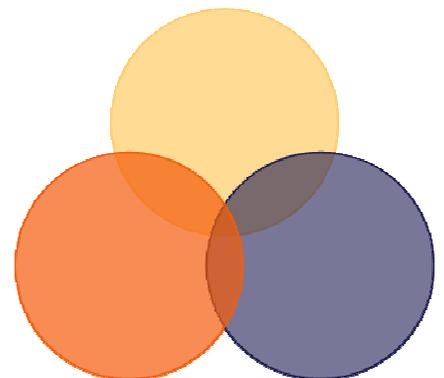




EFFECTIVE CLINICAL PRACTICES IN TREATING CLIENTS IN THE CRIMINAL JUSTICE SYSTEM

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.



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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.cj institute.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,

A handwritten signature in black ink, appearing to read "Elyse Clawson".

Elyse Clawson
Executive Director, CJI

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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 transinstitutionalization 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 *transinstitutionalization* 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:

[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

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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.

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. 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

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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

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.

and adjust course as needed. Critical thinking has sometimes been referred to as “thinking about thinking.” According to The Center for Critical Thinking (2007),

[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

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.

adaptation because of characteristics unique to the offender population. According to Gambrill (2006) some of the key values that are honored through the philosophy and standards of evidence-based practice include the duty to help clients and avoid harmful interventions; the duty to promote the client's autonomy and quality of life; the respect and integrity of clients; and practitioner competence.

I. *The duty to help clients and avoid harmful interventions*

Western medical providers take the Hippocratic Oath as defining the ethics of their professional mission, which requires them to help individuals in their care, or, at the very least, to avoid doing harm to them. This value is sometimes known as *beneficence*: "The ethical principle of beneficence obligates the healthcare professional to act in such a way as to produce a greater balance of goods over harms for the patient, as those goods and harms are understood from a vigorous clinical perspective" (Bioethics Resource Group, 2006).

For providers of correctional treatment, there is an added duty to serve the community at the same time help is offered to an individual offender; to incorporate information about the risk that an offender poses to community safety; to target anti-social thoughts and behaviors as part of the treatment plan; and to share relevant and pertinent information with the corrections professional when there are concerns about community safety. Because correctional treatment incorporates interventions from the criminal justice system—whether that is urinalysis, electronic monitoring, sanctions, or rewards—it is also, again, critically important for all professionals involved with an offender to be cognizant of those correctional interventions which have no proven effectiveness and will likely result in long-term harm (e.g. extended jail time vs. a lower-level sanction for minor technical violations of conditions of supervision).

II. *The duty to promote autonomy and quality of life*

Most healthcare exists to promote the functional independence of the client and increased freedom from physical and emotional suffering. While these are valuable goals for treatment for all clients, whether or not they are involved in the criminal justice system, it needs to be recognized that offenders have less autonomy because of their involvement in the criminal justice system and often a poorer quality of life. They are embedded in environments and contexts in which their behaviors are more closely scrutinized and their liberties restricted. Gambrill (2006) notes: "Some clients are not voluntary participants. This does not remove the [ethical] obligation to honor opportunities for autonomous acts in nonautonomous situations" (p. 278). Treatment providers can promote the client's autonomy by eliciting the client's intrinsic motivation, balancing informed consent with the mandates of

the legal system, and advocating that successful treatment completion can help release the offender from his involvement in the criminal justice system.

Additionally, for the provider of correctional treatment, involving clients in their own personal treatment decisions includes informing the corrections professional about the available treatment interventions, their evidentiary status, their suitability for a particular offender's condition, and the likely outcome of different courses of treatment.

Unlike any other form of behavioral healthcare—which strives to improve the quality of life for consumers—in the field of correctional treatment providers may advise and consult on the use of interventions that diminish the offender's quality of life: sanctions, jail time, and other types of accountability. While this does not improve the individual's perceived quality of life in the short-term, it has been demonstrated to improve treatment outcomes significantly from a long-term perspective (Bonta, 2006) and thus to enhance community safety and also, eventually, the offender's well-being.

