly.

**Skills-Based Interventions**. Next, participants complete either one or two skills-based cognitive group therapy modules. (Occasionally this material is adapted for individual sessions.) Using information gathered from the initial intake assessment, the Reentry Project addresses the RNR risk principle by determining the duration of intervention (one or two modules). Individuals assessed as low risk for recidivism need only complete the first module, which focuses on skills training and criminal thinking. Those assessed as medium or high risk for recidivism complete both the first module and a second module focused on reducing criminal thinking and increasing problem-solving skills. The need principle is considered by promoting the match between identified risk factors and subsequent interventions. If specific needs are identified that are not covered in the modules, then intervention services may be supplemented with additional individual sessions. The responsivity principle is incorporated by (a) developing group modules that address the areas of criminogenic need identified in the LS/CMI, using approaches that are empirically supported (general responsivity) and through supplementing this material by providing additional work that is adapted to that individual’s cognitive and interpersonal style (specific responsivity).

Each group meeting is co-facilitated by two Reentry Project clinicians from Drexel’s doctoral program in clinical psychology. Each meeting begins with a review of homework from the previous session. Following homework review, clinicians provide a topic for the day’s meeting along with relevant didactic material for discussion. Each session may include such didactic material, group discussion, role-plays, and occasional video. All group sessions meet for one hour once weekly. Sessions conclude with the assignment of homework for the following week. Following each session, an email is sent to the STAR program outlining the content of the present session, as well as participant attendance, participation, and homework completion. A manual providing a detailed description of the assessment, motivational enhancement, and group modules is available without cost from the first author.

**Program Development and Functioning**

A total of 32 participants have been referred and provided services between June 2015 and January 2017. All have been participants in the STAR program, as individuals returning to the community from federal incarceration. The development and current operation of the Reentry Project reflects ongoing program revision in light of feedback from group facilitators, the Reentry Court, and the participants. These changes, described in this section, involve modification of the overall structure of the program (e.g., number and length of group therapy modules, format of supervision), as well as some revision of the content and delivery of various group sessions.

**Service development and communication with courts and federal probation**. This project involves active communication between the referring STAR program (federal judges and probation officers) and the director and trainee clinicians involved in the Reentry Project. This communication began at the planning stage, and continued regularly through the implementation phase.

Such communication yielded a number of program-level changes during the planning and early implementation stages. For instance, to better accommodate the needs of the reentry court and clients, the original three-module intervention format (comprised of separate modules in Skills, Criminal Thinking, and Problem Solving) was condensed to its current two modules. The current one-hour motivational enhancement session that follows completion of all intake measures was initially conceptualized as two one-hour sessions that would occur on separate days, but this was impractical because of scheduling difficulties. A post-completion battery of measures on variables that may have been modified during services was implemented, covering problem solving abilities, criminal thinking, readiness for change, anger management abilities, and self-appraised risk level. A point system was developed to promote attendance, participation in the intervention sessions, and completion of homework. The assignment of points for various activities helped participants better understand what would be needed to successfully complete the program—and allowed STAR program staff to be more aware of the progress of any given individual (cumulative point totals as well as attendance and participation is provided weekly to the STAR program).

Revision of the content of various group sessions, based on feedback from clinicians and participants, has also been a continual process since the project’s inception. The accumulation of these smaller changes spurred a major revision of the Project manual in the summer of 2016. At this time, a session based on emerging literature about the bias blind spot (Croskerry, Singhal, & Mamede, 2013; Pronin, Lin, & Ross, 2002) was added, and a number of sessions were combined or reorganized to further streamline the intervention modules. Since a number of participants had difficulty with regular sleep and eating schedules, a “self care” session that provides material on sleep hygiene and healthy eating was incorporated into the Skills module.

Some revision of session format has also occurred. For instance, the Reentry Project team has developed the option for the current group-format modules to be administered individually. The decision to provide a participant with individual sessions is based on two primary considerations: (1) the participant’s cognitive capacity, and (2) the clinician’s judgment that a given client might respond more favorably to individually-delivered services. In addition, formatting changes were made to weekly homework assignments based on feedback that participants frequently either forgot or lost their homework. Accordingly, an electronic homework system using Qualtrics (https://www.qualtrics.com/) was developed that allowed participants to complete their homework on a computer or smartphone, and also gave clinicians the opportunity to view clients’ homework prior to the next session.

