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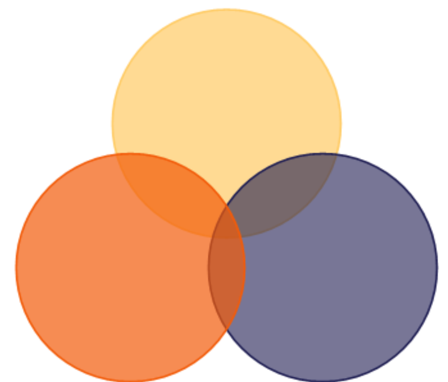
EFFECTIVE CLINICAL PRACTICES IN TREATING CLIENTS IN THE CRIMINAL JUSTICE SYSTEM

June 2008

Authored by Wayne Scott, MA, LCSW
for the Crime and Justice Institute and
the National Institute of Corrections



This paper was developed as part of a set of papers focused on the role of system stakeholders in reducing offender recidivism through the use of evidence-based practices in corrections.

Dot Faust, Correctional Program Specialist
National Institute of Corrections
Community Corrections Division
(202) 514-3001
dfaust@bop.gov
www.nicic.org

Elyse Clawson, Executive Director
Crime and Justice Institute
(617) 482-2520
eclawson@crjustice.org
www.cjinstitute.org

Author's Contact Information:
Wayne Scott, MA, LCSW
Multnomah County
501 SE Hawthorne Blvd., Suite 400
Portland, Oregon 97214
(503) 988-6904
wayne.scott@co.multnomah.or.us
www.co.multnomah.or.us

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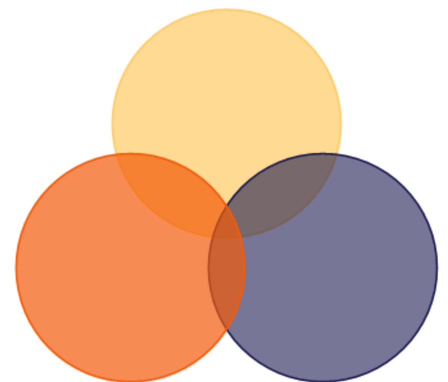

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CRIME & JUSTICE INSTITUTE

The Crime and Justice Institute (CJI) and the National Institute of Corrections (NIC) are proud to present a series of seven whitepapers known as the Box Set. The papers are designed to share information with criminal justice system stakeholders about how the implementation of evidence-based practices (EBP) and a focus on recidivism reduction affect their areas of expertise in pretrial services, judiciary, prosecution, defense, jail, prison, and treatment. This initiative stems from a cooperative agreement established in 2002 between CJI and NIC entitled *Implementing Effective Correctional Management of Offenders in the Community*. The goal of this project is reduced recidivism through systemic integration of EBP in adult community corrections. The project's integrated model of implementation focuses equally on EBP, organizational development, and collaboration. It was previously piloted in Maine and Illinois, and is currently being implemented in Maricopa County, Arizona and Orange County, California. More information about the project, as well as the Box Set papers, are available on the web sites of CJI (www.cjinstitute.org) and NIC (www.nicic.org).

CJI is a nonpartisan nonprofit agency that aims to make criminal justice systems more efficient and cost effective to promote accountability for achieving better outcomes. Located in Boston, Massachusetts, CJI provides consulting, research, and policy analysis services to improve public safety throughout the country. In particular, CJI is a national leader in developing results-oriented strategies and in empowering agencies and communities to implement successful systemic change.

The completion of the Box Set papers is due to the contribution of several individuals. It was the original vision of NIC Correctional Program Specialist Dot Faust and myself to create a set of papers for each of the seven criminal justice stakeholders most affected by the implementation of EBP that got the ball rolling. The hard work and dedication of each of the authors to reach this goal deserves great appreciation and recognition. In addition, a special acknowledgment is extended to the formal reviewers, all of whom contributed a great amount of time and energy to ensure the success of this product. I would also like to express my appreciation to NIC for funding this project and to George Keiser, Director of the Community Corrections Division of NIC, for his support. It is our sincere belief and hope that the Box Set will be an important tool for agencies making a transition to EBP for many years to come.

Sincerely,

Elyse Clawson
Executive Director, CJI

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Elyse Clawson
Executive Director
Crime and Justice Institute

Dorothy Faust
Correctional Program Specialist
National Institute of Corrections,
Community Corrections Division

Dara Glass
Assistant Project Manager
Crime and Justice Institute

Peter Greenwood
Executive Director
Association for the Advancement
of Evidence-Based Practice

Michael Guevara
Correctional Program Specialist
National Institute of Corrections,
Academy Division

Ginger Martin
Assistant Director for Transitional Services
Oregon Department of Corrections

Laura Burney Nissen
Associate Professor
Portland State University's School of
Social Work

Faye Taxman
Professor
George Mason University,
Administration of Justice Program

EXECUTIVE SUMMARY

Corrections professionals must manage and supervise offenders who present with high-risk behaviors and complex, overlapping problems, including addiction, chronic mental health challenges, domestic violence, and sex offending behaviors. The complexity of the multi-problem offender necessitates that, in order to be effective in their work and to reduce recidivism, corrections professionals must work collaboratively with professionals in other fields, particularly those who provide behavioral healthcare. Correctional treatment, as defined here, is multidisciplinary. Intentionally and strategically, correctional treatment combines the leverage of the judiciary and community corrections agents with the rehabilitative technologies of behavioral healthcare. Ideally, to be effective, professionals must integrate understanding of the best practices in two, if not more, fields.

This monograph attempts to de-mystify what is known as Evidence-based Practices (EBP), a term of art that straddles many fields, including corrections and behavioral healthcare. The EBP concept has been pervasively used in the fields of addiction treatment and mental health care and, in the last few years, also in the field of corrections. It is applied to many professional activities, with varying understandings of what is meant by it. To add to this complexity, different fields define evidence-based practice in different and sometimes seemingly incompatible ways. Within the corrections field, most scholars and researchers agree, EBP refers to specific intervention models or principles that research has proven to lead to desirable outcomes, i.e. reduced recidivism. While the field of behavioral healthcare also endorses specific research-backed intervention models as EBP, scholars and researchers in that field also call attention to an overarching conceptual model to guide practitioners' clinical and ethical decision-making about the interventions they provide.