III. *Respect and integrity*

In general healthcare, clients are involved as informed participants in their own healthcare decisions and coercive tactics are categorically avoided. Within the criminal justice system, however, coercion is unavoidable.

Offenders are mandated by the criminal justice system to treatment. By their very involvement in the criminal justice system, they are coerced. But there is a subtle, often misunderstood, but critically important difference about how this mandate is construed to the offender. The corrections professional—as a representative of the court system that has tried and convicted the offender—is responsible for mandating an offender into treatment. That requirement exists between the offender and the courts (or the probation/parole officer or the corrections institution). In the largest metaphorical sense, the mandate is between the offender and the society he has harmed. The consequences for ignoring that violation are between the courts and the offender.

The treatment provider's role is to help the offender satisfy this court requirement, but they themselves do not coerce or mandate treatment. They can encourage the offender to thoughtfully evaluate the likely consequences for noncompliance, but it is not their role to force or compel the offender to comply. The effectiveness of most treatment depends on the provider maintaining a reasonable neutrality about the choices that individual offender clients make. This strategy helps to enhance the offender's intrinsic motivation, by focusing on his responsibility for his choices and their consequences. At the same time, it is important for the provider to keep the corrections professional aware of offender choices that are out of compliance with the conditions of supervision. Through playing clearly differentiated roles in the offender's course of treatment, clinicians and corrections

professionals can maximize a cognitive dissonance within the offender client that ultimately enhances that individual's motivation.

The German writer Johann Wolfgang Von Goethe once wrote: "If you treat an individual as he is, he will stay as he is, but if you treat him as if he were what he ought to be and could be, he will become what he ought to be and could be." For example, it is important, as a therapeutic ritual, that offenders entering treatment programs personally sign an informed consent to treatment: they acknowledge that they have been advised about what treatment will and will not do, what is expected from them as clients in order to have a positive outcome, and the consequences for not following treatment recommendations. These consequences include both health-related effects of untreated addiction and mental health problems and the legal repercussions of the offender's non-compliance with court mandates. On some level, the offender must willingly consent to be in treatment. They should also know that correctional treatment has only limited confidentiality. As part of their collaboration with the criminal justice system, treatment providers will inform corrections professionals when offenders fail in treatment, which can lead to criminal justice sanctions for non-compliance. (See Appendix A: Confidentiality in Correctional Treatment.)

IV. *Practitioner competence*

This value underscores the expectation that practitioners be up-to-date in their practice-related knowledge and skills, including participating in ongoing education, training, and quality assurance. "[A] helper must be aware of the limitations of his or her own professional competence and not exceed those limitations in the delivery of his or her service" (Parsons, 2001). Addictions and mental health practitioners who treat offenders have an obligation to address criminality (anti-social beliefs and behaviors) as well as problems that might present in a more general sampling of the population. Most boards of ethics require clinicians to make referrals for clients if they are not appropriately trained to address the client's problems effectively. In implementing evidence-based practices, the imperative of practitioner competence is amplified as many EBPs require specialized forms of supervision, credentialing, and quality assurance, which will be discussed in a later section.

PART II: OVERARCHING PRINCIPLES OF EFFECTIVE CORRECTIONAL TREATMENT

Effective treatment with the criminal justice population is tied intimately and indivisibly with correctional practices such as probation and parole, drug courts, and the ethical and humane management of jails and prisons. Therefore, successful treatment with this population needs to incorporate the risk, needs, and responsivity principles—well-known in the field of corrections—and search out their application to clinical practices. This section will present a definition of correctional treatment and review one model for understanding stages of offender rehabilitation. It will also discuss three important conceptual frameworks for working with the clients in the criminal justice system, which are helpful in interpreting success or failure: the strengths perspective, cultural competency, and harm reduction. While these frameworks are not scientifically derived per se—i.e. they are not empirically tested interventions—they articulate values and principles that are widely held in the fields of both corrections and treatment. Logically, they support much of what is empirically proven in specific evidence-based modalities.

