Evidence-Based Practices: What's All the Fuss About?

As a correctional professional, you have probably heard about something called an "evidence-based" practice (EBP). There may have been whispered conversations in your workplace about this subject. Many in corrections still have only a vague notion of what, exactly, a shift to an evidence-based practice would mean to their profession. Amid rumors and misinformation surrounding this topic, it might be useful to clarify what an evidence-based practice is, and what it is not.

Simply put, a practice that is evidence-based is one that incorporates the latest research on effective practice into the daily operation of a correctional system. Be it a huge state or federal bureaucracy, or a small local agency, the principle is the same: Recidivism can be significantly reduced through a focus on improved assessment, client motivation, case planning, treatment and program evaluation.

As client populations have risen, correctional systems have become increasingly security-minded and compliance-oriented in order to survive a human tidal wave of clients entering the system (Pew Center for the States, 2009). In response, much emphasis has been placed on risk control strategies (making the required number and type of contacts, running the required number of drug tests, enhancing intensive supervision and surveillance efforts, and using technology (such as GPS monitoring and telephone supervision systems). These risk control processes have kept the public reasonably safe in the short term. Unfortunately, sole reliance on a risk control strategy has not significantly improved long-term client outcomes. This has been the finding of study after study, and our jails and prisons are full of examples (McGuire, 2002; Sherman et al, 1998). There is nothing wrong with risk control, per se; it is a necessary aspect of corrections work. The public needs to be protected today from those whose behavior is clearly out of control. Yet, a single-minded focus on risk control ignores a basic truth confirmed by over two decades of correctional research: *Lasting human change is an inside job.* That is, people change intrinsically when motivated to work toward a better future. No amount of external control will make people change the way they think or behave for long. After all external controls are lifted, most people, and certainly most clients, revert to the same lifestyle choices they engaged in previously (Miller and Rollnick, 2002). Consequently, more than one half of correctional clients ultimately return to the correctional system (Langan and Levin, 2002).

Given projections for continued growth in the American corrections population, it is clear that something has to change. Among other things, strategies will need to change, using as a guide what we have learned from a growing consensus about what works in reducing the risk posed by this client population. The reasoning is solid: Promoting lasting, positive client change, while holding those under our supervision accountable for their choices, reduces recidivism and improves long-term public safety (Gendreau, P., M. Paparozzi, et al.). We all win.

So, how to do it effectively? Given the workloads that correctional professionals face every day, how do those working in a correctional setting find the time, energy and motivation to change their practice to reduce long-term criminal risk?

The answer is to work *smarter*, using research to guide practice. There are proven tools, techniques and skills identified in the correctional literature that, once mastered and applied with fidelity, improve client outcomes and actually make life as a corrections practitioner easier, more productive and more enjoyable. The key is in getting a better handle on the risks and needs of those under supervision and what interventions achieve the biggest "bang" for the correctional "buck." An evidence-based practice can help agencies do just that, and, in the process, help practitioners better justify and defend the decisions they make.

The ideas supported by the research are simple:

- Identify levels of risk and make decisions on how resources are to be allocated for various correctional client populations by risk.
- Limit opportunities for high-risk clients to intermingle with low-risk clients, who get riskier by association.
- Become skilled in communication techniques (such as motivational interviewing) that serve to enhance the intrinsic motivation of clients to change for the better.
- Target for intervention those criminogenic (crime-producing) needs that tend to make clients riskier. These are the "dynamic" factors that are responsive to effective interventions.
- Apply the right dosage of treatment for the degree of need suggested as a result of the assessment.
- Make plans for intervention based on the whole person, their cultural orientation, their learning style and their unique challenges/barriers.
- Increase positive reinforcement through creative incentives, and establish graduated sanctions that teach as well as control.
- Enter into a collaborative effort with treatment providers, the client's family and community members to lessen the likelihood of recidivism.
- Measure and evaluate all components of the supervision process and strive to improve outcomes through a never-ending process of learning.

These are the cornerstones of an evidence-based practice (Bogue, et al, 2004).