**Staffing and supervision**. The Reentry Project is directed by a licensed clinical psychologist on the Drexel faculty, and staffed by trainee clinicians in the doctoral program in clinical psychology at the university. One hour of group supervision weekly includes viewing sessions from the previous week, documented on the Psychological Services Clinic’s video system. Additional individual supervision is provided as needed to trainee clinicians. A vertical supervision model, in which more experienced Reentry Project trainees model assessment services and serve as co-therapists with less experienced trainees, has also been implemented. Regular meetings are held involving all Reentry Project staff and participants’ parole officers.

**Discussion**

It is reasonably clear that there is good theoretical and empirical support for the provision of certain community-based psychological services designed to reduce reoffending risk during reentry. There are substantial challenges associated with the development and implementation of such services, however, particularly when they are developed programmatically and implemented in conjunction with oversight provided by a reentry court, probation services, or both. But if these challenges can be addressed, there is potential for providing services that can reduce the risk of reoffending and promote the prospects for better adjustment and responsible living during reentry.

This article describes the development and implementation of a prototypical program of this kind. It has several components that could usefully be incorporated into the development of other programs in different communities in the United States: close collaboration with an oversight authority; consistency with the RNR model; incorporation of assessment, motivational enhancement, and skills-based intervention; provision of services at no (or minimal) cost to participants through establishment in a training setting; the recording of relevant data (and subsequent seeking of post-completion outcome data) for research purposes; and the provision of intervention experience with justice-involved populations to trainees. When a university or professional training organization is also committed to community outreach and pro bono public service, then such a project offers additional value by contributing to that mission. This can also be considered as a logical extension of a university-based forensic clinic (Heilbrun, Kelley, Koller, Lane, & Peterson, 2013).

There are a number of challenges in developing and implementing a program such as the prototype we have described in this article. The first is logistical. Individuals involved in reentry court have multiple expectations related to treatment, employment, educational or vocational training, meetings with court and probation officers, and court appearances. Accordingly, scheduling group therapy sessions and ensuring consistent, punctual attendance is often difficult. Participants may be seeking a job, and have interviews or trainings that that conflict with treatment. Even those who are employed frequently have unpredictable work schedules, making punctuality difficult. The Reentry Project has attempted to schedule therapy sessions around participants’ schedules, and has multiple scheduled groups that allow participants an initial choice of time and day.

 The second challenge involves family and finances. Family obligations often arise; most participants have children and/or significant others who depend on them. Many participants are required to pay child support, an additional expense that may cause them to look for second jobs or request overtime. To help participants deal with these challenges, the Reentry Project maintains a listing of outside resources (e.g., childcare, job-seeking) that may be helpful. The Project also has ongoing relationships with social workers and case managers to improve communication and facilitate wraparound services.

The third challenge has involved physical and behavioral health difficulties experienced by participants. Those served by this project have experienced migraines, concussions, gastrointestinal problems, muscle pain, and arthritis. Additionally, participants have presented with various behavioral health concerns, including insomnia, PTSD, severe anxiety, and depression. All of these can limit participants’ ability to attend or participate meaningfully in sessions. (It should be noted that participants in this project have not been selected in any way for their experience of behavioral health problems; such concerns may simply be representative of those from an unselected population of individuals returning to the community from incarceration.) To address these challenges, the Project offers individual therapy as an optional supplement—and can refer clients for additional treatment to staff in the Psychological Services Clinic who treat anxiety, sleep and eating disorders, and other difficulties experienced by those seeking services in a community-based mental health clinic.

The fourth challenge has involved participants’ living situations. Some live in halfway houses, which can create scheduling and communication challenges, as those individuals require permission to leave their living space. The Project staff has developed open lines of communication with probation officers and halfway house staff to promote better attendance and avoid absences created by miscommunication and other problems impeding attendance.

As a consequence of these challenges, there have been some significant delays between the delivery of the initial assessment, the subsequent motivational enhancement session, and the beginning of group therapy sessions. These delays have created difficulties, as the program was designed to have each phase of service following closely from its predecessor. Once again, the active communication between STAR personnel and Project staff has been the most effective way to address these scheduling delays.