Integrating treatment and corrections functions. Effective correctional treatment, according to Wanberg and Milkman (2004), “must integrate the principles of both the therapeutic and correctional treatment models” (p. 3).² In his history of addiction treatment in the United States, William L. White, describing drug courts, catalogues the combination of elements from judicial, probationary, and treatment frameworks: “rigorous judicial case review, explicitly defined behavioral contracts for participation, intense case management services, specialized treatment that looks at criminality as well as addiction, graduated penalties that provide consequences short of program expulsion, closely supervised aftercare, and—where needed—re-intervention” (White, 1998, p. 305). Within this recipe of correctional treatment, the client is embedded in systems intent on achieving pro-social change—from the supervision, incentives, and praise offered by the probation officer, to the attention and expectations of the court, to the rehabilitative plans and interventions of treatment providers.

² For the purposes of this monograph, the terms “treatment,” “psychotherapy,” “behavioral healthcare,” and “counseling” will be used interchangeably. “Psychotherapy” is sometimes in common parlance considered to refer to therapeutic intervention that is psychoanalytic, client-centered, or confined to private practice therapists who work primarily with the “worried well.” In the professional literature, however, “psychotherapy” refers more generally to a diverse menu of professionally directed clinical interventions for different problems. Usually, in working with the offender population, the word “treatment” is preferred.

Wanberg and Milkman (2004) offer a slightly different formula for explaining the distinctive characteristics of correctional treatment:

Conceptually, correctional treatment has a broader focus than treatment provided to clients not involved in the criminal justice systems, in that “the client” is defined simultaneously as the individual needing help, the referral source, and the larger community impacted by the individual’s behavior.

The basic treatment of the [alcohol and other drug] addicted person is, for the most part, psychotherapeutic. It is *client-oriented* in that counseling or therapy starts where the client is and with the client’s self-perceived treatment needs (or in the case of collaterals, treatment needs as perceived by the significant other). With the offender, however, treatment needs are defined by *external* sources and systems outside of the treatment process. Treatment is, in part, society-centered and directed at the behavioral pattern which is a threat to society, which has violated the laws and integrity of society and thus is part of the sanctioning process” [emphasis added] (p. 106).

What is correctional treatment? As mentioned previously, 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 refers to specialized clinical interventions delivered by trained and qualified clinicians (mental health professionals or alcohol and drug counselors) to individuals who are involved in the criminal justice system, either on probation or parole or in jails or prisons. Correctional treatment differs from treatment provided to clients not involved in the criminal justice systems in six significant ways:

1. Correctional treatment should rely on an active, multidisciplinary partnership with the referral sources. “Official sanction (diversion, probation, custody) is best viewed as a setting condition or context within which treatment services may or may not be applied” (Andrews, 1994). Not only do these partnerships provide the necessary contexts for treatment, but, with successful teaming, they can also be the source of its potency.
2. In addition to addressing the mental health and addiction issues that these clients face, correctional treatment should address criminogenic factors identified by the referral source, such as anti-social thinking and behaviors, anti-social peers, and impulsivity, among others.
3. As appropriate through this collaboration, correctional treatment should integrate accountability interventions (both incentives and sanctions) to enhance treatment outcomes, as well as case management, brokering, and linkage to resources that are often necessary to aid offender rehabilitation.
4. Conceptually, correctional treatment has a broader focus than treatment provided to clients not involved in the criminal justice systems, in that “the client” is defined simultaneously as the

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- individual needing help, the referral source, and the larger community impacted by the individual's behavior.
5. Correctional treatment is coerced, or mandated by the court of conviction (see Appendix C: Coerced Treatment).
 6. Correctional treatment should measure its success by different outcomes than traditional treatment (i.e. reduced recidivism as well as personal and economic costs to society that are avoided when offenders are rehabilitated).