This monograph attempts to provide a definition of evidence-based practice that synthesizes the values and empirical wisdom from both corrections and behavioral healthcare. It conceptualizes EBP in correctional treatment as both a *process* and *philosophy* of clinical decision-making, which is broader and more abstract than how the corrections literature has historically defined EBP. In this more clinical manner of thinking, EBP integrates information about the client's unique condition with research on that condition, the values and preferences of the referral source and the offender, and the imperative for the practitioner to be transparent about why they are doing what they are doing. At the same time, this monograph delineates (in section 4) a catalogue of specific intervention models or principles that have been empirically demonstrated to reduce recidivism. Whether correctional or clinical, professionals who read this monograph will

understand two components key to providing effective services: a conceptual model for making sound clinical judgments about the most effective course of intervention for individual offenders who present with myriad complexities, as well as a menu of the most commonly used evidence-based practices.

While there have been significant empirical advances in the field of community corrections and behavioral healthcare, not all evidence-based models of intervention fit all offenders perfectly. Many empirically supported interventions do not account for the impacts of gender and minority status. The way of thinking about evidence-based practice that is presented here, because it emphasizes the importance of rigorous and individualized care, is inclusive and applicable to offenders from all social and gender groups. This definition of EBP also acknowledges that science has not provided answers to many problems with which offenders struggle.

With these challenges in mind, this monograph has several goals, intended to strengthen and improve the dissemination of evidence-based rehabilitative technologies for offenders, within the multidisciplinary context of correctional treatment:

1. To provide a conceptual framework for understanding effective clinical practices with clients in the criminal justice system, including evidence-based practice, controversies inherent in the determination of what evidence-based practice means, and critical thinking and ethical decision-making;
2. To examine what is known about effective practice in corrections and how these empirically supported models and principles should be integrated into behavioral healthcare for offenders (i.e. correctional treatment);
3. To review what works generally in behavioral healthcare for different problems—the "common factors" such as the therapeutic relationship and instillation of hope— and how to apply this knowledge responsibly to the offender population; and
4. To discuss some of the specific modalities that are widely considered evidence-based clinical practices for clients in the criminal justice system, such as Motivational Interviewing, Contingency Management, and empirically supported psychopharmacology, among many others.

Providing this information in these four areas, it is hoped, will improve collaboration between correctional professionals and behavioral healthcare providers. Most importantly, these multidisciplinary partnerships—so critical to reducing recidivism—will strengthen and become more intentional and strategic, as professionals on both sides understand the practice wisdom of each others' fields.

INTRODUCTION: EFFECTIVE CLINICAL PRACTICES IN TREATING CLIENTS IN THE CRIMINAL JUSTICE SYSTEM

The Complexities of Treating Clients in the Criminal Justice System

Corrections professionals—staff working with offenders in parole, probation, and jail or prison settings—face considerable challenges in working with individuals who are deeply entrenched in criminal behaviors. Not only do these professionals contend predictably with individuals who exhibit anti-social thinking, patterns of rule-breaking and violence, and other socially noxious conduct, but they also must deal with other underlying components of offenders' lives: drug and alcohol addiction, serious mental health problems, poverty, and forms of social and institutional oppression. Untreated addiction and mental health problems correlate significantly to recidivism in the criminal justice population, making the job of maintaining community safety significantly more difficult.

Prevalence of drug and alcohol issues within the criminal justice population. Drug and alcohol addiction are prevalent throughout the criminal justice population. According to the National Institute of Justice (2003), between 25 and 50% of all adult male arrestees demonstrated that they were at risk for drug or alcohol dependence. Only a small percentage of these arrestees (between 2 and 17%) had any kind of treatment for their drug problems. Between 20 and 42% of all adult female arrestees were found to be at risk for drug or alcohol dependence. On average only 11% of adult female arrestees had received any form of treatment. Among the population on probation—which represents 75-85% of all offenders within correctional systems, three times the number in prisons—large percentages have substance abuse related issues: 26% had convictions for violating drug laws and 15% for drunk driving. According to Taxman, Perdoni, & Harrison, "nearly 50% of probation sentences include court-ordered commitment to drug treatment or alcohol treatment services" (2007). Although studies estimate that approximately 80% of prison inmates are in need of treatment, less than 15% receive any during their imprisonment. Ninety-five percent of prisoners relapse into drug abuse following their release, and two-thirds are rearrested within three years of leaving prison (Belenko et al, 2005).

In spite of the intense level of need demonstrated by these data—indeed surveys indicate that addicted offenders have substance dependence

The systematic under-funding of community mental health and the failure to provide for coordination of and accountability for care, along with the prosecution of non-violent offenders, have led to what is essentially a transinstituionalization of people with mental illness—out of the mental health system and into the jails and prisons (Goin, 2004, p. 2).

rates four times greater than those demonstrated in non-offender client populations—the availability of appropriate addiction treatment is seriously limited. In a comprehensive review of the availability of correctional treatment programming for addicted offenders, The National Criminal Justice Treatment Practices Survey found that jurisdictions were more likely to provide substance abuse education and awareness, the least intensive intervention for this population (Taxman, et al, 2007).

> Drug treatment services can be offered as stand-alone programs or as part of other criminal justice programs, such as drug courts, boot camps, intensive supervision, day reporting centers, and work release. These can be in-house, contracted, and/or referral-based programs that vary in terms of their integration with the criminal justice system (ibid., p. 240).

Prevalence of serious mental health issues within the criminal justice population. Similarly grim statistics exist for offenders with severe mental illnesses. Since the 1950's, due to overconfidence in new psychotropic medications and policy mandates that mentally ill individuals be treated in less restrictive settings, there has been a mass migration of mentally ill people into the community. The population in state mental hospitals decreased from 559,000 individuals in 1955 to less than 80,000 in 1999—a staggering 86%. Over the same time period, the trend in incarceration in both jails and prisons increased dramatically. Writing for the American Psychiatric Association (APA), Goin observes:

> The systematic under-funding of community mental health and the failure to provide for coordination of and accountability for care, along with the prosecution of non-violent offenders, have led to what is essentially a *transinstituionalization* of people with mental illness—out of the mental health system and into the jails and prisons [emphasis added] (Goin, 2004, p. 2).