These same basic dynamics have been a part of the evolution of other professions, from business, to science, to medicine. Let's take surgery, for instance. Brain surgery has been practiced for centuries, dating back to ancient Egypt. Early brain surgery was largely a matter of educated guessing, drilling holes in the skull and extracting a certain amount of "stuff" based largely upon the surgeon's experience. Some patients lived, but beyond that, it is uncertain how much better they got as a result of the medical "intervention".

Modern surgery is sophisticated. Detailed medical histories are taken, followed by careful examination and questioning about type, severity and onset of symptoms. A CAT scan or MRI is often done to "see" inside the brain and locate the source of the problem. Only then will the surgeon prepare a plan for surgery that removes the tumor while minimizing damage to healthy tissue nearby. Medicine has evolved because of research-driven changes in practice as the field has advanced. Corrections should be no different.

The following is a brief discussion of the major components of an evidence-based correctional practice. The body of research on this subject is vast, and this provides only a starting point in applying the science of corrections in your work.

Assessment

There are many ways to assess the likelihood that someone may recidivate. As professionals, we are often been guided by gut feeling, based upon our experience and past history. Yet, correctional research has concluded convincingly that reliance on human judgment and static factors alone provides an incomplete and often biased interpretation of risk potential (Meehl, 1996). An evidence-based practice relies upon the use of actuarial assessment data as its foundation, blended with human judgment, to inform correctional decision-making. State-of-the-art, 4th generation risk assessment tools use sophisticated statistical models to accurately assess both *static risk factors* (those things, such as prior criminal history, that can't change) and *dynamic risk factors* (those things, such as criminal thinking and attitudes, that can change). Static risk factors remain an important predictor of risk, but they offer nothing upon which to focus the intervention process to reduce it. Dynamic risk factors are also predictive, but since they are happening right now and are subject to change, may serve as the focus for effective intervention.

Accurately assessing and interpreting static and dynamic risk factors does three things for correctional practitioners: it tells us *who* are at highest risk to recidivate (the risk principle), *what* their greatest crime-producing issues are (the needs principle), and suggests *how* we might craft an intervention that works to successfully address those issues, surmounting whatever barriers that might stand in the way of positive change (the responsivity principle).

Getting good data up front is critical to achieving successful client outcomes. It is the assessment instrument that helps inform and defend the decision-making process. Poor or inadequate data means inaccurate or incomplete interpretation, leading to misguided planning and intervention. Good data allows for more accurate interpretation of risk and needs, more-focused case planning, better follow-through and better results.

So, what are these crime-producing needs upon which we should be concentrating? Criminological researchers have identified the "Big Five," the five best predictors of future criminality (Andrews, et al, 1990). These are:

- History of Antisocial Behavior (including criminal record). The key factors here are the early onset of a criminal lifestyle, the severity of the criminal history, the sheer volume of crimes committed and the versatility of the criminal record.

- Criminal Peers (those with whom clients choose to associate, particularly those who are gang or drug-affiliated and have done time).

- Criminal Attitudes (what clients think, what they believe, what they value, their attitudes about the world and their place in it). Thinking errors are often manifested in antisocial stances, blaming others, minimizing responsibility, rationalization and excuse-making, justifying harmful behavior, and a false sense of entitlement.

- Criminal Personality (impulsivity, lack of caring for others, domination/manipulation, narcissism, hedonism, selfishness, callousness, lack of compassion or conscience, etc.).

- Criminal Opportunity (engaging in a high-risk lifestyle, thrill-seeking, restlessness, impulsivity, boredom and lack of pro-social, constructive activities).

In addition to the Big Five, a 4th generation assessment instrument should also identify the strength of second-tier predictors such as substance abuse, family influences, vocational/educational failure and the influence of their neighborhood/community, as well as protective factors such as pro-social friends/family, crime-free neighborhoods, economic opportunities, and the prospects for a better future.

All of these factors, once measured and interpreted, create a detailed picture of what is going on in a client's life, allowing the practitioner to see the connections between the client's past, present and future. The real skill is in the interpretation of the data, the ability to "connect the dots," to draw accurate inferences from the assessment, and to share these insights with the client in such a way that they "get it" and buy into a plan to change the course of their life. At its finest, assessment is a careful blend of art and science, intuition and statistics, guts and numbers.

