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From Case Management to Change Agent: The Evolution Of 'What Works' Community Supervision

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Abstract

Traditionally, the role of a community supervision officer has in large-part been that of a case manager. However, knowledge in the area of 'What Works' in offender rehabilitation has stimulated efforts to revolutionize what it means to supervise clients in the community; that is, moving from a case-management approach to what we call a 'change-agent' approach. In this article, we define what cognitive-behaviourism looks like in a criminal justice context and how it can be used to maximize the impact of community supervision. Through the amalgamation of cognitive-behavioural techniques and risk/need information, we propose the use of a theoretically and empirically-based framework (i.e., the STICS Action Plan) to assist community supervision officers in planning, prioritizing and effectively achieving change with their clients.

Authors' Notes

We would like to thank Jim Bonta and Tanya Rugge who are integral to the Strategic Training Initiative in Community Supervision team. Our special gratitude is extended to the probation officers and their managers who have allowed us to look at what goes on behind closed doors and have begun their own transformation into change agents.

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The work of community supervision continues to evolve and change placing greater demands on supervision officers' knowledge, skills, and abilities. With the introduction of risk and need assessments into routine practice, community supervision officers are now required to administer and score these instruments. Not only must community supervision officers communicate this risk/need information to other criminal justice professionals, they are asked to utilize this information for classification purposes and to interpret the information to develop case management plans. Officers are also asked to make efforts to maximize offender compliance, plan and manage the client's rehabilitative services, and are often expected to facilitate positive prosocial changes in the clients that they work with.

With these increasing demands, community corrections agencies and their staff have paid more attention to the research on what works to reduce reoffending and in doing so, struggle with the process of bringing empirically supported practices into the everyday work of community supervision (Taxman, 2008; Taxman, Hendersen, & Lerch, 2010). In this article, we briefly review what works in offender rehabilitation and what is known about community supervision. This is followed by some reflections on what we see as an evolution of the work of community supervision officers; that is, the evolution from 'case manager' to one we term 'change agent'. This 'change agent' role asks the officer to play a more substantive and direct role in facilitating client change in, dare we say, a 'therapeutic' manner. Finally, we describe what we believe to be two key interrelated challenges that we consider to be critical in this transformation to evidence-based 'change agent'. They are: understanding the fundamentals of cognitive-behavioural interventions and clinically translating risk/need assessment into an intervention plan.

'What Works' & Community Supervision

Over the past 30 years, the research initiated by Andrews and his colleagues in Canada on offender treatment has shown that rehabilitative efforts can reduce re-offending (Andrews & Bonta, 2010; Hanson, Bourgon, Helmus & Hodgson, 2009; Lipsey, 2009; Lösel & Schmucker, 2005). This "What Works" body of evidence has demonstrated that rehabilitative efforts are not all equal: interventions can maximize their effectiveness via adherence to the principles of effective intervention known as the Risk-Need-Responsivity (RNR) model of correctional treatment (Andrews & Bonta, 2010). There are currently 17 principles represented in the model, however, three of these principles have been at the core since 1990 (Andrews et al., 1990). They are the *Risk principle* (match the level of service to the offender's level of risk; provide intensive services to higher risk clients and minimal services to lower risk clients), the *Need principle* (target criminogenic needs or the dynamic risk factors functionally related to criminal behavior such as procriminal attitudes and substance abuse), and the *Responsivity principle* (match the style and mode of intervention to the abilities, motivation and learning style of the offender; cognitive-behavioral interventions are generally the most effective with offenders).

In their most recent review (Andrews & Bonta, 2010), it has been shown that adherence to these three principles mediates the effectiveness of rehabilitative efforts with a step-wise reduction in recidivism with increases in adherence. Specifically, non-adherence to the three principles was actually associated with a small 2% increase in recidivism

(r = -0.02, k = 124). When treatment adhered to at least one of the principles, there was a small 3% decrease in recidivism (r = 0.03, k = 106). Larger decreases were observed with increased adherence to the RNR principles with adherence to two principles demonstrating a 17% difference, (r = 0.17, k = 84) and three principles (r = 0.25, k = 60) showing a 25% difference.