The Center for Substance Abuse Treatment (CSAT), a federal agency, estimates that over 70% of jail inmates who are mentally ill also have concurrent drug problems (cited in APA, 2004). Not only are these offenders generally jailed for non-violent crimes, but they are also, disproportionately, people of color (APA, 2004).

Treatment works. Fortunately, the aforementioned problems—drug and alcohol addiction and serious mental health issues—are considered treatable (Hubble, Duncan, & Miller, 1999). Although they are often chronic, relapsing conditions, sufferers can learn to manage them effectively and to reduce the incidence of relapse and the concurrent life disruptions that follow it (Mueser, et al, 2003; Wanberg & Milkman, 2004; White, 1998). Without

appropriate clinical intervention for their addiction, it has been shown through numerous studies that substance-abusing offenders are highly likely to recidivate (Harrison, 2001).

But it is not always clear how treatments for these conditions can occur effectively and ethically within the host settings of the criminal justice system, whether those settings are jails, prisons, drug courts, or other types of community supervision, like probation and parole. Criminal justice systems necessarily, for the sake of community safety, impose restrictions on the lives of offenders: mandates that fly in the face of informed consent; limitations on confidentiality; and periods of physical confinement. Those restrictions can, however, sometimes undermine or sabotage effective treatment as it would be practiced with consumers who are not in the criminal justice system. Because of their austerity, jails and prisons can be inhospitable settings for effective clinical practices, many clinicians believe. Conversely, clinical protocols that attempt to address addiction and mental health issues but ignore criminal conduct, including offenders who can become assaultive within treatment settings, have been shown ultimately to fail (Wanberg & Milkman, 2004). Psychologists and social work clinicians who work with clients in the general population have complained that evidence-based practices are too difficult to replicate outside controlled research settings (Goodheart et al, 2006; Miller et al, 2006). This challenge is magnified when treating offenders, whose lives are embedded in restrictive contexts.

Correctional Quackery vs. Evidence-Based Practices. Additionally, it is well known that there is a considerable lag-time between the development of an innovation and its adoption in direct practice in agencies (Rogers, 2003). According to a recent study, "Most programs for drug-involved adult offenders employ fewer than 60% of the specified evidence-based practices" known to be effective with this population (Friedmann, et al, 2007). The field of corrections has only recently, and sometimes fitfully, begun to incorporate evidence-based practices into its usual ways of doing business. Latessa (2002) has identified "correctional quackery" as the general operating practice in too many settings that work with offenders:

"Most programs for drug-involved adult offenders employ fewer than 60% of the specified evidence-based practices" known to be effective with this population (Friedmann, et al, 2007).

> [Q]uackery is dismissive of scientific knowledge, training, and expertise. Its posture is strikingly over-confident, if not arrogant. It embraces the notion that interventions are best rooted in 'common sense,' in personal experiences (or clinical knowledge), in tradition, and in superstition…. 'What works' is thus felt to be 'obvious,' derived only from years of an individual's experience, and legitimized by an appeal to custom.

Latessa concludes: "*Correctional quackery*, therefore, is the use of treatment interventions that are based on neither 1) existing knowledge of the

causes of crime nor 2) existing knowledge of what programs have been shown to change offender behavior" (Latessa, Cullen, & Gendreau, 2002).

Correctional quackery can inhibit effective collaboration, as professionals from different disciplines second-guess each other, resist input from other disciplines, or exclude each other from important decision-making conversations about offender treatment. It creates resistance within correctional organizations to understanding the scientific underpinnings of effective practices.

Collaboration between corrections and treatment professionals is vital to the success of those charged with maintaining community safety and rehabilitating offenders (Center for Effective Public Policy, 2005).

Quackery in addiction treatment. Similarly, the fields of addiction and mental health treatment have been slow to incorporate new scientific findings into its routine practices. In particular, Miller et al (2006) point to the evolution of addiction treatment as separate from mainstream medicine, largely due to the stigma attached to it. "The gap between science and standard practice seems to be particularly wide in substance abuse treatment in the United States" (ibid., p. 25). Many addictions counselors are paraprofessionals, with minimal experience treating clients with co-occurring disorders. Regarding clinical social workers, who provide 86% of the mental health services in this country, McNeil observes: "It has been shown that social workers do not rely on research-based knowledge as a basis for making clinical decisions" (2006, p. 147). Another study found that promoting the use of manualized techniques produced negative effects on treatment providers, including a predisposition to view the client negatively, and decreased optimism and support (Henry et al, 1993).

Collaboration Is Critical to Success

The complex presentation of modern offenders requires corrections professionals to take a multidisciplinary approach to the management of their caseload and to work collaboratively with professionals from other disciplines. One key component of that multidisciplinary approach is working effectively with providers of clinical treatment, whether it is addiction treatment, mental health or psychiatric treatment, domestic violence intervention, or sex offender treatment.[1] Collaboration between corrections and treatment professionals is vital to the success of those charged with maintaining community safety and rehabilitating offenders (Center for Effective Public Policy, 2005).

[1] For the purposes of this article, treatment will refer primarily to addiction and mental health treatment. EBPs also apply to sex offender and domestic violence treatment; however, the application is somewhat different, given that the referring problem is not generally considered to be a healthcare problem. Evidence-based sex offender and domestic violence treatment will be covered in section four.

But that collaboration is certainly uneasy and requires mutual cross education and thoughtfulness. Corrections professionals are oriented primarily to the safety of the larger community and mitigating the risk that offenders pose to community safety. While they achieve that effect partially through building a high-quality relationship with offenders, their ultimate goal is the mitigation of risk. Public health clinicians, on the other hand, are oriented toward the alleviation of individual suffering and ultimately the improvement of community health; for them, the client's needs are primary. Taxman, Perdoni, & Harrison (2007) note:

> Tension is natural in the merging of treatment goals within correctional programs, in which the emphasis is placed on behavioral change rather than merely adhering to requirements, and the same can be said for the merging of the philosophies of correctional and treatment agencies (p. 242).