Enhancing Intrinsic Motivation

One of the most effective ways to improve outcomes is simply to enhance the client/practitioner relationship. This requires a reliance less on "sticks" and more on "carrots." People change when they generate a compelling level of internal motivation, and the best way to enhance that motivation is through encouragement, reward and reinforcement of positive behaviors. It is often easier to identify and point out what a client is doing wrong. They are used to having other people notice that. Clients are less accustomed to having someone acknowledge when they do something right. An evidence-based practice builds on the notion that praise and other incentives are prime motivators for anyone to do better. Clients are no different than the rest of us in this regard.

Often a client has either given up hope of changing or fails to acknowledge the need for change. They are pre-contemplative. A set of skills and techniques collectively known as Motivational Interviewing (MI) can help them explore their ambivalence about change and create some discrepancy between their stated life goals and the repeated thinking and behavioral choices that prevent the attainment of those goals.

Motivational interviewing employs the skill of reflective listening, asking open-ended questions that are aimed at methodically digging deeper into the criminal logic that causes repeated problems for a client. A skilled MI practitioner is adept at reflecting value-laden statements back to the client by repeating, rephrasing, paraphrasing or reflecting the emotional dimensions of the client's statements. Words can be very powerful in generating self-reflection, when mirrored back. Summarizations can then be used to move the conversation to a deeper level. Ultimately, the MI practitioner is trying to elicit self-motivating statements from the client about what *they* see as problem areas, the consequences of continuing to live and behave the way they do, and alternatives worth considering. This is done through a variety of techniques that require a client to ultimately make a choice as to whether to change or not, given the consequences of the options available.

Motivational interviewing is a high-level skill that takes significant time, training and ongoing practice to master. However, when done with skill, MI encourages a dialogue that is change-focused, and clarifies the expectation that the client is responsible for their life and the choices they make. This is entirely consistent with an evidence-based practice focused on intrinsic motivation.

Target Interventions

The development of an effective case plan is one of the most critical pieces of the correctional puzzle. The plan should drive the supervision process and serve as a roadmap for an effective intervention. Far too many plans are created as cookie-cutter examples of a "one size fits all" mentality. Officers, often suffering from information overload, tend to standardize their plans to ensure compliance with supervision standards. From an efficiency standpoint, this makes sense: Set up the case to facilitate making the required number and type of contacts, because that's what "matters".

In fact, what really matters is the *quality* of the contacts, and how they address the goals of the case and the most problematic criminogenic issues. The research clearly shows that the frequency of client contact has very little impact on long-term outcome. Supervision plans should therefore be established that enhance the quality of the officer-client relationship and the mutual goals of the supervision process, as outlined in the supervision plan.

In order for this to happen, the plan must be carefully constructed to address the crime-producing needs identified during the assessment. During the case planning process, the following questions need to be asked:

- Which of the criminogenic needs are the highest-scoring?
- What kinds of patterns do you see in the assessment data? Have you seen this pattern before?
- Can one or more criminal theories help explain what is going on in the client's life?
- Can you infer a causal relationship between factors, a logical chain of events along each unique pathway to a criminal lifestyle?
- Where might that causal chain best be broken?
- Which factors need immediate attention?
- Which factors might be most amenable to treatment?
- Which factors are transient, and which are well-entrenched?
- What triggers have historically inhibited movement toward change? How can they be minimized?
- What strengths are present, and how can they be built upon?
- How can the client's interests be incorporated into the planning process?

- What incentives might be most effective in reinforcing the change process?
- What sanctions might be useful as learning tools when things don't go according to plan?
- What can realistically be done at the beginning to serve as a foundation for success, and how can the more difficult factors be "staged" in the supervision plan to build upon those early successes?
- What intermediate steps might be required to properly stage and sequence the intervention?
- How is success to be measured?

All of these questions require the practitioner to focus on key factors, to "connect the dots" from the onset of a criminal career to the present, so that an intervention can address the whole person, how they became the way they are, and what needs to change on so that their risk of reoffending is lowered.