Although the majority of this evidence has been gleaned from studies examining formal treatment programs that are typically group-based, it is reasonable to expect that these principles are also relevant in the case of one-on-one supervision of offenders in the community. It is believed that community supervision has positive benefits by minimizing the criminogenic effects of imprisonment and facilitating the community integration of offenders (Abadinsky, 2009; Gibbons & Rosecrance, 2005). However, evidence on the effectiveness of community supervision questions its association with reduced offender recidivism. In a review of 15 studies that compared some form of community supervision with an alternative criminal sanction (e.g., prison sentence, fine), Bonta, Rugge, Scott, Bourgon and Yessine (2008) found that recidivism was only two percentage points lower on average for offenders under community supervision. There was no decrease in violent recidivism associated with community supervision. Such findings, which contrast to the more positive results found in reviews of the offender rehabilitation literature, beg the question of why this is so.

The answer to this question is only recently emerging as researchers begin to pay more attention to what exactly goes on behind closed doors during supervision. Bonta et al. (2008) examined case files and audio recorded supervision sessions of 62 probation officers with 154 clients in Canada. What they found was that adherence to the principles of Risk, Need and Responsivity was lacking. For example, the frequency of contact between officers and their clients was only mildly related to the offender's risk level (Risk principle) and officers rarely directly intervened to facilitate change in important criminogenic needs such as procriminal attitudes and friends (Need principle). Furthermore, officers exhibited cognitive-behavioural techniques of interpersonal influence in less than one-quarter of the audiotapes (Responsivity principle). The findings strongly suggested that what goes on between the officer and client during supervision should more closely adhere to the RNR principles.

Research on applying the RNR principles to one-on-one supervision is almost non-existent. This is somewhat surprising given that there is rich literature on the "core correctional practices" derived from the RNR principles (Andrews & Bonta, 2010; Dowden & Andrews, 2004). It is only recently that researchers have begun to pay more attention to the training of community supervision staff in how they interact with their clients during supervision. In 1996, Trotter developed a training program that followed some of the elements of the Responsivity principle. In this study, 30 probation officers were provided five days of training on prosocial modeling, empathy and problem-solving. After the initial training, 12 officers attended ongoing training sessions and applied the skills during supervision. The recidivism rate of 93 clients of the trained officers who continued their involvement in the ongoing training and applied these new skills was compared to 273 clients of officers who reverted to their routine supervision practices. The four year reconviction rate was 53.8% for the clients of the officers who continued to apply the skills taught in training as evidenced by

file reviews. The recidivism rate for the clients of the officers who engaged in routine supervision practices was 64%.

More recently, Canadian psychologists (Bonta et al., 2010; Bourgon, Bonta, Rugge & Gutierrez, 2010a; Bourgon, Bonta, Rugge, Scott, & Yessine, 2010b) developed the Strategic Training Initiative in Community Supervision (STICS). This training program included three days of training and on-going clinical support activities (i.e., refresher courses, individual feedback, and monthly meetings) with specific, practical, and concrete RNR-based intervention techniques and skills. After randomly assigning officers to training or no training, the results showed that STICS trained officers significantly improved their behind closed door interactions (employed RNR-based skills and intervention techniques) with clients as measured by audio recorded one-on-one supervision sessions. When client recidivism was examined, it was found that clients supervised by STICS trained officers had a 2-year recidivism rate of 25.3% compared to 40.5% for clients supervised by the officers assigned to the control group (Bonta et al., 2010). This project has stimulated others to develop similar training programs, for example Staff Training Aimed at Reducing Re-arrest (STARR) from Lowenkamp and colleagues at the United States Office of Probation and Pretrial Services, and Effective Practices in Community Supervision (EPICS) from the Corrections Institute of the University of Cincinnati. The promising results of these efforts are only beginning to emerge (Robinson, Vanbenschoten, Alexander, & Lowenkamp, 2011).

The Evolving Work of Community Supervision Officers

As our knowledge about the importance of what happens behind closed doors increases, we see a need to re-examine and re-focus the work of community supervision. Traditionally, community supervision has been dominated by a case management approach to working with clients. In this approach, officers are expected to “manage” their clients and the services they receive. At a minimum, the community supervision case manager ensures the client is complying with the sentence handed down by the court and documents the client’s behaviour in this regard. With the introduction of risk/need assessments into community corrections, additional tasks are demanded. The community supervision officer must conduct risk/need assessments and share the results with a variety of criminal justice partners (e.g., courts). In addition, the officer may also be responsible for more complex rehabilitative case planning that goes beyond simple compliance with the conditions of the sentence.