Another shorthand way of conceptualizing the difference between the disciplines is that public safety focuses on the reduction of *risk*, while public health focuses on the reduction of *need*. Generally speaking, corrections professionals have a communitarian focus, emphasizing the uniform applications of laws, rules, and conditions, while the clinical practice is highly contextual, with an interest in individual conditions and circumstances. *Neither is wrong and both must be balanced and reconciled within the hybrid model of correctional treatment.* In his history of addiction treatment, White (1998) observes:

> Collaborative efforts between the criminal justice system and local addiction treatment agencies strove to balance the former's role in punishing and preventing injury to the community with the latter's concern for the individual rehabilitation of the addict.

Correctional treatment, therefore, is a collaborative enterprise between corrections and treatment professionals. There is, in fact, considerable evidence that the provision of supervision, sanctions, case management, and wraparound services to offenders increases positive outcomes in addiction and mental health treatment. "Several studies have shown that criminal justice clients do as well if not better than other clients in drug abuse treatment and the criminal justice involvement helps clients stay in drug abuse treatment" (Wanberg & Milkman, 2004). Hubbard et al (1988) observe: "Given the high rate of illegal activity of criminal justice clients before treatment, reductions during treatment have societal benefits, even if the reductions are not maintained after the clients leave treatment" (p. 64).

One of the challenges of importing the philosophy and frameworks of evidence-based practice into correctional treatment is that it forces

professionals to reconcile these two divergent perspectives on the helping relationship. Corrections professionals will be compelled to understand the thinking of healthcare providers and to balance the practice wisdom of that specialized field with what they understand about maintaining public safety. Providers of behavioral healthcare will be compelled to look for ways of fitting models of healthcare practice within the varied contexts of criminal justice work. Dialogue, balance, and compromise will be critical to this blending of practice wisdoms.

High-quality, sophisticated collaboration is critical. Carter (2005) notes: "[J]ustice can be more effectively served when those tasked with carrying it out define their roles, responsibilities, and relationship to one another … and work together in pursuit of shared visions, missions, and goals." One of the hopes of this monograph is that it will foment improved working relationships between treatment providers and corrections professionals, by examining the respective and equally important contributions of both to the achievement of reduced recidivism. Corrections professionals make a significant contribution to the success of correctional treatment through case management, building a high-quality relationship that supports the offender's treatment, fair and immediate sanctioning when offenders commit violations, and clear and timely communications to the courts, with realistic expectations, about offenders' progress in treatment.

This paper will introduce both corrections and treatment professionals to cutting-edge information about the current state of evidence that informs effective correctional treatments. It covers four important and interrelated topics:

1.) *What is Evidence-Based Practice?* This section de-mystifies what is meant by the term "evidence-based practice" and applies the framework to effective correctional treatments. It examines necessary adaptations of a model that evolved primarily for healthcare purposes. This section also discusses salient ethical considerations in providing treatment to the offender population, including informed consent and confidentiality;
2.) *Overarching principles of effective correctional treatment*. This section develops a working definition of "correctional treatment," including reviewing the well-known risk, needs, and responsivity principles and their application to clinical practices, the philosophy of harm reduction, and the importance of strength-based assessment and interventions. At its core, correctional treatment involves collaboration between treatment and corrections staff. This section also reviews a developmental model for understanding offender rehabilitation;
3.) *Common Therapeutic Factors: What works in treatment generally?* This section situates effective practices in correctional

treatment within the larger context of what is known about effective treatment generally, identifying both points of agreement as well as points of divergence. It discusses the importance of high-quality therapeutic relationships as the vehicle for offender change, across all correctional treatment modalities, integrating cutting-edge research on brain development and healthy attachment; and

4.) *Specific Evidence-Based Modalities for Criminal Justice Clients*. This section reviews specific modalities for treating clients affected by addiction and mental health problems, domestic violence perpetrators, adult female offenders, and sexual offenders.

In addition, a number of appendixes will address key issues for improved collaboration, including: release of clinical information; the complementary roles of probation/parole professionals and treatment providers; coercion and treatment; and clinical supervision and quality assurance.

Before further discussion of this complex topic, two caveats are in order, as they often unduly influence dialogues about the rehabilitation of the adult offenders. First, one of the hazards of writing about a unique hybrid such as correctional treatment—a field of practice that combines elements of both public healthcare and corrections—is that at any point the discussion can seem to be biased or prejudiced toward one or the other perspective. Is the author more oriented toward rehabilitation and social work? Is the author placing too much attention on accountability and sanctions? *By its very definition, correctional treatment incorporates and balances both perspectives.* Without doubt, corrections and treatment professionals play different and equally important roles in the rehabilitation of individuals in the criminal justice system. They are both components of a rigorous, multidisciplinary response to criminal activity. At times the partnership is uneasy and conflictual, but in the best of all possible worlds it is *synergistic*. The American Heritage Dictionary defines synergy as "the interaction of two or more agents or forces so that their *combined effect* is greater than the sum of their individual effects" (Soukhanov, ed., 1996). An important goal of this monograph is to maintain the balance that allows that synergy to occur.

Second, dialogues about offender rehabilitation can sometimes become saturated with cynicism and contempt. Its poster children are high-profile criminals and its public relations are largely run by individuals who have failed out of the criminal justice system. Indeed, the multiple forms of media in contemporary society keep an unrelenting focus on the heinous crimes that offenders commit. Those offenders who successfully exit the criminal justice system—never to be considered "offenders" again—rarely make headlines. Negative public relations are just as intense within the criminal justice field,

where many corrections professional commit much more professional time and energy managing the crises of the offenders who are failing than they do congratulating the offenders who succeed. It is worth remembering: given the severity and complexity of most offenders' problems, the most respected criminal justice researchers acknowledge an acceptable success rate that might appear modest to a layperson:

> [T]he reviews of controlled outcome evaluations of correctional treatment services found a minimum of 40% and up to 80% of the studies reporting reduced recidivism (Andrews, 1994).