Case planning is an area where art meets science. It is an interactive process, of which client buy-in is a key component. Many a "great" plan has been ignored by the client because they had no hand in its construction or execution. At the virtuoso case-planning level, the practitioner uses all of their communication and motivational skills to engage the client in the planning process, with the client assuming responsibility for its follow-through. This engagement process should include an honest discussion of the triggers that throw the client off track, and any strengths and interests that can be optimized. It is also important to spell out what incentives are appropriate when key performance measures are achieved, and of course, the sanctions to be imposed when performance falls below agree-upon benchmarks. These performance measures should be explicit, complete with timelines.

Often the first items to be addressed in a supervision plan are those that are most basic. Homelessness, joblessness and mental health/substance abuse issues come to mind. Until someone has a roof over their head, food in their belly and a clear mind, efforts to address criminal thinking and attitudes will largely fall upon deaf ears. Starting small and taking incremental baby-steps toward goal attainment produce the best long-term results. There is a tendency to over-stuff supervision plans with too many goals at once. This will doom a plan to failure by sending the client into "information overload". There will be plenty of time to address other criminogenic needs, once the client's basic needs are met and good levels of rapport and confidence in the relationship are generated.

Ultimately, a good supervision plan is about building long-term skills: problem-solving, behavioral management and coping skills. At the expert level, case planning takes into account

responsivity issues, accurately assesses the stages of change, and reaches a deeper explanation of what's going on in the case and what to do about it.

There's one more thing to consider. A good supervision plan is a "living" document. It grows and changes, at regular intervals, as the supervision unfolds. The plan is not meant simply as a paperwork requirement that gets shoved in the file and forgotten. It should drive the supervision forward, and do so with regular modification over time, dictated by conditions in each specific case. At its best, the supervision plan can be used as a highly effective motivational tool, to hold clients accountable for making the positive changes they have identified as necessary.

Skill Train with Directed Practice

Most behavior is learned, first by observation, then by imitation and practicing the behavior until it closely resembles that which was observed. Shooting a basketball is a good example. Standing in the driveway, at age 5 or so, looking up at the rim way up there, your first shot in all likelihood did not go in, even after you carefully observed your dad make one with ease. Why did his shot go in, while yours landed well short and wide?

There are a number of reasons. First, you weren't ready. You were too short, with weak arms and small hands. Secondly, you lacked the eye-hand coordination required to aim correctly. Lastly, you had no experience to help you shoot the ball with the proper mechanics. These three deficits doomed your first shot to failure. However, assuming you were properly motivated, and had sufficient coaching and time to practice, shots eventually started falling.

Adult behavioral change happens much the same way (Prochaska et al., 1996). First, you are exposed to a new way of thinking about how you live. Let's take smoking, for instance. Over time, after years of smoking, you develop an intrinsic appreciation that cigarettes are harming your health. You may have denied it for some time (*pre-contemplation*). Then, you develop a cough that won't go away, shortness of breath when you climb stairs, along with the lines on your face that all conspire to send a distinct message: "Cigarettes are slowly killing me and I need to stop" (*contemplation*). You are at least willing to acknowledge the damage you are doing to yourself, but are not quite ready to change. Then one day, you go in for your annual check-up, and your doctor tells you flatly that you lungs are filling with crud and that your health is endangered. You make a vow to stop smoking then and there, but you have no real idea how you are going to accomplish it (*preparation*). Your doctor helps you develop a plan to quit smoking, complete with strategies to overcome cravings (*action*). You carry through with that plan, and join a support group with others who are trying to quit (*adaptation/maintenance)*. Leaders of that group model and reinforce good coping skills, and the group practices and role-plays strategies for dealing with high-risk smoking-relapse situations. Occasionally, you will backslide and sneak a cigarette in the bathroom (*relapse)*. You are honest about these slips, and learning takes place. Finally, after several attempts, you can say that you have quit for good.

