Promoting Reentry Well-Being: A Novel Assessment Tool for Individualized Service Assignment in Prisoner Reentry Programs

Working Paper #AJI120216

Christopher A. Veeh, MSW, PhD, Washington University in St. Louis
Tanya Renn, MSW, MPH, PhD, Washington University in St. Louis
Carrie Pettus-Davis, MSW, PhD, Washington University in St. Louis

August 2016

Correspondence concerning this article should be addressed to Dr. Christopher Veeh, George Warren Brown School of Social Work, Washington University in St. Louis, One Brookings Dr., St. Louis, MO 63130. Email: cveeh@wustl.edu
Abstract

Within multimodal prisoner reentry programs, an important challenge for practitioners is how to effectively assign participants to services based on individual need. The Reentry Well-Being Assessment Tool (RWAT) is an innovative practice tool to systematically guide individualized assignment into reentry program services based on a participant’s changing needs during the transition from prison to the community.

Clearly defined treatment targets that promote an individual’s well-being are paired with a comprehensive set of assessments within the RWAT to measure progress throughout a prisoner reentry program. This assessment data is then integrated with practitioner expertise to decide whether the type and intensity of services should be increased, decreased, or maintained at pre-determined programmatic time points. The use of the RWAT is a collaborative process between the practitioner and the participant that guides treatment planning towards increased well-being of formerly incarcerated individuals. Future research into the effectiveness of the RWAT within prisoner reentry programs is discussed.

Keywords: prison reentry; adaptive intervention; well-being; treatment plan
At the turn of the 21st century, the United States experienced a build-up of prisoner reentry programs to assist the more than 600,000 individuals released from prison each year (Jonson & Cullen, 2015). An ongoing challenge is how to effectively individualize treatment assignment within a reentry program that targets multiple areas (i.e., employment, education, housing, etc.). While a one-size-fits-all approach (i.e., despite need, people get the same services) is the most straightforward, it can lead to wasted resources (Collins, Murphy, & Bierman, 2004).

To meet this challenge, prisoner reentry programs need to be designed based on an adaptive intervention framework (Collins et al., 2004). Initial efforts to individualize reentry services have been based on actuarial risk assessments to tailor programming based on risk factors for crime (Andrews & Bonta, 2010). However, the use of risk assessments has been criticized for ineffectiveness to guide treatment planning beyond general resource allocation (i.e., more intensive services for high risk and little to no services for low risk; Ward, 2015). Moreover, recent research has found risk assessments to have limited predictive ability to identify targets for treatment planning (Duwe & Rocque, 2016), which suggests the need for a new way forward.

Collins and colleagues’ (2004) adaptive intervention framework consists of tailoring variables that determine a participant’s progress towards an ultimate distal outcome (i.e., reincarceration). Once the tailoring variables(s) are set, the next step is to identify measures that have validity and reliability to ensure usefulness in clinical decision-making (Collins et al., 2004). Then, a set of decision rules are specified to guide how different values on each treatment target measure will guide assignment into service.
Finally, the implementation of decision rules is maintained through fidelity to limit any deviations (Collins et al., 2004).

Adaptive interventions can employ a range of methods to assign treatment services, from invariant decision rules to general principles to guide decision-making. In the criminal justice context, Marlowe and colleagues (2014) developed an adaptive treatment design with specific decision rules to step-up services based on missed counseling sessions, failure to submit urinalysis, or submission of positive urinalysis. In contrast, Multisystemic Therapy (MST) provides a less regimented structure to treatment assignment based on fidelity to nine treatment principles, and if treatment decisions are made with fidelity to the principles, effectiveness of MST is maintained (Henggeler, Schoenwald, Borduin, Rowland, & Cunningham, 2009). Overall, MST places greater responsibility for treatment decision-making on practitioner expertise. This contrasts with Marlowe et al. (2014) that views clinical judgements to only create idiosyncratic variation in services. Collins and colleagues (2004) take a more ambivalent view towards clinical judgement in that it could have both positive (i.e., practical applicability) and negative (i.e., variability) effects.