Put another way, if a correctional program scored within the middle of this range—60%—it would be considered successful (although a college student scoring the same percentage on a final exam would fail the course). In any other branch of healthcare, behavioral or otherwise, this success rate might seem like a concerning or even dismal claim; however, given the frequency and duration of destructive criminal activity that characterizes the typical high-risk offender, society avoids incalculable costs and damages when this proportion of high-risk offenders become sober, pro-social, and law-abiding citizens. In spite of its challenges and the predictable occurrence of failures, correctional treatment will continue to be a sound investment of public dollars and a noble professional calling.

PART I: WHAT IS EVIDENCE-BASED PRACTICE?

After reviewing some of the controversies involved in defining evidence-based practice—especially different definitions offered within different disciplines—this section will review the healthcare model for evidence-based practice (EBP) and propose an adaptation of that model for correctional treatment. It will also introduce some of the ethical considerations that are pertinent to this adaptation when engaged in evidence-based practice with the offender population.

Controversies about the definition of evidence-based practice. As previously mentioned, the concept of evidence-based practice has been used in the behavioral healthcare field as well as in corrections, but the fields define the term somewhat differently. These differences can sometimes lead to controversy and misunderstanding. Within corrections, as well as other fields, evidence-based practice usually refers to *specific intervention models* or *principles* that research has proven to lead to desirable outcomes.

> Interventions within corrections are considered effective when they reduce offender risk and subsequent recidivism and therefore make a long-term contribution to public safety…. Models provide us with tangible reference points as we face unfamiliar tasks and experiences. Some models are very abstract, for example entailing only a set of testable propositions or principles. Other models, conversely, may be quite concrete and detail-oriented (Bogue et al, 2004).

Evidence-based practices can involve research-tested principles that guide intervention—e.g. the Responsivity Principle—or they can refer to specific intervention models—e.g. Motivational Enhancement or Cognitive-Behavioral Treatment.

The field of behavioral healthcare also defines evidence-based practice in terms of specific intervention models and principles; however, it also includes a broader, more abstract *conceptual framework* for how professionals think about the integration of research evidence, assessment of the client's needs and values, and the specific condition being treated. This conceptual framework allows the practitioner greater facility to individualize a course of treatment for a particular client with unique needs.

While the two frameworks may appear at times to be contradictory, they are reconcilable. The model of evidence-based practice introduced within this monograph appropriates the healthcare model of evidence-based practice and adapts it for the purposes of clinical treatment in correctional settings.

What is evidence-based practice? Within the healthcare field, where the term originated, evidence-based practice is considered to be both a standard and a philosophical framework for making clinical decisions. Sackett offers the following definition, widely accepted within healthcare settings: "Evidence-based practice is the integration of best research evidence with clinical expertise and patient values" (Sackett et al, 2000). The anti-thesis of quackery, evidence-based practice arose initially within the field of medicine "as an alternative to authority-based decision-making, in which consensus, anecdotal experience, or tradition are relied on to make decisions" (Gambrill, 2006). Its emergence has been correlated with the rise of the Internet, the growing ability of healthcare practitioners to access cutting-edge research to inform their interactions with patients, and imperatives from managed care organizations to use scarce healthcare dollars efficiently. (Good examples of such an online resource are the Cochrane Library and the Campbell Collaboration, which catalogue thousands of high-quality systematic reviews of different treatments, including summaries of their effects.) Gambrill expands upon Sackett's definition:

> [Evidence-based practice] describes a *philosophy* and *process* designed to forward the effective use of professional judgment in integrating information regarding each client's unique characteristics, circumstances, preferences, and actions, and external research findings" (emphasis added, p. 253).

Evidence-based practice does not suggest that prior to its emergence healthcare providers were not using research to make healthcare decisions. Rather, evidence-based practice promotes providers evaluating and integrating research findings differently, within a collaborative interaction with their client around personal healthcare decisions. Providers are required to search out the best available research (generally considered to be randomized controlled trials); to use their critical thinking to appraise the merits of that research and its application to a client's situation; and to implement any intervention with fidelity to its developers' tested design. Evidence-based practice promotes the use of standardized treatment manuals and expert supervision for quality assurance, as well as ongoing specialized training. Providers of evidence-based practices are required to demonstrate fidelity to the treatment model they say they are practicing: to have the pre-existing credentials to deliver the practice; to undergo specialized training and sometimes certification in the practice; and to adhere to standards of quality assurance developed to measure fidelity to the design of the practice.

Within this framework, healthcare practitioners are required to acknowledge what is known and not known about particular treatments and to facilitate the client making a sound appraisal of the best course of action, given the client's condition, values, and preferences. Evidence-based practice

is the "conscientious, explicit and judicious use of current best evidence in making decisions about the care of individual [clients]" (Sackett et al, 1996). Gambrill adds: "Transparency and honesty regarding the evidentiary status of services is the hallmark of this philosophy" (2006, p. 258).

How will this work in correctional treatment? One significant caveat about evidence-based practice, as it was originally conceptualized within the healthcare field, is its emphasis on educating clients to make informed decisions and valuing client preferences in making healthcare decisions (Goodheart et al, 2006, p. 50). Offenders receiving correctional treatment are mandated by the courts to seek treatment. Most prefer not to be in treatment at all and many actively resist and sabotage professional efforts to help them. So how can evidence-based practice apply to correctional treatment?

While evidence-based practice emerged in the field of healthcare, it holds significant benefits for the field of correctional treatment. More effective treatment for underlying behavioral health conditions, such as addiction or mental health disorders that contribute to recidivism, will lead to improved public safety.