Case planning and the associated activities of the case manager vary considerably across different jurisdictions. For jurisdictions with a strong emphasis on public protection, the case manager is primarily concerned with how the offender will fulfill the obligations of the sentence (e.g., completing community service, urine testing), monitoring the client’s compliance and conducting surveillance of the client. For those jurisdictions with more emphasis on offender rehabilitation, the case manager identifies the client’s criminogenic needs and makes efforts to connect the client with appropriate services to meet these needs. The case manager typically acts as a broker and/or advocate for the offender to utilize community-based social services such as welfare programs, employment, housing, and health (e.g., addictions, mental health, and medical) services. During face-to-face supervision, the case manager may engage in problem-solving with the client to resolve various barriers

and/or obstacles the client faces in obtaining such services. Motivational Interviewing techniques are also common. In terms of the work behind closed doors, the case manager primarily assists, motivates, directs, guides and supports the client to receive appropriate services. With a case management approach, the actual 'change-work' - that is the work of facilitating prosocial change - is considered to be the domain of the professionals who are actually providing the rehabilitation, treatment, and/or social services as opposed to the case manager.

On the one hand, the case management model can appear to line up quite nicely to the principles of Risk and Need. In terms of the Risk principle, higher risk clients (when identified via a valid risk/need instrument) can be provided with more services through more frequent contacts and more frequent referrals and connections to treatment and social services. Basic administrative policies, such as those requiring more contact with higher risk clients, can be developed that attempt to enhance adherence to the Risk principle. The case management model can appear to adhere to the Need principle if and when officers identify specific criminogenic needs and there are efforts made to refer, connect, and assist the client in obtaining services that target those criminogenic needs. Finally, a well laid out case management approach appears to adhere to a number of other more recently added principles (see Andrews & Bonta, 2010 for a full list of principles) such as the use of structured assessments and other organizational/administrative factors when the agency pays attention to such details as staff training, supervision policies and organizational practices.

On the other hand, the case management approach does lack specific attention to the Responsivity principle. The Responsivity principle is almost exclusively focussed on the intervention itself regarding what goes on behind closed doors. Responsivity adherence requires the use of cognitive-behavioural interventions and structuring skills during interactions with the clients (Andrews & Bonta, 2010). In a case management approach, what exactly is the 'intervention'? In our opinion, the use of cognitive-behavioural interventions does not seem critical to case management functions where the focus is on brokerage, advocacy, support, assistance, and social problem-solving. The therapeutic intervention or 'change-work' is the responsibility of the professionals providing the treatment and/or social services and the case manager is not directly responsible for facilitating change. In fact, analysis of audio recorded supervision sessions by Bonta and colleagues (Bonta et al., 2008; Bonta et al., 2010; Bourgon et al., 2010a) suggests that community supervision officers generally do not take on an active or direct role in 'change-work' with clients unless they are specifically trained to do so.

It is the recent work of STICS (Bonta et al., 2010; Bourgon & Gutierrez, in press; Bourgon et al., 2010a) and other similar new training initiatives (Robinson, Vanbenschoten, Alexander & Lowenkamp, 2011) suggests community supervision officers take on a more active and direct role in the change process to be more effective. A closer look at these training programs illustrates how community supervision officers are being encouraged to take on the 'change agent' role. At the heart of these training courses are fundamental therapeutic concepts, cognitive-behavioural intervention techniques, and structuring skills. Officers are taught to take on a 'change agent' role where the dominant task is to actively engage in the therapeutic change process with the client while traditional case management work is viewed

as supplementary. This is a new demand on community supervision officers, challenging them to work with clients in a therapeutic manner and to employ skills and techniques that are firmly rooted in RNR principles so that they can directly facilitate personal, attitudinal, and behavioural change.

What's critical for the 'change agent' community supervision officer?

In our work with criminal justice professionals, we have noticed that this shift from a case management to 'change agent' approach is significant and challenging. One of the major challenges that we have observed concerns officers' understanding of cognitive-behaviourism and the practical implications of this model to 'change-work' that goes on behind closed doors. Another significant practical challenge for the 'change agent' community supervision officer is translating traditional risk/need assessment information into a strategic therapeutic intervention plan. This intervention plan is not simply a case management plan, but rather one that guides the day-to-day direct 'change-work' the officer engages in with the client. Once the officer has this road map for change, the 'change agent' can now focus on initiating and facilitating attitudinal and behavioural change via cognitive-behavioural therapeutic processes. Provided these two challenges are addressed, along with learning concrete interventions and interpersonal skills and techniques, the evolution of community supervision officers from case manager to 'change agent' can begin.