**Reluctance to Participate and Readiness for Treatment**

 Participant reluctance and limited readiness for treatment have also presented as challenges. Participants attend the Reentry project with the strong, active encouragement of their reentry court judge. However, this encouragement is not synonymous with a mandate for treatment, and potential participants who decline to begin (or continue) with the Reentry Project are not dropped from the STAR program for that reason alone. Some participants dislike even this “soft” requirement, and view group therapy sessions as an unnecessary burden in their reentry. Eliciting buy-in from such participants can be challenging, and can negatively affect the others in the group and the group’s atmosphere. Project staff have learned to consider themselves advocates for the skill development and thinking changes that are targeted as part of these planned interventions. This begins with the motivational enhancement session, and continues as part of therapist-client communication during the group modules. Although each module is fairly structured, therapists must identify and address important issues that are raised by clients that may be beyond the immediate agenda for the day’s session.

**Multicultural Considerations**

 Many multicultural considerations have arisen in working with individuals who have recently been released from incarceration. All referred individuals to date have been African-American males; all therapists are female and of varying racial/ethnic backgrounds. The Project staff are also doctoral trainees in their 20s or early 30s, while participating clients have been considerably older. Finally, most facilitators come from upper-middle-class families who valued education and provided social support, while participants generally did not have these opportunities while growing up. These differences have often created tension and threatened rapport between therapists and clients. For participants who are male and older, it may be difficult to accept that a younger female is in a role with greater perceived authority. Some participants have commented that facilitators are not able to fully understand the lives and circumstances of their clients.

To handle these differences, facilitators are educated and supervised on multicultural issues, and trained to develop clinical skills that incorporate multicultural awareness. It can help to address these differences directly. Often explicitly discussing such differences has defused tension, and led to a productive and open exchange that allows progress in the planned areas of work while simultaneously communicating a sense of awareness of and respect for differences.

The religious orientation of participants has also presented some challenges. Many participants are Muslim and some are Christian. Religious beliefs sometimes clash with topics covered in the group therapy session. Some participants have used religion as justification to avoid personal accountability (“It’s all in God’s plan”). Facilitators attempt to balance respect for participants’ beliefs with the need to deliver the intervention effectively.

**Effective Treatment Delivery**

 Several challenges to effective delivery of treatment services have also arisen. First, participants often have different levels of formal education, ranging from elementary school to high school graduation and occasionally some college credit. There are differences in personal style and capacity for reflection as well. Some participants easily engage in self-reflection, while others struggle to do so. Low risk and high risk individuals have occasionally been placed in the same group when there are no practical alternatives. Facilitators under these circumstances must determine how to present material to individuals of differing education and risk levels, and with varying personal styles and capacities. Striking a balance in these situations can be challenging. As the Reentry Project continues to expand, we anticipate that the number of different groups and the increased opportunities for delivering services in different modalities will allow group composition to become more homogenous.

Finally, in the early stages of the Reentry Project, participants frequently failed to complete their homework, often forgetting to bring it or losing it during the week. To address this problem, we developed a means of completing homework via a secure, web-based survey that can be accessed on a smartphone or computer. This greatly increased the completion rate for assigned homework. Paper homework assignments remain optional for participants who do not have smartphones or computer access.

The Reentry Project experience suggests that the development of community-based services to individuals returning from incarceration is feasible when there is a partnership between a larger justice-related entity (e.g., a reentry court, parole and probation services) and a mental health provider. But there are a range of challenges that must be addressed, beginning with the structure and specific content. The use of RNR (Andrews & Bonta, 2010) as a foundational theory and guide has been quite helpful, as has the awareness of comparable effectiveness of many specific interventions for targeting criminogenic need (Heilbrun et al., 2016). Projects can provide trainees with the opportunity to obtain intervention experience with justice-involved individuals, which is often difficult to acquire outside of correctional facilities. The incorporation of a research component, which the Reentry Project is building through careful selection of relevant variables and ongoing recording in a database, can provide the opportunity for refining existing interventions, developing new ones, and measuring the impact of such interventions with the opportunity to incorporate a control or comparison group. Other challenges have been described, with some variably effective solutions, throughout this article. We hope this offers some evidence and guidance for the development and refinement of other community-based diversion and reentry program.