This is exactly how an effective intervention takes place. Behavioral adaptations take time, patience, good modeling, motivation and the understanding that all behaviors start as thoughts. Cognitive-behavioral treatment is an evidence-based treatment approach. CBT works on the logic behind the behavior; the attitudes, values and beliefs that either reinforce or inhibit a certain behavior. Careful examination of the thinking gets at those underlying attitudinal components and how they tend to "give permission" for bad behavior. A skilled cognitive-behavioral therapist can help a client work through the stages of change outlined above, one at a time. Each intervention must start where the client is. If they are pre-contemplative, motivational interviewing techniques will be needed to explore ambivalence to change and to create discrepancy between stated goals and current actions. If the client has reached a decision that change is needed, the goal is then to teach the skills necessary to make the change, to reinforce pro-social thinking, to model coping strategies, and to direct the practice of those strategies.

If done correctly, in sufficient dosage and for a sufficient duration, cognitive-behavioral treatment has been shown by research to improve outcomes, especially when the therapist and the corrections agent work together to reinforce the learning and reward the behavioral change they want (Aos et al., 2006). A high level of open, honest communication between the treatment staff and supervision officer is critical, so that the client receives a consistent message that maximizes the impact of the intervention effort.

Increase Positive Reinforcement

People respond positively when they are rewarded. It turns out that rewards are far more powerful as motivators than are punishments. Often the most powerful rewards are intrinsic. We care what others think of us. Clients are no different.

Let's consider your average three-year-old, Carmen. She cares what her parents think of her. Carmen is motivated to do her "chores" because she desires her parents' approval, and likes to do fun things. Carmen has a chore chart posted on the refrigerator. Each time she engages in one of her "chores" (goes to the bathroom in the potty, eats all of her dinner, puts away her toys, goes to bed without a fuss, etc.), she gets a star by that chore. As stars accumulate, she earns rewards (maybe a cookie, extra time playing her favorite game, getting to walk the dog, playing her favorite DVD again…). Carmen knows that failing to do her chores will result in fewer stars, fewer rewards, and parental disapproval. This is classic operant conditioning, and parents use it to great effect.

The same strategy can be used in a corrections setting. The research tells us that a ratio of at least four positive reinforcements for each negative sanction is optimal in producing better supervision outcomes. Such reinforcements can be informal (a pat on the back, a word of praise and encouragement, a note left on a door) or formal (a letter of commendation sent to a judge, formal acknowledgement from the chief or warden placed in the file, reduction of drug-testing

frequency or required contacts, reduction in treatment or community service requirements, early release from supervision).

If a positive relationship between the officer and client has been well-established, these reinforcements will have a much greater effect than if the relationship is superficial or oppositional. Believe it or not, most clients *care* what their officers think of them, and will perform at higher levels for an officer who values and acknowledges their efforts. The supervision relationship can be far more effective if based on a "win-win" strategy, with mutual respect and the establishment of incentives to reward the kind of pro-social change that is desired.

Engage Ongoing Support in the Community

Research supports the notion that positive support in a client's "natural community" can improve outcomes (Meyers et al., 2002). This makes a lot of sense. This is where the client lives and spends much of their time. Social learning theory suggests that it is in these regular, daily connections with other people that patterns of thinking and behavior are observed, imitated, reinforced and rewarded. If positive behavioral models in the neighborhood can be identified, recruited and included in the intervention process, then chances of a positive outcome improve. Identifying and recruiting supportive community members requires a kind of outreach that is currently uncommon in corrections. Yet, there are untapped opportunities to do so. Home visits are a good example. Routine home visits can serve as a chance to get to know the family, find out who in the home has the client's best interests at heart, and identify those family members that may exert a negative influence. Getting a bead on the household dynamics is the first step in putting together a community support plan.

Well-intentioned family members can act as eyes and ears for the supervising officer in the community. At least some home visits, and especially the initial one, should be scheduled with supportive family present, so that they can become engaged in the intervention process. Business cards should be handed out like candy during these visits, and the family should be encouraged to contact the supervising officer with any observations or concerns about the client's neighborhood activities.

Other community members are equally important. Pastors, employers, community leaders and mentors can all be recruited to help support the client's successful completion of their behavioral contract. There is strength in numbers, and in positive relationships. Start building this coalition by having an honest discussion with the client. Ask them to identify those who are a positive influence in their life, and seek out the involvement of those people when designing and executing the case plan. The plan will have more meaning and impact when it is supported by everyone close to the client.