For the remainder of this article, we elaborate on these two challenges. First, we discuss cognitive-behaviourism at the very practical level in terms of what goes on behind closed doors. We offer the reader what we consider to be the four fundamental steps or change tasks to facilitating change using a cognitive-behavioural model, with an emphasis on community supervision officers working with criminal justice clients. Next, we discuss the difficulties community supervision officers often have regarding translating risk/need assessment results into a practical and useful change plan that takes into account all the pressures and realities of working with clients who are under supervision in the community. We present the STICS Action Plan to provide a concrete and practical framework to assist officers in understanding and interpreting risk/need assessments in order to develop a strategic therapeutic plan of change to work directly with the client.

Cognitive-Behavioural Interventions

There is substantial empirical evidence regarding the importance of utilizing cognitive-behavioural interventions with criminal justice clients (e.g., Bourgon & Gutierrez, in press; Cullen & Gendreau, 1989; Gendreau & Andrews, 1990; Lipsey, Chapman & Landenberger, 2001; Landenberger & Lipsey, 2005; Lösel & Schmucker, 2005; Wilson, Bouffard & Mackenzie, 2005). Often these programs use terms like 'triggers', 'thinking errors', and 'negative thoughts' and employ cognitive restructuring techniques such as 'reframing' and 'positive self-talk'. Today, it seems that just about every program and service purports itself to be cognitive-behavioural. But what does cognitive-behavioural really mean?

The simple answer is that in addition to the recognition of the fundamental principles of learning (e.g., reinforcement and punishment), cognitive-behavioural approaches recognize the role that cognitions or thoughts play in determining behaviour. However, the answer to what constitutes effective cognitive-behavioural interventions in practice and behind closed doors is more complex. A few years ago, a discussion took place between the first author and his long time colleague, Barb Armstrong. At that time, it was agreed that there are four practical steps or tasks required to effectively conduct cognitive-behavioural interventions. They are (1) identifying with the client the link between thoughts and behaviour; (2) helping the client identify personal thinking patterns that cause that client's problem behaviours, (3) teaching the client concrete thinking and behavioural skills, and finally (4) facilitating the client's practice of and generalization of these new skills. On the basis of these four steps/tasks, we quickly recognized that there is considerable variation in how effectively, if at all, each of these is accomplished via the multitude of programs and services that claim to be cognitive-behavioural. For officers interested in acting as change agents, we believe that it is critical to understand each of these four steps/tasks and how they can promote or hinder effective change when directly and actively facilitating client change.

We would argue that the most critical step or clinical task, and the most difficult, is illustrating to the client the direct link between thoughts and behaviour. To do this effectively, this causal link must be clear, explicit and direct. In STICS, officers are taught how to show clients, in a concrete and practical manner, that *the reason they behave as they do is a direct result of their thoughts alone and for no other reason.* The "for no other reason" is crucial. In our experience, when a client is presented with a model of behaviour that suggests, either explicitly or implicitly, that the cause for behaviour is the result of external stimuli (i.e., things outside of the individual), it reinforces his/her problematic and procriminal thinking patterns. We do not believe that the model presented to clients should legitimize their excuses, justifications and neutralizations for behaviour.

With this in mind, the model avoids limiting the amount of personal responsibility clients can take for their thoughts, feelings, and behaviours; in other words, for the choices that they make. For example, many cognitive-behavioural interventions and models suggest that the external stimuli are 'triggers' for certain thoughts and/or emotions. Clients are taught that it is their responsibility to manage the resulting events of these 'triggers'. This 'external event caused the internal event which caused the behaviour' outlook is exactly the kind of thinking we are attempting to change. Believing that circumstance is the reason and thus the justification for the behaviour, and blaming outside forces for behaviour, thoughts and feelings leads to clients believing that they cannot control what they think, feel and do (i.e., they are a victim) when in reality, the opposite is true.

In our opinion, the direct causal link of thought to behaviour is the crux of the matter. Either I am responsible for all of what I think, feel and do *or* I am not responsible. If I am not responsible, then I have excuses. If I am responsible, then I recognize that I have choices and I cannot blame others, circumstances, or anything else but myself for my problems and for my successes. Practically, this must occur before the 'change agent' can actually conduct any 'change-work'. Once clients understand the direct causal link between their thoughts and their behaviour (that the only reason for behaviour is the thoughts) then clients are in a

position to begin to evaluate the costs and benefits of their behaviour *and* of their thinking. In terms of change, the table is set for the client in the sense that the client is ready to accept that in order to change behaviour, he/she must change his/her thoughts first. Once clients are at this stage, they are in a position to examine what it is they think and to examine the behaviour that this thinking promotes.