**Limitations**

There are three clear limitations to the information provided, and the conclusions drawn, in this article. First, the Reentry Project has operated for a relatively short period of time and has served a fairly small number of individuals (N=32). For these reasons, it is possible that the Project’s experience to date has not provided a stable representation of the opportunities, challenges, and resolutions that are needed to develop and successfully operate such a program. Second, the environment is which this project was developed may differ substantially from others in terms of resources, client characteristics, and oversight programs. It may well be that the generalizability of this experience is limited by the specific context in which this project has been developed and operated. Third, the information provided has been descriptive and qualitative. It would clearly be preferable to include quantitative data obtained in the context of a project design that incorporates a control or comparison group, with post-treatment outcome data obtained over a period of a year or longer. This third limitation is being addressed, as the project was developed with the intention of incorporating quantitative measures of process and outcome. We anticipate these will be available in the coming years.

**Conclusion**

Empirical evidence in assessing and reducing the risk of criminal reoffending indicates that the field is prepared to offer such effective services in a variety of community contexts, including reentry, diversion, and specialized alternatives such as problem-solving court. Using the experience obtained in developing and implementing such a program with individuals undergoing reentry, we offer a prototypical description of a program that provides such services. Despite the presence of multiple challenges, our experience suggests that such programs can be developed, particularly in partnership with larger oversight programs, to effectively serve justice-involved clients by helping them to reduce their reoffense risk and improve the quality of their lives.

References

Andrews, D. A. & Bonta, J. (2010). *The psychology of criminal conduct (*5th ed.)*.* New Providence, NJ: LexisNexis.

Andrews, D. A., Bonta, J., & Wormith, J. S. (2006). The recent past and near future of risk and/or need assessment. *Crime & Delinquency, 52*, 7-27. doi: 10.1177/0011128705281756

Andrews, D. A., Bonta, J., & Wormith, J. S. (2011). The Risk-Need-Responsivity (RNR) model: Does adding the Good Lives model contribute to effective crime prevention? *Criminal Justice and Behavior, 38,* 735-755. doi: 10.1177/0093854811406356

Andrews, D. A., Bonta, J., & Wormith, S. J. (2000). *Level of Service/Case Management Inventory: LS/CMI*. Toronto, Canada: Multi-Health Systems.

Andrews, D. A., Bonta, J., & Wormith, S. J. (2004). *The Level of Service/Case Management Inventory (LS/CMI).* Toronto, Ontario, Canada: Multi-Health Systems.

Andrews, D. A., Zinger, I., Hoge, R. D., Bonta, J., Gendreau, P., & Cullen, F. T. (1990). Does correctional treatment work? A clinically relevant and psychologically informed meta-analysis. *Criminology*, *28*, 369-404.

Bonta, J. & Andrews, D. A. (2007). *Risk-Need-Responsivity model for offender assessment and rehabilitation* (Public Safety No. PS3-1/2007-6). Retrieved from https://www.publicsafety.gc.ca/cnt/rsrcs/pblctns/rsk-nd-rspnsvty/index-eng.aspx

Brooks Holliday, S., Heilbrun, K., & Fretz, R. (2012). Examining improvements in criminogenic needs: The risk reduction potential of a structured re‐entry program. *Behavioral Sciences & the Law*, *30*, 431-447.

Bush, J., Glick, B., & Taymans, J. (1997, revised 1998). *Thinking for a change: Integrated cognitive behavior change program*. National Institute of Corrections. Washington D.C.: U.S. Department of Justice.

Casey, S., Day, A., Howells, K. and Ward, T. (2007). Assessing the suitability for offender rehabilitation: development and validation of the treatment readiness questionnaire. *Criminal justice and behavior, 34,* 1427–1440.

Corcoran, C. B., Green, B. L., Goodman, L. A., & Krinsley, K. E. (2000). Conceptual and methodological issues in trauma history assessment. In A. Shalev, R. Yehuda, & A. McFarlane (Eds.), *International handbook of human response to trauma* (pp. 223-232). New York: Plenum.

Corrections Department New Zealand (nd). Short motivational programme. Retrieved 1-24-17 from <http://www.corrections.govt.nz/working\_with\_offenders/prison\_sentences/employment\_and\_support\_programmes/rehabilitation\_programmes.html>.