While evidence-based practice emerged in the field of healthcare, it holds significant benefits for the field of correctional treatment. More effective treatment for underlying behavioral health conditions, such as addiction or mental health disorders that contribute to recidivism, will lead to improved public safety. Aos et al (2006) did a meta-analytic cost-benefit analysis for Washington State on the implementation of evidence-based practices in addiction and mental health treatment: "We found that the average evidence-based treatment reduces the short-term incidence or seriousness of alcohol, drug, or mental health disorders 15 to 22 percent," a significant positive effect. However, correctional treatment is a unique hybrid: it is both a form of behavioral healthcare as well as a means of achieving a public safety effect. It combines elements of two distinctly different realms: public health and public safety. Therefore, to be of optimal use to providers of correctional treatment, the standards and philosophy of evidence-based practice require some re-appraisal and adaptation.

A philosophical framework for evidence-based practice. What follows is a comparison of two models of evidence-based decision-making: one model that arose originally from the healthcare field and an adaptation of evidence-based decision-making developed for correctional treatment. Because EBP arose within the field of healthcare, it will be important to describe how healthcare providers conceptualize those standards and frameworks for practice before discussing how they can be adapted for correctional treatment.

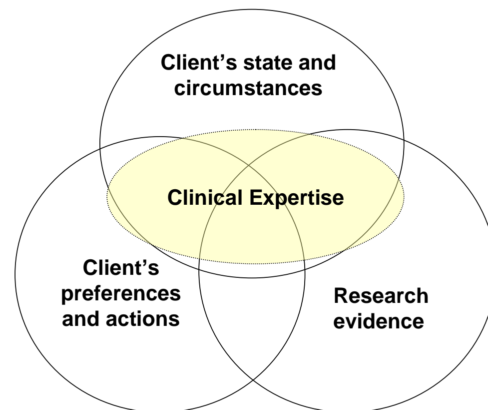
Understanding the healthcare model. As contextual background, Figure One illustrates one healthcare model for evidence-based practice, incorporating key variables that need to be balanced in order to make effective collaborative decisions with non-offender clients (Haynes et al, 2002). Haynes et al define "clinical expertise" as "advanced clinical skills to assess, diagnose, and treat disorders" through an interpersonal relationship grounded in objectivity, trust, and respect (ibid.). In essence, clinical expertise is the capacity to achieve positive outcomes in behavioral healthcare. It incorporates three overlapping areas: research evidence; an assessment of

client preferences; and an assessment of the condition in question. While this model will be described in a fashion that appears linear, in actuality this model of clinical practice is circular and interactive, involving a simultaneous and ongoing assessment and reassessment of all three areas.

Figure One underscores that evidence-based practice is not a cookbook approach to client problems, but requires factoring in numerous highly individual variables.

1. *Client's state and circumstances*. Through careful interviewing and assessment, the practitioner arrives at an objective appraisal of the client's condition as well as those social and environmental factors that are likely to impact the course of treatment. Most critically, this factor involves the determination of what diagnosis or problem afflicts the client, as well as those resources and strengths, both individual and systemic, that can be enhanced to support recovery. The accurate determination of the diagnosis is a critical component for guiding the practitioner to relevant, up-to-date research regarding interventions for that particular problem.

FIGURE 1: A model for evidence-based decisions (Gambrill, 2006)



2. *Research evidence*. Once the problem has been objectively identified, the practitioner can investigate what interventions are likely to benefit the client, including assessing the strength of the practitioner's confidence in different possible interventions. It involves a rigorous and systematic assessment of the current state of evidence, as well as a critical appraisal of their potential usefulness or harm to a client. Within this philosophy of practice, healthcare providers must be willing to say "I don't know" if there is no compelling evidence to support any intervention. They must inform clients of the likely ramifications of *no intervention*.

   Evidence-based practice promotes providers having an increased capacity to evaluate and judge research evidence. The "gold standard" of research designs is the randomized controlled trial (RCT), which is ideally suited to evaluate causal inferences about treatment interventions.

> RCTs of psychotherapy are characterized by pre- and posttreatment assessment and comparison of means between conditions (e.g. treatment and control groups) using statistical analyses of the data (A. Kazdin, in Goodheart et al, 2006, p. 170).

The American Psychological Association (APA) has pointed out that the RCT design is the predominant form of research in the healthcare field and a model most often used to test the effectiveness of medications. The drive to make it the *sine qua non* in healthcare has come from managed care organizations intent on the efficient utilization of resources. Some practitioners have questioned the applicability of the RCT to testing treatment interventions, especially when so much of the potency of treatment interventions rests in the individual provider relationship, which is subjectively experienced and highly individualized. Others have noted that it is unrealistic to expect that practitioners can reproduce the same conditions as those used in clinical trials (Kazdin, ibid., p. 170).

…EBP shifts away from a presumed omniscient authority of the healthcare provider; it also underscores the need for humility in the face of critically appraised evidence.

> The simplifications and controls that are essential to science cannot be imposed in practice. Each problem must be addressed as it occurs in nature, as an open living process in all its complexity, often in a political context that requires certain forms of action and prohibits others (Peterson, quoted in Goodheart et al, 2006, p. 40).

The APA points out that there are other research designs that have applicability but are not considered as rigorous, including process-outcome studies, qualitative research, and meta-analytic studies (Goodheart et al, 2006). Not without some controversy, McNeece and Thyer (2004) offer the following rank hierarchy of research evidence, from weakest to strongest: anecdotal case reports; correlational studies; single-subject research designs; uncontrolled clinical trials; quasi-experimental controlled clinical trials; and individual randomized controlled trials.

The spirit of evidence-based practice requires the provider to search out and critically appraise all the research support, whether or not there are RCTs, and to share that information with the client so that the client can make an informed decision. Gambrill (2006) notes: “EBP involves sharing responsibility for decision-making in a context of recognized uncertainty” (p. 269). Again, EBP shifts away from a presumed omniscient authority of the healthcare provider; it also underscores the need for humility in the face of critically appraised evidence.

Finally, several researchers have questioned the applicability of evidence-based practices to non-dominant social and cultural groups. "Unfortunately, many empirically supported treatments seem to miss the important role diversity variables have on the process and outcome" of treatment (Goodheart, Kazdin, & Sternberg, 2006). While this trend is slowly reversing and many interventions have now been tested on non-dominant social and cultural groups, this caveat should inform the practitioner's critical appraisal of any research knowledge. Has the existing research specifically looked at differential impacts of the intervention on different social and cultural groups?