Informed by these treatment assignment approaches, we present a new practice tool for individualized treatment assignment, the Reentry Well-Being Assessment Tool (RWAT; see Figure 1), intended for use by practitioners in collaboration with participants to guide reentry program services.
A Proposed Alternative: The Reentry Well-Being Assessment Tool

Treatment targets and measurement

Individualized assignment of services within prison reentry programs has been primarily centered on the assessment of risk factors to identify treatment targets (i.e., tailoring variables), but risk factors have demonstrated limited ability to guide treatment decision-making beyond basic resource allocation (Duwe & Rocque, 2016). In contrast, RWAT uses as treatment targets the Five Core Facilitators of Reentry Well-Being (hereafter “Core Facilitators”) that are evidence-driven proximal outcomes focused on individual well-being and empirically associated with decreased recidivism (for further details see Pettus-Davis, Veen, & Renn, 2016). The Core Facilitators are operationalized with specific definitions to provide an unambiguous understanding of what is to be
achieved by participants (see Table 1). Additionally, within the RWAT is a set of valid and reliable assessments that were selected to tap into key definitional components of the Core Facilitators. Each set of assessments attached to a Core Facilitator allows the practitioner to track an individual’s progress over time during a reentry program.

Table 1. Definitions of the Five Core Facilitators of Well-Being Development

<table>
<thead>
<tr>
<th>Occupational Balance</th>
<th>Occupational Balance means that the compatibility between an individual’s goals and abilities and the demands of that individual’s occupation is sustainable.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Definitions:</strong></td>
<td>1. Compatibility is defined as a state in which two things are able to exist or occur together without problems or conflict.</td>
</tr>
<tr>
<td></td>
<td>2. Occupation is defined as obligation(s) / job paid or unpaid.</td>
</tr>
<tr>
<td></td>
<td>3. Sustainable is defined as able to be maintained or kept going, as an action or process.</td>
</tr>
</tbody>
</table>

Positive Cognitions are adaptive mental actions or processes, the presence of empathy, and the acceptance or internalization of values and norms that promote pro-social behavior.

**Definitions:**
1. Pro-social behavior is defined as actions that are intended to benefit another individual, groups of individuals, or society as a whole.

Positive Coping Strategies are adaptive behavioral and psychological efforts taken to manage and reduce internal/external stressors in ways that are not harmful in the short- or long-term.

**Definitions:**
1. Effort is defined as work done by the mind or body.
2. Stressor is defined as demands that cause mental tension.

Positive Social Activities occur when an individual is engaged in social experiences organized for beneficial social purposes that directly or indirectly involve others. These social activities are engaged in during an individual’s discretionary time and are experienced as enjoyable.

**Definitions:**
1. Beneficial social purpose means the intention of an activity is to promote greater societal good.
2. Discretionary time is defined as time free from obligations, work, and daily living tasks (e.g., housework).
3. Indirectly involve others is defined as individuals co-located in a common physical space.

Positive Interpersonal Relationships means an association between two people that occurs in person and can range in duration from brief to enduring within formal or informal social contexts. The relationship is reliable, mutually beneficial, and enhances psychological well-being.

**Definitions:**
1. Formal social context is defined as paid or unpaid work settings, healthcare/treatment settings, and social service settings.
2. Informal social context is defined as all settings outside of paid or unpaid work, healthcare/treatment, and social services.
3. Reliable is defined as a relationship that promotes honesty and trust.
4. Mutually beneficial is defined as a relationship that supplies the needed level of honesty and trust for all people involved.

The first treatment target (i.e., tailoring variable) within RWAT is the Core Facilitator positive cognitions. Formerly incarcerated individuals that can pro-socially respond to others with empathy and hope in difficult or stressful situations are less likely to become involved in crime (Van Vugt et al., 2011). To measure positive cognitions, the assessments of Cognitive Flexibility Inventory (Dennis & Vander Wal, 2010) and the Pro-Social Personality Battery (Penner, 2002) were selected (see Figure 2).

The next treatment target within RWAT is positive coping strategies. Research has shown that formerly incarcerated individuals who improve their coping strategies, particularly addressing drug and/or alcohol use, are less likely to recidivate (Brown, Amand, & Zamble, 2009). The measurement of positive coping strategies is based around the Ways of Coping Questionnaire (WCQ; Folkman & Lazarus, 1980) and two subscales from the Social Problem Solving Inventory - Revised (see Figure 1; D’Zurilla, Nezu, & Maydeu-Olivares, 1999).