Croskerry, P., Singhal, G., & Mamede, S. (2013). Cognitive debiasing 2: Impediments to and strategies for change. *BMJ Quality and Safety, 22*, 65-72.

D’Zurilla, T.J., & Nezu, A.M. (2001). Problem solving therapies. In K.S. Dobson (Ed.), *Handbook of cognitive-behavioral therapies* (2d ed.) (pp. 211-245). New York: Guilford.

D'Zurilla, T. J., Nezu, A. M., Maydeu-Olivares, A. (1990). *Manual for the Social Problem Solving Inventory-Revised (SPSI-R)*. North Tonawanda, NY: Multi-Health Systems.

Dowden, C., & Andrews, D. A. (1999). What works in young offender treatment: A meta- analysis. *Forum on Corrections Research, 11,* 21-24.

Eno, Louden, J., Manchak, S., O’Connor, M., & Skeem, J. (2015). Applying the Sequential Intercept Model to reduce recidivism among probationers and parolees with mental illness. In P. Griffin, K. Heilbrun, E. Mulvey, D. DeMatteo, & C. Schubert (Eds.), *The Sequential Intercept model and criminal justice; Promoting community alternatives for individuals with serious mental illness* (pp. 118-136). New York: Oxford.

Gendreau, P., & Andrews, D.A. (1990). Tertiary prevention: What the meta-analyses of the offender treatment literature tell us about what works. *Canadian Journal of Criminology, 32*, 173-184.

Goldstein, A.P., & Glick, B. (1987). *Aggression replacement training: A comprehensive intervention for aggressive youth*. Champaign, IL: Research Press.

 Goodman, L., Corcoran, C., Turner, K., Yuan, N., & Green, B. L. (1998). Assessing traumatic event exposure: General issues and preliminary findings for the Stressful Life Events Screening Questionnaire. *Journal of Traumatic Stress, 11*, 521-542.

Grieger, L., & Hosser, D. (2013). Which risk factors are really predictive? An analysis of Andrews and Bonta’s “Central Eight” risk factors for recidivism in German youth correctional facility inmates. *Criminal Justice and Behavior*, *41*, 613-634.

Griffin, P.A., Heilbrun, K., Mulvey, E.D., DeMatteo, D., & Schubert, C.A. (Eds.) (2015). *The Sequential Intercept Model and criminal justice: Promoting community alternatives for individuals with serious mental illness*. New York: Oxford University Press.

Heilbrun, K., DeMatteo, D., King, C., Thornewill, A., & Phillips, S. (2016). Risk-reducing interventions for justice-involved individuals: A critical review. In B. Bornstein & M. Miller (Eds.), *Advances in Law and Psychology* (pp. 271-304). New York: Springer.

Heilbrun, K., DeMatteo, D., Yasuhara, K., Brooks Holliday, S., Shah, S., King, C., Bingham DiCarlo, A., Hamilton, D., & LaDuke, C. (2012). Community-based alternatives for justice-involved individuals with severe mental illness: Review of the relevant research. *Criminal Justice and Behavior, 39,* 351-419. DOI: 10.1177/0093854811432421

Heilbrun, K., Kelley, S.M., Koller, J.P., Lane, C., & Peterson, L. (2013). The role of university-based forensic clinics. Published online 2-13, DOI: 10.1016/j.ijlp.2013.04.019. *International Journal of Law and Psychiatry*, *36*, 195-200.

Hettema, J., Steele, J., & Miller, W. (2005). Motivational interviewing. *Annual Review of Clinical Psychology, 1*, 91-111.

King, C. (2016). *The prediction of criminal recidivism using self- and evaluator appraised risk and needs* (Doctoral dissertation). Retrieved 1-24-17 from <http://search.proquest.com/docview/1790102519>.

Landenberger, N.A., & Lipsey, M.W. (2005). The positive effective of cognitive-behavioral programs for offenders: A meta-analysis of factors associated with effective treatment. *Journal of Experimental Criminology, 1,* 451-476. Doi: 10.1007/s11292-005-3541-7.

Lipsey, M.W., Landenberger, N.A., & Wilson, S.J. (2007). Effects of cognitive-behavioral programs for criminal offeners. *Campbell Systematic Reviews, 6*, 1-27.