The second step/task is helping the client to identify personal thinking patterns that cause that client's problem behaviours. In the case of criminal justice clients, problem behaviours are those behaviours empirically related to crime, essentially the criminogenic needs. As the first step/task establishes to the client (and the officer for that matter) that all behaviours are the result of the client's thoughts (of which they have choices and can exert control), the client is ready for the next step. However, identifying what thoughts, beliefs, and attitudes contribute to procriminal behaviours (in STICS, these thoughts are called Tapes) is not an easy skill, particularly with criminal justice clients who are characterized as impulsive, with poor self reflection and self-awareness. But, it is a skill nonetheless and like all skills, it can be taught.

To accomplish these two tasks (i. e., the thought-behaviour link and identifying personal thinking patterns and behaviours), the 'change agent' provides structured activities for clients to learn and to practice self-awareness skills. This is done to identify specific thoughts and also to evaluate their contribution to specific behaviours. In addition, the 'change agent' also assists the client in recognizing and identifying the consequences of these behaviours. It is through concrete and practical examples that the client learns these skills and begins to recognize the complexity of thoughts, behaviours, and consequences. For example, it is easier for the client to understand that the thought, "Taking cocaine will make me feel better" results in the choice to buy and use cocaine and that there are many short term (e.g., getting high, having fun with peers) and long term (e.g., jail, nose bleeds, paranoia) consequences. However, it is harder to see the link between the thought "It's my way or the highway" and the choice of using drugs and the consequences. The 'change agent' accomplishes this task through exercises and interventions that specifically increase the client's awareness of his/her own personal thinking patterns and abilities of observation of both internal and external events. The client is then in a position to evaluate whether or not the thinking and behaviours are 'worth it' and at the same time recognize that he/she is completely responsible for the choices made, including the choice to change.

It is at this point that the client is ready for the third task; learning cognitive *and* behavioural skills on how to think differently and thus how to act differently. The skills target *both* thinking and behaviour. Given the importance of thinking, the first skill focuses on learning how to change thinking. Often referred to as Cognitive Restructuring, STICS calls this Countering. This skill should be clearly and directly linked to the change from procriminal to prosocial thoughts and behaviours. In addition to learning the skill of Countering, and particularly for moderate and higher risk criminal justice clients, the 'change agent' must also teach the client a variety of prosocial behavioural skills (e.g., resume writing, basic communication skills, negotiation/conflict resolution, and problem-solving). In accordance with the Responsivity principle, and in order to be practical and effective, all the skills outlined above should be concrete, simple, and presented to criminal justice clients in ways that are easy to learn.

The last task in effective cognitive-behavioural interventions is providing ample opportunities for clients to practice and generalize the new skills they are learning. Practice is a foundation for learning as it requires emitting behaviour, receiving feedback about the behaviour, and using that feedback to facilitate change and reinforce new patterns of thinking and behaving. Criminal justice clients need to use the new skills they are being taught within supervision sessions (e.g., doing role plays) as well as outside of supervision (e.g., trying communication skills with their partner) so that the process of learning and generalization may take place. The task for the 'change agent' is to provide opportunities to use the skills, provide feedback, and encourage and reinforce the use of these new skills.

In summary, these are the four clinical tasks that the community supervision officer needs to do if he/she is going to play a direct and active role in facilitating change. These four tasks are the fundamentals of what we believe to be truly cognitive-behavioural intervention, a foundation of the Responsivity principle of effective correctional interventions. Of course, how to actually accomplish these tasks behind closed doors is challenging and that is the majority of what is taught in our STICS training; learning the skills and tools necessary to intervene in a concrete, direct, practical, and personally relevant manner for the client.

From Assessment to Change Plan

Prior to embarking with a client on this process, it is considerably beneficial for the 'change agent' to have a general strategic plan for change for each individual client. This is where the assessment of the client's risk and need factors can aid the officer in developing this action plan for prosocial change. Traditionally, risk/need assessment information has primarily been used to guide a series of criminal justice decisions rather than clinical intervention strategies per se. For example, risk/need assessments are used for sentencing decisions and institutional classification. In terms of interventions, risk/need assessment information may be used to identify client needs in order to match them to appropriate services. In community corrections, the risk/need assessments are often central in determining levels of supervision (e.g., type and frequency of client contact with the officer) and guide either the courts in mandating, or the officer encouraging, client participation in specific treatment services (e.g., substance abuse treatment for addicts).

Traditionally for the case manager, the role is one of identifying the specific set of criminogenic needs and to start the referral-admission process. Making the effort to connect the client to the program(s) and supporting and encouraging (i.e., enhancing motivation) this connection is primary. It matters little which program the client gets first, second, or third as most programs and services are designed to address discrete problems or needs (i.e., male domestic violent offenders, employment programs, substance abuse programs that sometimes target very specific drugs of choice like cocaine, heroin, or meta-amphetamines). In this fashion, the case manager monitors and documents what needs were addressed.