Positive social activities is the third treatment target in RWAT, and it captures that the constructive use of one’s free time is an important predictor of recidivism (Mackenzie & Brame, 2001). Positive social activities specifically focus on activities that could likely decrease the social stigma of having an incarceration history, as well as facilitate development of positive informal social capital that is sustainable for the participant long-term (Laub & Sampson, 2003). Quantifying a participant’s positive
social activities for use within RWAT is accomplished with a time diary (see Figure 2; Stinson, 1999)
### Figure 2. Treatment Targets, Measures, and Services

<table>
<thead>
<tr>
<th>Treatment Targets</th>
<th>Measurement of Treatment Targets</th>
<th>Services*</th>
</tr>
</thead>
</table>
| **Positive Cognitions**  | • Cognitive Flexibility Inventory measures an individual’s tendency to view difficult situations as controllable as well as the ability to develop alternative solutions to a problem. | • Motivation Services  
  • Mental Health Services  
  • Criminal Thinking Services  
  • Substance Use Disorder Services |
| • Adaptive thinking  |  |  |
| • Empathy  |  |  |
| • Pro-social personality  |  |  |
| **Positive Coping Strategies**  | • Ways of Coping Questionnaire focuses the participant on a situation of high stress and based on that situation measures eight different coping styles:  
  • Social Problem Solving Inventory-Revised assesses the individual’s approach to problem solving through positive problem orientation – does the individual view problems as solvable and believe in their ability to solve problems – and avoidance style – does the individual address problems with procrastination and passivity. | • Life Skills Services  
  • Mental Health Services  
  • Criminal Thinking Services  
  • Substance Use Disorder Services  
  • Trauma Services  
  • Behavioral Services |
| • Coping strategies  |  |  |
| • Problem solving  |  |  |
| **Positive Social Activities**  | • Time Diary systematically captures the typical activities engaged in during a 24-hour period. The time diary is completed collaboratively for the practitioner to further drill down into each activity using five structured follow-up questions. | • Life Skills Services  
  • Behavioral Services |
| • Number and proportion of activities organized for a beneficial social purpose  |  |  |
| **Positive Interpersonal Relationships**  | • Genogram asks about five generations of a participant’s family, including: grandparents, parents, siblings, children, and grandchildren. Each family member is then noted for mental disorder, substance abuse, criminal justice involvement, education, and employment to identify any intergenerational patterns.  
  • Social Network Chart provides pictograph of social support available to participant by looking at the quality (e.g., positive, negative, or mixed) of support across the four domains of family, community, work, and friends/acquaintances. | • Motivation Services  
  • Mental Health Services  
  • Criminal Thinking Services  
  • Substance Use Disorder Services  
  • Trauma Services |
| • Number and proportion of positive relationships among family and friends  |  |  |
| **Occupational Balance**  | • Now-Next-Later Employment/Education Goals consist of sequential sub-goals to measure an individual’s progression to achieve their self-defined career goal.  
  • Vocational/Education Aspiration and Satisfaction measures an individual’s desire to improve one’s work situation and obtain additional education as well as satisfaction with one’s work situation and the current level of education. | • Employment Services |
| • Individualized education and employment goals  |  |  |
| **Reentry Well-Being**  | • Levenson’s Internality, Powerful Others, and Chance Scales measures an individual’s sense of internal and external control over his or her life.  
  • Generalized Self-Efficacy Scale measures an individual’s belief in his or her ability to succeed or accomplish a task.  
  • Herth Hope Index assesses an individual’s level of hope.  
  • Readiness Ruler measures the readiness to work on each of the Core Facilitators.  
  • Life Balance Assessment compares how an individual actually spends his or her time on a daily basis to how he or she would like to spend her time.  
  • Timeline Followback measures the use of alcohol and drugs over seven days. | • Not linked to any specific services.  
  • Provides a broad snapshot to the practitioner on how an individual is faring overall within a prisoner reentry program. |
| • Locus of control  |  |  |
| • Self-efficacy  |  |  |
| • Hope  |  |  |
| • Readiness to change  |  |  |
| • Substance use  |  |  |

* For further details on the specific services included within each category (i.e., motivation, mental health, criminal thinking, etc.), see the article [blinded...
The fourth RWAT treatment target is positive interpersonal relationships. The presence of positive social support following release from prison have been shown to lead to lower recidivism (Berg & Huebner, 2011). The measurement of positive interpersonal relationships is divided between two assessments: (1) a genogram to assess family relationships and (2) a social network chart to assess overall relationships (see Figure 2). Both the genogram and the social network chart are visual tools that the practitioner uses to facilitate a discussion on the quality of the individual’s community support structure.