3. *Client preferences and actions*. This conceptualization of evidence-based practice requires that clients be involved in decision-making regarding their healthcare. Client's values, needs, and preferences are important variables in determining the ultimate course of treatment. It is particularly important to take into account any culturally-specific meanings that clients attach to symptoms and behaviors, and the cultural context that clients bring to encounters with a healthcare practitioner.

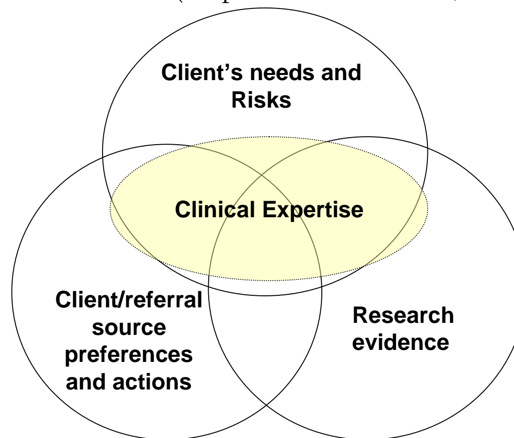
> The nature of a set of disorders, as well as the service system developed to treat those disorders, is moderated by the culture of its participants. Research has specifically shown that the effectiveness of critical components of dual disorder programs is affected by the ethnic background of consumers….[P]eople of color…can be effectively engaged and served in dual disorders programs when issues of culture and diversity are strategically implemented in the program (Corrigan, McCracken, & McNeilly, 2005).

The practitioner needs to involve the client in critically appraising the different possible interventions, possible outcomes, and possible side effects. At the same time, client behaviors—for example, the degree of their adherence to clinical recommendations, quality of their interpersonal supports for treatment, and their intrinsic motivation to improve—are another important variable to consider for ongoing intervention.

An adaptation of EBP for correctional treatment. While this model for evidence-based practice is relevant to correctional treatment, it requires some adaptation because of the unique healthcare issues affecting clients in the criminal justice systems, the correctional context within which the problems are identified (e.g. drug court, probation or parole, jail or prison), and other restrictions imposed on the offender population. An overarching principle of this adaptation is that, within correctional treatment, the "client"

is both the individual receiving treatment as well as the larger community affected by the offender's behaviors. This whole system needs to be included in the practitioner's assessment of "the problem." The perspective of the larger community is personified by the correctional professional who refers the offender to treatment and monitors their progress (a judge, probation, parole, or facility staff). Figure Two illustrates this adaptation of evidence-based practice for correctional treatment.

FIGURE 2: A model for evidence-based decisions in correctional treatment (adapted from Gambrill, 2006)



1. *Offender's risks and needs.* In addition to assessing individual conditions such as addiction and mental health issues, the practitioner must take into account the degree of *risk* that the client's behaviors pose to the community. *Risk*— defined as "offenders with a higher probability of recidivating" (Lowenkamp & Latessa, 2006)—is determined by the corrections professional, prior to a referral to treatment, by assessing what are known as criminogenic risks and needs (e.g. anti-social beliefs and behaviors, lack of pro-social support, impulsivity, and poor problem-solving skills, etc.). Generally, correctional treatment is focused on offenders who are deemed medium- or high-risk. "There is considerable empirical evidence that programs that target offenders who are higher risk are more effective in reducing recidivism than those that do not" (Lowenkamp & Latessa, 2006).

   The last decade has witnessed a remarkable development of actuarial instruments to facilitate the classification of offenders within institutions and on community supervision. Many of these instruments—such as the third generation actuarial risk assessments Level of Service Inventory–Revised (LSI-R) (Andrews & Bonta) and the Correctional Offender Management Profiling for Alternative Sanctions (COMPAS) (Northpointe Institute for Public Management, Inc.)— assess a variety of static and dynamic variables and can be useful sources of information for the provider of clinical treatment (Meloy, 2000).

Third generation actuarial risk assessments are available to measure these dynamic risk factors and are central to evidence-based practice in corrections. When validated and normed for a specific population, third generational actuarial assessments have proven essential for more effective offender classification, case-planning, and the development of needs–driven treatment/transition plans (Christensen, 2007).

Within this correctional adaptation of the healthcare model of evidence-based practice, the "client's preferences and values" includes *both* the mandate of the referral source as well as the individual offender's statements of what they want from treatment. In addition to clinically assessing the client's mental health or addiction condition and integrating information about the offender's risk to the community, the practitioner must also assess what the referral source needs from the clinical intervention and what role the corrections professional can play in increasing or maintaining client motivation to change. *The hallmark of correctional treatment is that it addresses both the behavioral healthcare condition as well as the criminality.* Ensuring community safety is a key organizing value for all professionals working with offenders.

In dealing with the offender's statements of what they want from treatment, it is critically important for providers and referral sources to take into account the inherent initial ambivalence that offender clients have about their condition (regardless of what level of resistance they overtly and typically present). The field of Motivational Enhancement, an evidence-based modality, has applications for both treatment and correctional case management (Miller & Rollnick, 2002). For both, the professional's role is to elicit and enhance the offender's own intrinsic motivation (based on a developmental model which will be presented next), which may not be immediately obvious, especially to the corrections professional who deals with the offender generally within a more restrictive and punitive setting. To be effective, the professional must develop a collaborative relationship with the offender; and the referral source's mandate can provide important leverage to ensure compliance.

2. *Research evidence.* Once the risks and needs have been objectively identified, the practitioner can investigate what interventions are likely to benefit the client, including those interventions from the criminal justice system (case management, linkage and brokerage of resources, drug tests, incentives, and sanctions) that can complement and enhance client outcomes in treatment. The practitioner needs to do a rigorous and systematic assessment of both the current state of evidence in the

fields of addiction and mental health, but also to take into account what is known about effective correctional treatment and effective probation, parole, and facility practices. Concomitantly, it behooves both the treatment professional and the correctional professional to *avoid* those criminal justice sanctions (e.g. military-style boot camps), supported only through experience, anecdotal support, "common sense," or tradition, that have in fact been proven to harm clients or adversely impact their success (Bonta, 2006).