The 'change agent' approach however, asks the officer to understand the risk/need assessments from a slightly different, and perhaps more complex, viewpoint. Here the question is not just about what the client's needs are and what services can best meet these needs but also, where to start and how to intervene with a particular client. One difficulty is that the moderate and high risk clients present with multiple needs and these needs are inter-related. So how does the 'change agent' discriminate which of the multiple needs is primary? To be strategic in facilitating change, the 'change agent' attempts to identify and then tackle the more 'basic' or primary criminogenic need which should then influence the more 'secondary' and interrelated criminogenic needs.

To answer this question, the cognitive-behavioural model provides clear and concrete guidance for the 'change agent' on how to translate the results of a risk/need assessment into a coherent, comprehensive, strategic, and practical therapeutic plan to facilitate change. Rather than view risk and needs as a set of discrete and individual criminogenic factors, the client must be viewed from a holistic perspective taking into account all of the information the risk/need assessment provides. However, there is still considerable variability and difficulty associated with translating traditional risk/need assessments into a comprehensive and practical therapeutic 'change plan'. In our STICS training, by providing officers with a solid foundation of cognitive-behaviourism, it becomes easier to see the inter-relatedness and hierarchy of different criminogenic needs. From this, we developed a helpful tool we call the STICS Action Plan which aids community supervision officers to understand and practically formulate strategic intervention plans with each client.

The STICS Action Plan

Translating risk/need information into a strategic change plan can be a complex and challenging hurdle for community supervision officers. Besides the complexity of the individual's risk/need profile, the officer must also consider additional factors. One set of factors centers around administration of the sentence. This means that there are typically sentencing requirements, such as the variety of potential conditions/restrictions that the client must comply with. There are other 'business' related details the officer must be cognizant of, such as the policy directives and practices that may be in place for certain types of offenders (e.g., specific directives regarding the supervision of sexual offenders) or for offenders of certain levels of risk (e.g., high risk offenders must report to their probation officers in person at least three times per month).

A second set of factors centers around the client's life itself. Criminal justice clients often have rather chaotic and unpredictable lives (e.g., unstable and sporadic employment, rocky relationships, unstable residences, and financial difficulties) and their situations often change frequently and dramatically over short periods of time. Probation officers must be sensitive to a client's crisis and acute needs without such crises overwhelming and preventing the officers from actually engaging in 'change-work'.

It is typically after these two sets of factors are addressed, that the 'change agent' can focus on criminogenic needs and facilitating change. The officer must not only be able to identify which criminogenic needs the client has, but must also determine which ones are most salient

and which take priority over others. Officers must also consider the resources at their disposal (i.e., treatment programs and related services) and the inevitable waiting list for admission. For the 'change agent', they must also take on active therapeutic work and start the process of facilitating attitudinal and behaviour change.

In order to aid the officers with this complex task, the STICS Action Plan (See Figure 1) provides a framework and is intended to provide an overall picture of the client's risk/need factors. It is sensitive to the community corrections policies and the complexity of client's lives, and ultimately, assists the officer in knowing what and where to focus 'change' efforts. The STICS Action Plan is conceptually coherent with a cognitive-behavioural model and thus, adheres to the RNR principles. In our work to date, the STICS Action Plan has been found to be a very useful and practical tool by a vast majority of the officers involved in the project. Below, we describe the steps to completing the STICS Action Plan.

The first step, following the formal risk/need assessment (typically done either immediately preceding or following sentencing), is to address the policies around supervision levels and reporting frequency. This step involves indicating what level of risk the client poses for re-offending and the overall need level (traditionally low, moderate or high) to determine the specifics of supervision (e.g., frequency of reporting in person). We recognize that there are potential reasons for overriding this level of supervision (e.g., frequently seen with sex offenders who often have higher levels of supervision than what is indicated from actuarial risk/need assessments) and the Action Plan encourages documenting such reasons.

The second step involves identifying acute needs or crises that may require immediate attention. Common examples of these include suicidal ideation or behaviour, and the presence of information suggesting an immediate threat of harm such as a homeless client in the middle of winter, a client who is presently psychotic, or a client with a history of domestic violence with evidence of recent escalation of marital discord and conflict. In essence, this step provides the opportunity for the officer to identify issues that require immediate attention before working on long-term prosocial changes.