The fifth treatment target is occupational balance. An individual with a job that satisfies his or her aspirations and empowers them to utilize their skills and talents is less likely to recidivate (Laub & Sampson, 2003). The primary measurement of occupational balance is achievement of individualized sub-goals that move towards an ultimate vocational and educational goal (see Figure 2). The individualized sub-goals are framed with the structure of Now-Next-Later, which focuses on the job a participant can get now, while preparing for the next and later job that increases occupational balance. In addition, the practitioner also assesses for educational and vocational aspiration/satisfaction to ensure the Now-Next-Later goals are adequate to the individual’s occupational ambitions (Rich & Delgado, 2010).

Finally, RWAT overlaid on the Core Facilitators a brief set of assessments that aim to measure overall reentry well-being, which includes: locus of control, self-efficacy, hope, readiness to change, life balance, and substance use (see Figure 2). Assessment of overall well-being is conducted with six separate measures to capture each component (Levenson, 1981; Lennings, 1994; Herth 1992; Hesse, 2006; Sheldon, Cummings, &
Kamble, 2010; Sobell & Sobell, 1996). These six different assessments help to provide a broad snapshot to the practitioner on how an individual is faring within a prisoner reentry program.

**Decision process and implementation**

The adaptive intervention framework of Collins and colleagues (2004) identifies decision rules as *a priori* steps that are clearly defined to guide a practitioner when a cutoff score is obtained on a treatment target. However, RWAT does not propose a set of explicit decision rules. Rather RWAT more closely adheres to the approach of Multisystemic Therapy (MST), where practitioner decision-making is guided by fidelity to defined treatment principles. The MST treatment principles are not ironclad rules that dictate practitioner behavior; instead the treatment principles provide an organizing structure, like a code of ethics, to guide treatment decisions.

Likewise, RWAT aims to systematize the individualized assignment of services throughout a prison reentry program, but does not divorce the final decision-making from practitioner expertise. We viewed previous practice tools for individualized assignment that attached a menu of services to specific cutoffs as too constraining for the skill necessary to be an effective practitioner within a complex social intervention. In RWAT, scores on each of the assessment tools are not separated into binary cutoffs, but, instead, a structure is provided where assessment data is integrated with the expert judgement of the practitioner to guide decisions.

Within RWAT, the Core Facilitators not only serve as treatment targets but also provide the structuring principles, via the definitions, to guide assignment into services. Decision-making in the RWAT is based on the development of well-being, and decisions
that are consistent with the Core Facilitators are hypothesized to result in both increased well-being as well as decreased recidivism risk (Pettus-Davis et al., 2016). Further guiding practitioner decision-making is the matching of each service in a reentry program to a specific treatment target (see Figure 2). By clearly indicating which services include the necessary key ingredients to impact upon a Core Facilitator, decisions to change services an individual is participating in at any given time maintain consistency with the orientation of the Core Facilitators. Therefore, the practitioner never must guess whether a service is targeted for the Core Facilitator that is the focus of the treatment decision.

The battery of assessments within RWAT, which take approximately 3 ½ hours to complete, is administered at multiple time points in a program. Administration time points need to be decided *a priori* based on programmatic milestones and transition points. For example, a practitioner could first administer assessments at program start prior to release from prison to make initial service assignments. The next administration would be at one month prior to release to inform which services are needed for community transition. Then, the assessments can be delivered again after the first month in the community to determine the services needed to establish long-term supports for the participant. Additional assessment time points could also be scheduled based on when new services are scheduled to begin in the community as well as when the participant is approaching program graduation. The final schedule of assessment time points needs to balance two important concerns. First, the frequency of assessment needs to collect enough data to establish a trend in how a participant is progressing over time, but, secondly, the assessments battery cannot be too frequent to create testing bias by participants memorizing or becoming bored with the assessment process. Once the
schedule of assessment time points has been set, there needs to be ongoing practitioner feedback and if either of these concerns are identified then changes should be made to the assessment schedule.