Measure Relevant Practices

What gets measured gets done. Keeping that in mind, correctional agencies that embrace an evidence-based practice are always looking to quantify their efforts and the results they produce. Gathering solid empirical data is an essential part of accurate program analysis. Collecting and using the right kind of data to support a detailed analysis of performance is essential if the agency is to learn what is working and what isn't. Practices that cannot be accurately measured should be reexamined to determine whether they have a valid place in the agency. Effective ways to evaluate relevant practices must be found so that wasteful policies, procedures and standards can be adjusted or eliminated. It is this feedback loop that allows an agency to take an honest look at its performance, to correct deficiencies, to eliminate poor-performing practices and programs, and build on proven successes.

Measurement should also extend to individual officers, and their mastery of critical skills. Methods of empirical skill assessment must be developed, to provide staff with fair and accurate feedback concerning their level of proficiency and fidelity in practicing the skills necessary to support better client outcomes. Officers who fall below acceptable skill proficiency levels should be targeted with additional training, coaching and support.

Likewise, the agency must be held accountable for the outcomes it produces. Results that are inconsistent with improved client outcomes and reduced recidivism suggest that changes in practice are needed. Corrective plans and new performance measures evolve from this feedback loop, and the process begins anew.

Closing

Keep in mind that an evidence-based practice is less of something you "do" and more of something that you "think". EBP is not a program, nor is it a policy. Instead, it is a way of looking at the work in a way that focuses our efforts on practices that have been proven to work in enhancing public safety. In a long-term sense, improvements in public safety are best achieved when we focus less on processes and more on outcomes. Do clients complete supervision knowing more about themselves, with better coping and decision-making skills? Do they have an effective support system in place and a clear plan for their future that minimizes their chances of coming back into the correctional system? If so, than the goal of an evidence-based supervision approach has been achieved.

References:

Andrews, D.A, J. Bonta, and R. Hoge. (1990). Classification for effective rehabilitation: Rediscovering psychology. *Criminal Justice and Behavior* 17:19-52.

Bogue, B. N. Campbell, M. Carey, E. Clawson, D. Faust, K. Florio, L. Joplin, G. Keiser, B. Wasson and W.Woodward. (2004) Implementing Evidence-Based Practice in Community Corrections – The Principles of Effective Intervention. Washington, DC: National Institute of Corrections.

Gendreau, P., M. Paparozzi, et al. (1993). Does "Punishing Smarter" Work? An Assessment of the New Generation of Alternative Sanctions in Probation. Forum On Corrections Research 5: 31-34.

Langan, P. A. and Levin, D. J. (2002). *Recidivism of Prisoners Released in 1994*. Washington, DC: Bureau of Justice Statistics.

McGuire, J. (2001). What works in correctional intervention? Evidence and practical implications. Pp. 25-43 in *Client rehabilitation in practice: Implementing and evaluating effective programs.*, edited by D. F. Gary Bernfeld, Alan Leschied. New York, NY: John Wiley & Sons, LTD.

Meehl, P.E. (1996). Clinical versus statistical prediction: A theoretical analysis and a review of the evidence (New Preface). Lanham, MD: Rowan & Littlefield/Jason Aronson. (Original work published 1954)

Meyers, R.J, W.R. Miller, J.E. Smith, and S. Tonnigan. (2002) A randomized trial of two methods for engaging treatment-refusing drug users through concerned significant others. Journal of Consulting and Clinical Psychology, Vol. 70:5,1182-1185.

Miller, W. and S. Rollnick. (2002). *Motivational interviewing: Preparing people for change.* New York, NY: Guilford Press.

Pew Center on the States, *One in 31: The Long Reach of American Corrections* (Washington, DC: The Pew Charitable Trusts, March 2009).

Prochaska JO, Velicer WF, Rossi JS, Goldstein MG, Marcus BH, Rakowski W, et al. Stages of change and decisional balance for 12 problem behaviors. Health Psychol 1994;13:39-46.

Sherman, L.W., D.C. Gottfredson, D.L. Mackenzie, J. Eck, P. Reuter, and S.D. Bushway. (1998). Preventing Crime: What works, what doesn't, what's promising. National Institute of Justice.