The third step involves conceptualizing the client's risk-need profile for intervention planning and ensuring consistency with the cognitive-behavioural model of human behaviour and change. This involves answering four very basic questions regarding the client in a specific order from highest to lowest priority in terms of facilitating change. More specifically: (1) Should intervention target procriminal attitudes and behaviours? (2) Should intervention target the client's interpersonal relationships? (3) What are specific problem behaviours that should be targeted? and (4) Are there other minor criminogenic needs that require help? Answers to these questions, we believe, aid the officer in conceptualizing, prioritizing, and developing an overall personalized map of strategic change for each client, as well as providing concrete direction on where to start and where to proceed to facilitate cognitive-behavioural change.

As indicated by the cognitive-behavioural model, procriminal attitudes (i.e., thoughts, attitudes, values and beliefs that promote procriminal behaviours) are considered to be the most central causal factor contributing to criminal behaviour. We know from research that attitudes are one of the Big Four (along with history of antisocial behaviour, antisocial personality pattern, and antisocial associates) and one of the strongest predictors of re-offending (Andrews & Bonta, 2010). Unfortunately, it is our opinion that the current assessment of procriminal attitudes in most risk/need assessments is comparatively weaker than the assessment of other criminogenic needs.

For example, the procriminal attitude/orientation subscale of the LS/CMI (Andrews, Bonta, & Wormith, 2004) has four items whereas the substance abuse subscale, a weaker predictor of criminal behaviour, has eight items. The employment/education section has nine items. In addition, the four items assess rather limited and very general procriminal attitudes; those towards crime, towards convention, towards the client's sentence and offence combined, and towards supervision and treatment combined. We believe that this weak assessment of attitudes explains why in our STICS study (Bonta et al., 2010) we found the following: of the 143 clients in the project, 55% were assessed as High Risk and 40% as Moderate Risk, but close to 60 % of these clients were assessed as *not* having a problem with procriminal attitudes. For a cognitive-behavioural model which points to thinking as the primary determinant of behaviour, it does not make sense that so few clients were assessed as having problems with procriminal thinking when 95% are moderate or higher risk to reoffend.

This seemingly contradictory information is really only a reflection of the method used to identify procriminal attitudes when one considers other indicators or proxy measures of procriminal attitudes that are available in almost all risk/need assessment instruments; namely criminal history and antisocial personality pattern. Given that behaviour is a direct result of thinking, it is reasonable to evaluate client attitudes by also examining client history of criminal behaviour and client antisocial personality pattern. It seems reasonable to assume that when a client's personality is antisocial and/or the client has a lengthy history of criminal behaviour, then that client must also have strong procriminal attitudes and thinking patterns.

In the STICS Action Plan, the answer to the question of whether or not the officer should begin facilitating change in procriminal attitudes is answered by examining the results of three typically separate assessment sections; criminal history, antisocial personality pattern, and procriminal attitudes. The officer need only to indicate low, moderate, or high in each of these areas. Unless all three are rated low, change efforts must begin targeting the client's thinking. In virtually all the cases that should receive correctional treatment services (i.e., according to the Risk Principle, those would be clients of moderate risk or higher), the 'change agent' begins the process where it all starts; the client's thinking.

The next question regarding criminogenic needs deals with whether or not interventions should focus on the client's relationships. As in the previous section, the STICS Action Plan utilizes much of the information found in the risk/need assessment and asks the officer to rate the level of need for <u>all</u> the different types of interpersonal relationships. This includes family of origin, marital or present family life, and the client's circle of friends and acquaintances. Using the LS/CMI as an example, the officer can look at the results of the Family/Marital

section to get an idea of the criminogenic potential of the client's family of origin as well as their present family life (i.e., spouse or equivalent). The Companions subsection of the LS/CMI provides information on the client's peer group. This information is transcribed to the STICS Action Plan to aid in making efforts to address criminogenic relationships. The priority, however, remains facilitating the change in thinking as our cognitive-behavioural model holds that changing thinking leads to changing behaviour, including choices regarding how and with whom the client interacts and for how long this interaction takes place.

The third section regarding criminogenic needs revolves around specific lifestyle choices. That means substance abuse, impulsive/aggressive behavioural patterns, and poor education and employment lifestyle. Again, sections of most risk/need instruments directly assess these criminogenic needs. Similar to relationships, these specific criminogenic behaviours or lifestyle choices are secondary to thinking and attitudes but can provide a concrete context to facilitate change in client thinking.

The last section regarding criminogenic needs is examining highly detailed and very specific needs, which include housing, financial difficulties, and leisure/recreation activities. These criminogenic needs are relatively simple targets and link very nicely with many social/welfare/community services. In our experience, they are generally easier to address after having made significant progress in changing the procriminal thinking.