3. *Offender's and referral source's preferences and actions.* An important value in all realms of healthcare is informed consent and client self-determination. In short, clients have the right to know the different options for treatment for their condition—including the likely outcomes when no treatment is pursued—and ultimately to choose their own course of action. In correctional treatment, given that the "client" is both the individual offender as well as the referral source representing the community's interest in the offender's rehabilitation, both the offender and the professional need to be informed and to weigh in on the different options for treatment. The individual client's values, needs, and preferences are still important variables in determining what treatment is pursued. Even offender clients need to be involved collaboratively in their own treatment, if the outcome is to be successful, although ambivalence about any treatment is both normal and tolerated, especially in the early stages of treatment. Offenders can decline to be involved in treatment; however, they need to be apprised of the likely consequences from the criminal justice system that has mandated them (e.g. jail or other sanctions). The practitioner still needs to involve the client in appraising the different possible interventions, outcomes, and side effects of the treatment plan. This is actually a hallmark in much addiction counseling, in which clients are given education about the impact of continued drug and alcohol abuse (Miller & Rollnick, 2002; White, 1998).

The role of critical thinking. Within this healthcare-based model of evidence-based practice, both the practitioner and the corrections professionals, working collaboratively, must utilize *critical thinking skills*. They must *synthesize* what is objectively known about the offender's condition, their risks and needs, the preferences of both the offender and the referral source, and the research literature about effective treatment for the offender's condition. They must then *make a decision* about the best—i.e. most likely to be effective—course of intervention for each individual offender. As the intervention progresses, both the practitioner and the corrections professional must evaluate the effectiveness of the intervention and adjust course as needed. Critical thinking has sometimes been referred to

as "thinking about thinking." According to The Center for Critical Thinking (2007),

> One significant repercussion of implementing evidence-based practice in correctional treatment is that it will require both correctional professionals and treatment providers to revise the manner in which they critically appraise whether an offender succeeds or fails in treatment.

> [H]uman thinking left to itself often gravitates toward prejudice, over-generalization, common fallacies, self-deception, rigidity, and narrowness…. Critical thinking is that mode of thinking—about any subject, content, or problem—in which the thinker improves the quality of his or her thinking by skillfully analyzing, assessing, and reconstructing it. Critical thinking is self-directed, self-disciplined, self-monitored, and self-corrective thinking. It presupposes assent to rigorous standards of excellence…. It entails effective communication and problem-solving abilities, as well as a commitment to overcome our native egocentrism and sociocentrism.

A critical thinker is characterized by several core competencies, including the abilities

- to articulate both problems and questions about the problems in a manner that is thoughtful, clear, and precise;
- to gather pertinent data, using theoretical concepts to interpret them correctly;
- to examine in an open-minded manner all possible conclusions about the best course of action; and
- to arrive at a logical conclusion about the best course of action after considering the *ethical implications* of different possible decisions (Center for Critical Thinking, 2007).

Redefining resistance and "failure" in treatment. One significant repercussion of implementing evidence-based practice in correctional treatment is that it will require both correctional professionals and treatment providers to revise the manner in which they critically appraise whether an offender succeeds or fails in treatment. Typically, treatment non-compliance has been interpreted as the offender's defiance of the court's expectations to enroll in and complete treatment. Non-compliance has led to serious sanctions, including imprisonment. This model of evidence-based practice promotes an objective and critical appraisal of the offender's success or failure in treatment. It underscores the need for professionals to acknowledge, when appropriate and true, that practitioners do not always know how to effectively treat all problems that clients bring to them (the "I don't know" factor). Sometimes offenders may "fail" in treatment because the treatment was ineffective, or inappropriate to their particular condition. For example, mandating an addicted, mentally ill offender to attend 12 step-groups as the only "treatment" for his alcoholism will likely end up in a poor outcome, as will requiring an illiterate, developmentally delayed offender to seek treatment through a cognitive-behavioral treatment group. That cannot be considered

the offender's "failure." Another way that the concept of treatment failure becomes more complicated is the area of treatment fidelity. For example, within the modality of Motivational Interviewing (MI)—a specialized, evidence-based model of engaging offenders in a collaborative addiction treatment process—an offender's "failure" in treatment may in fact reflect that the practitioner did not appropriately assess the offender's stage in the change process or did not adhere appropriately to the MI model.

An assessment of "treatment failure" will require both the clinician and the corrections professional to critically and objectively appraise whether a treatment course was well-matched to a client's condition and whether interventions are executed with appropriate fidelity to their research-based design.

Ethical considerations. Evidence-based practice occurs within a context of ethical accountability. Ethics outline the moral principles and values of a profession. They are a central part of most types of clinical practice. Psychologists, social workers, and other counselors are bound to a professional code of values (Congress, 1999). Values are "generalized, emotionally charged conceptions of what is desirable; historically created and derived from experience; shared by a population or a group within it, and provide the means for organizing and structuring patterns of behavior" (Reamer, 1999). While values tend to be emotionally laden and sometimes subjective—different from evidence, which is objective and dispassionate—they are a critically important—indeed, unavoidable—part of evidence-based practice. Similarly, within the field of corrections, some practices—such as financial restitution toward victims—are pursued not because they have evidence supporting their effectiveness at reducing crime, but because they are informed by community values and the ethical framework of the profession.

Both healthcare and corrections are informed by deeply held values. Corrections professionals also adhere to professional ethics and values, many of which are unknown to the healthcare provider. For example, Balanced and Restorative Justice is central to the mission of many probation and parole offices, jails and prisons, and drug courts. Balanced and Restorative Justice focuses on the fact that crime is an injury to a victim and a community, and the harm of that injury obligates the offender to make things right. Accountability in this model refers to the offender acknowledging responsibility for the harm they have caused and to help with repairing or correcting the damage of his or her actions. Restoration refers to that value of repairing the harm to victims and rebuilding the community that was damaged (Krisberg, 2005).

For correctional treatment, the values that inform the practice of healthcare providers are applicable, but they also require re-appraisal and adaptation because of characteristics unique to the offender population.