At each administration time point, the assessment scores are tracked on a line graph to identify trends over time. For the initial development of RWAT, mean scores on each assessment were extracted from the literature to help contextualize the data. Mean scores were obtained on community samples that performed well on each construct as well as on disadvantaged samples where performance was reported as low. Based on this literature, a range of high and low performance on each assessment is graphically depicted for the practitioner. These ranges help to contextualize a participant’s progress relative to high and low performing scores as well as to compare the individual’s own score trends over time. Progress is primarily determined relative to the participant, and there is no *a priori* benchmark that a participant is expected to reach. Instead, the goal is to see consistent progress over time while still being cognizant that the therapeutic process is likely to include digressions. Moreover, an individual’s place within a prison reentry program should be considered when contextualizing what a score means. For example, while an individual may be making treatment progress pre-release, there may be notable digression upon return to the community. Because the period immediately following release from prison is high stress, it should be expected that some of the pre-release progress may decline and practitioners should keep this contextual factor, among others, in mind when interpreting scores.

RWAT allows a practitioner to examine client progress across all areas of reentry well-being (i.e., occupational balance, positive cognitive, positive coping strategies,
positive social activities, and positive interpersonal relationships) simultaneously. With the basic matrix delineating which services match to each treatment target (see Figure 2), a practitioner can bring together the different trend graphs to formulate a treatment decision. As detailed in Figure 1, once the practitioner completes the assessment battery and reviews as well as contextualizes each set of trend graphs, this quantitative information is integrated with clinical expertise to decide whether services need to be stepped up, stepped down, or maintained. For example, the practitioner can see that a person is performing well on positive coping, but poorly on occupational balance. RWAT will help the practitioner to perhaps enhance efforts in the areas of occupational balance and scale back programming targeted at coping. Then, at the next administration of the assessment battery, the practitioner can review whether the client’s prior progress on coping has been maintained. Particularly important is to always ensure that a participant is being programmed relative to their need for services. For instance, if a participant is demonstrating success in the community, the best treatment decision may be to step-down all programming to allow the individual to conduct daily activities free from services that may be only having minimal benefit. In contrast, a participant who is showing deterioration may need to be stepped-up to more intensive one-on-one sessions with the practitioner or referred to an upcoming cognitive thinking intervention that had previously seemed unnecessary.

**Maintaining fidelity to RWAT**

In addition, a fidelity assessment instrument is included in RWAT to help account for possible variations in decision-making. The fidelity assessment monitors the consistency in the treatment assignment across practitioners using RWAT. The fidelity
assessment is modeled on the Multisystemic Therapy, Therapist Adherence Measure (Henggeler et al, 2009). As indicated by Marlowe et al (2014), there is concern for the consistency of treatment assignment when it is driven in large part by professional judgement. However, our assertion is that the solution to this concern is not to remove professional judgement from the decision-making as the drug court program developed by Marlowe does. Instead, rigorous assessment of fidelity to ensure proper implementation of RWAT by practitioners strikes an appropriate balance between invariant decision rules and the art required of a skilled practitioner to deliver a multimodal intervention.

**Implications of RWAT for Advancing the Science and Practice of Prisoner Reentry**

Current tools designed to individually assign services for prisoner reentry programs are not sensitive to regular adjustments needed by participants. Thus, practitioners must rely primarily on anecdotal participant-practitioner interactions to make treatment decisions. Or, as is the case with many programs, the amount and timing of services is driven by what is being offered and completion/graduation dates. We propose a tool for individualized treatment assignment that allows for services to change to match participants’ needs and progress over time. RWAT is a “living document” in that it is intermittently administered and the type and amount of service a participant is enrolled in can be adjusted accordingly. Despite the primary focus of a given reentry program, in some fashion most reentry programs address the Core Facilitators of positive coping, cognitions, interpersonal relationships, social activities, and occupational balance (at a minimum employment). However, to date, no standardized tool is available to help monitor and adjust for progress on these mechanisms of well-being. RWAT responds to
this limitation in current approaches with a comprehensive process that provides defined treatment targets of well-being, valid and reliable measures, and an organizing structure for the integration of assessment data and practitioner expertise to make treatment decisions.

The Core Facilitators identifies for prisoner reentry programs positive treatment targets to work towards as opposed to a sole focus on controlling risk and preventing criminal justice involvement. Evaluations of reentry programs have been primarily focused on the outcome of recidivism, which has been identified as a major limitation to determining program effectiveness (Petersilia, 2004). Perhaps most limiting to a program that only uses recidivism as the outcome is the lack of data on how participants are doing until a problem rises to the level of involvement in the criminal justice system. Informed by existing literature and extant theory, we knew there were numerous indicators that could be tracked to help practitioners decide additional services were necessary prior to a problem metastasizing into criminal behavior. RWAT is our proposed approach to developing a standardized process that can help prisoner reentry programs both evaluate themselves and their participants on a wider range of outcomes besides recidivism.