Listwan, S. J., Cullen, F. T., & Latessa, E. J. (2006). How to prevent prisoners re-entry programs from failing: Insights from evidence-based corrections. *Federal Probation*, *70*, 19.

Loeber, R., Pardini, D., Homish, D. L., Wei, E. H., Crawford, A. M., Farrington, D. P., Stouthamer-Loeber, M., Creemers, J., Koehler, S. A., & Rosenfeld, R. (2005). The prediction of violence and homicide in young men. *Journal of Consulting and Clinical Psychology 73,* 1074-1088. doi: 10.1037/0022-006X.73.6.1074

Lowenkamp, C. T., Latessa, E. J., & Smith, P. (2006). Does correctional program quality really matter? The impact of adhering to the principles of effective intervention. *Criminology & Public Policy*, *5*, 575-594.

NIC (National Institute of Corrections) (1996). *Cognitive interventions program: Think*. National Institute of Corrections Information Center. Washington D.C.: U.S. Department of Justice.

Novaco, R. W. (2003). The Novaco Anger Scale and Provocation Inventory. *Los Angeles, CA: Western Psychological Services.*

 Patrick, C. J. (2010). *Triarchic psychopathy measure (TriPM*). Retrieved from [https://www.phenxtoolkit.org/index.php?pageLink=browse.protocoldetails&id=121601](https://www.phenxtoolkit.org/index.php?pageLink=browse.protocoldetails&amp;id=121601)

Polaschek, D. L. (2012). An appraisal of the risk–need–responsivity (RNR) model of offender rehabilitation and its application in correctional treatment. *Legal and Criminological Psychology*, *17*, 1-17.

Prins, S., Skeem, J., & Link, B. (2015). Criminogenic factors, psychotic symptoms, and incident arrests among people with serious mental illness under intensive outpatient treatment. Law and Human Behavior, 39, 177-178. http://dx.doi/org/10.1037/lhb0000104

Pronin, E., Lin, D. Y., & Ross, L. (2002). The bias blind spot: Perceptions of bias in self versus others. *Personality and Social Psychology Bulletin, 28*, 369-381.

Raynor, P. (2007). Risk and need assessment in British probation: The contribution of LSI-R*.* *Psychology, Crime & Law, 13*, 125-138.

Ross, R.R., & Fabiano, E.A. (1985). *Time to Think: A Cognitive Model of Delinquency Prevention and Offender Rehabilitation*. University of Tennessee: Institute of Social Sciences and Art.

Schlager, M. D., & Pacheco, D. (2011). An examination of changes in LSI-R scores over time: Making the case for needs based case management*.* *Criminal Justice and Behavior, 38*, 541-553.

Skeem, J., Steadman, H., & Manchak, S. (2015). Applicability of the Risk-Need-Responsivity model to justice-involved people with mental illness. *Psychiatric Services, 66*, 916-922. http://dx.doi.org/10.1176/appi.ps.201400448

Van Dorn, R., Desmarais, S., Petrila, J., Haynes, D., & Singh, J. (2013). Effects of outpatient treatment on risk of arrest of adults with serious mental illness and associated costs. Psychiatric Services, 64, 856-862. doi: 10.1176/appi.ps.201200406.

Vieira, T. A., Skilling, T. A., & Peterson-Badali, M. (2009). Matching court-ordered services with treatment needs predicting treatment success with young offenders. *Criminal Justice and Behavior*, *36*, 385-401.

Walters, G. D. (1995). The Psychological Inventory of Criminal Thinking Styles: Part I. Reliability and preliminary validity. *Criminal Justice and Behavior*, *22*, 307–325. doi: 10.1177/0093854895022003008

 Wechsler, D. (2011). *Wechsler abbreviated scale of intelligence–second edition (WASI-II).*San Antonio, TX: NCS Pearson.

Wilson, D.B., Gallagher, C.A., & MacKenzie, D.L. (2000). A meta-analysis of corrections-based education, vocation, and work programs for adult offenders. *Journal of Research in Crime and Delinquency, 37*, 347-368. doi: 10.1177/0093854804272889.

Wooditch, A., Tang, L. L., & Taxman, F. S. (2013). Which criminogenic need changes are most important in promoting desistance from crime and substance use?. *Criminal Justice and Behavior*, 0093854813503543.