The final and fourth section of the STICS Action Plan is the identification of specific responsivity issues. These specific responsivity issues guide the officer in the way he/she interacts with the client and how he/she may present information and facilitate learning. This would include any noncriminogenic needs such as mental health issues (e.g., schizophrenia, developmental delays, depression, anxiety, and childhood trauma), physical handicaps, and the like.

Overall, the STICS Action Plan was developed to be a concrete and practical tool for community supervision officers at the same time as attempting to permit the flexibility and versatility that is required when working with individuals who are under community supervision. It attempts to provide a comprehensive and holistic view of the client, encourages adherence to RNR principles, and should be able to accommodate a variety of policies and practices that are inherent in community supervision work. Most importantly, we believe it can assist the community supervision officers evolution from case manager to 'change agent' by guiding the understanding, planning, and implementation of direct one-to-one cognitive-behavioural interventions that can facilitate reductions in criminal behaviour.

Summary

In today's world of community corrections, professionals whose job it is to supervise offenders are being asked to assume more and more responsibilities. From traditional supervision practices to case management, the profession of community supervision officer continues to evolve. Officers are beginning to take on a more direct and active role in the therapeutic change process. This new role challenges existing skills, abilities, knowledge and resources.

To meet these new challenges of becoming a 'change agent', we have presented what we hope to be some fundamental and practical information that facilitates this evolution. Guided by the empirically derived principles of Risk, Need, and Responsivity, as well as clinical experience, we have attempted to translate from theory to practice what exactly cognitive-behavioural truly means. Similarly, through the use of the STICS Action Plan, officers may practically understand risk/need assessment information from a 'change agent' perspective. We hope that this information can guide community supervision officers on the journey to becoming effective 'change agents' with the individuals they supervise.

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Figure 1.
STICS Action Plan

STICS ACTION PLAN

Instructions: Complete the form below by circling the appropriate scoring and writing any additional short notes or comments in the appropriate sections. Use all available case information (e.g., Risk/Needs Assessment Measure, case file) to score the various items.

Case Information				Decisions for Case Planning & Intervention			
1. What is the appropriate level of supervision/service for this client as indicated by the Risk Assessment measure?							
Overall Risk Level	L	M	H	LOW	MED	HIGH	Supervision Level Determination
Overall Need Level	L	M	H				Reporting Frequency (note monthly, weekly, etc.)
2. Is there any acute need or crisis requiring immediate attention?							
Crisis, Acute Needs or Concerns				NO	YES		Specify:
3. What are the client's criminogenic needs?							
a. Should intervention target procriminal attitudes & behaviours?							
Criminal History	L	M	H	NO	YES		Target procriminal attitudes & behaviours ▪ ↓ procriminal & ↑ prosocial attitudes & behaviours ▪ Teach core cognitive & behavioural skills
Antisocial Personality*	L	M	H				
Attitude/Orientation	L	M	H				
b. Should intervention target the client's relationships & associates?							
Family of Origin	L	M	H	NO	YES		Target interpersonal associates & relationships ▪ ↓ procriminal & ↑ prosocial ties & associations ▪ Teach skills & ↑ access to prosocial rewards
Marital/Significant Other	L	M	H				
Companions/Peers	L	M	H				
c. What are the specific problem behaviours that should be targeted?							
Substance Abuse/Misuse	L	M	H	NO	YES		Target substance abuse: ↑ relapse prevention skills
Aggression & Impulsivity	L	M	H	NO	YES		Target aggression: ↓ impulsivity & ↑ self-control
Employment & Education	L	M	H	NO	YES		Target ↑ employment, education & job skills
d. Are there other criminogenic needs (i.e., housing, financial, or leisure problems) that require help?							
Housing/Financial Issues	L	M	H	NO	YES		Target residence: ↑ stability, ↑ financial skills/supports
Leisure & Recreation **	L	M	H	NO	YES		Target leisure time: ↑ prosocial pursuits & activities
4. Are there any special responsivity issues and/or noncriminogenic needs to note?							
Noncriminogenic Needs				NO	YES		Specify:
Special Responsivity Issues/Concerns				NO	YES		Specify:

* Refers to a long-standing pattern of criminal behaviour. Can include, but not limited to, problems with impulsiveness, self-control, self-management, aggression, and violence (general, domestic, and sexual).
** Refers to the type and frequency of organized activities individual engages when not working, evaluating the degree to which these activities are prosocial, conventional pursuits.