Moreover, the collaborative nature of the RWAT assessment battery helps to facilitate the therapeutic relationship. Each of the assessments is tailored to be completed by the participant in collaboration with the practitioner. This collaborative approach makes the assessment more than a means to collect data but also a structured method for the practitioner to have a larger discussion with participants about their well-being. Through the discussion facilitated by the assessments, the practitioner can identify issues that may be hindering a participant’s progress beyond even the data collected on the
assessment itself. To illustrate how the assessments can enhance collaboration between the practitioner and the participant, the Ways of Coping Questionnaire (WCQ) is described in more detail. First, the WCQ asks the participant to respond to the assessment while thinking about a specific high stress situation that occurred in the participant’s life. The practitioner can then use the WCQ to both elicit the actual coping strategies the participant used in the stressful situation to discuss those in further detail as well as bring up alternative coping strategies also included on the WCQ to facilitate a conversation on how different ways of coping may have changed the outcome for the participant. Overall, the entire assessment battery provides practitioners with a structured means to delve into a range issues relevant to the participant’s well-being on a consistent schedule.

RWAT has the potential to improve uptake by explicitly valuing the role of practitioners within the treatment assignment process. In RWAT, practitioners’ expertise and experience is acknowledged as integral and vital, and the practitioner is never asked to simply implement a set of rules without any deviation. It is the authors’ contention based on many years of direct experience with prisoner reentry programs that effective practice is a highly complex undertaking with shades of gray and nuance, thus complex interventions with humans can never be reduced to an algorithm of decision rules. The RWAT strikes an appropriate balance between the art and science of delivering a multimodal intervention like a prisoner reentry program. This balance is intended to address research that has shown criminal justice practitioners often ignore risk assessments when assigning participants to services (Miller & Maloney, 2013). With increased practitioner adherence to a structured process for individualized assignment of services, the RWAT can decrease the likelihood of misallocated program resources.
Future research that rigorously tests the RWAT will be important. Specifically, randomized controlled trials can help to determine whether the full battery assessments are needed to make effective treatment decision-making. Perhaps there is a more parsimonious set of assessments that does not hinder the quality of information on treatment targets. Furthermore, experimental studies can begin to identify more appropriate range scores on each of the assessments, and further knowledge on how the assessment battery operates within a criminal justice population will provide practitioners with improved information to contextualize scores for prisoner reentry program participants. Additional research on the RWAT can also determine whether there is a minimum length of program time necessary for the tool to prove useful within practice. There is likely a lower bound of time when the assessment battery would not demonstrate a practically relevant degree of change to assist in treatment planning. The adoption of the RWAT across different reentry programs could begin to identify a recommended length of program time that is likely to allow for participant change on the assessment battery.

Also of interest for further research is the RWAT fidelity tool. As noted by Marlowe et al. (2014) and Collins et al. (2004), practitioner judgement in treatment assignment can introduce inconsistencies into a reentry program with possibly negative effects for participants. Therefore, the RWAT fidelity tool intends to act as a guide for practitioners on how to appropriately integrate clinical judgement with assessment data to arrive at a treatment decision that is conceptually consistent with the Core Facilitators. The reliability and the validity of the RWAT fidelity tool needs to be tested in practice
along with a structured feedback process with practitioners to work through any irregularities in the treatment assignment process.

Finally, the RWAT has applicability to interventions beyond prisoner reentry programs both in the criminal justice system and across a variety of other practice areas. Nonprofit organizations operate in a constrained resource environment and their ability to effectively target service delivery to ensure that participants are never over- or under-programmed can help to extend the benefit of what resources are available. The approach to this issue is not to take a binary approach where either the clinician has full autonomy to make all programming decisions or, on the flip side, treatment planning is restricted to a set of invariant decision rules. Instead, the Reentry Well-Being Assessment Tool is a first step towards forging a middle ground that balances these two approaches to human service delivery.
References


at 6, 12 and 18 months. *Journal of Experimental Criminology, 10*, 129-149. doi:10.1007/s11292-013-9196-x