Risks, needs, and responsivity. While correctional treatment is a specialized form of behavioral healthcare, it nevertheless does conform to most standards of clinical practice. It draws from much of the same research and practice literature, and it involves the same frameworks for clinical and ethical decision-making. Those clinical practices do, however, take place within a context (corrections) that has its own knowledge base and best practices. Because of the close partnership with probation, parole, courts, and institutions, professionals providing correctional treatment must also understand the research behind effective correctional practices. This research helps determine not only which offenders are referred to treatment, but also what interventions, in terms of supervision and treatment, are likely to be most effective in aiding their rehabilitation. Andrews (1994) is unequivocal on this principle: "Providing correctional treatment services that are inconsistent with the principles of risk, need and responsivity does not work" (p. 2).

The risk principle. Risk assessment is a key role that corrections professionals play in sorting which clients are referred to more intensive treatment interventions. It helps determine type of treatment as well as duration and intensity of services. In the last ten years, several instruments have been developed, such as the Level of Service Inventory—Revised (LSI-R) and the Correctional Offender Management Profiling for Alternative Sanctions (COMPAS)—that objectively measure risk factors. Research indicates that treatment resources should be targeted toward offenders who pose significant *risk* to society in terms of their likelihood to commit new crimes. "There is considerable empirical evidence that [correctional] programs that target offenders who are higher risk are more effective in reducing recidivism than those that do not" (Lowenkamp & Latessa, 2006). Conversely, it has been shown that placing low-risk offenders in intensive correctional programs *increases* their likelihood to recidivate. Longitudinal and meta-analytic research has amply demonstrated that the probability of recidivism is linked to empirically validated risk factors, including:

1. pro-criminal attitudes and beliefs;
2. disconnection from pro-social support systems and affiliations with anti-social peers;
3. a history of criminal conduct;

-
4. poor impulse control and faulty problem-solving skills;
 5. weak or inconsistent family support;
 6. difficulties in succeeding in school, work, and leisure contexts (Andrews, 1994).

Level of supervision, sanctions, accountability, and provision of treatment resources are determined based on the preponderance of empirically-validated risk factors, with more intensive services being targeted to offenders who are high- and medium-risk. Correctional treatment—that distinctive pairing of criminal justice interventions with rehabilitative treatment—is wasted on clients who come to the attention of the criminal justice system but in fact exhibit few risk factors.

Criminogenic need principle. Research on effective correctional practices has determined that the most promising targets for any intervention are dynamic, changeable variables. Andrews (1994) offers the following catalogue of promising objectives to guide the rehabilitative process: modifying pro-criminal attitudes and beliefs; promoting pro-social supports, including more affectionate and attentive family relationships; improving impulse control and problem-solving abilities; reducing substance dependence and abuse; and relapse prevention. Criminogenic needs can be used to guide practices in probation, parole, and institutions, as well as correctional treatment.

Responsivity. Any intervention—whether correctional or therapeutic—will be more effective, research has shown, if it is tailored to the unique learning style of the client who receives it (Andrews, 1994). High-quality clinical assessment is therefore critical for matching offenders to the appropriate array and intensity of services (Friedman, Taxman, & Henderson, 2007). Factors which influence responsivity include:

1. A high-quality interpersonal relationship, characterized by respect, concern, hopefulness, and enthusiasm;
2. The firm, fair, and consistent use of authority, variously called “respectful guidance toward compliance” (Andrews, 1994) and “invitations to responsibility” (Jenkins, 1990);
3. The hands-on *demonstration* and *reinforcement* of pro-social attitudes, behaviors, and styles of problem-solving (including role modeling, role playing, offering opportunities for graduated practice of increasingly complex skills, and giving clear directions); and
4. Concrete assistance, including advocacy, linkage, and brokering of services (Andrews, 1994; Lowenkamp & Latessa, 2006).

Interestingly, in the research literature on the effectiveness of treatment generally—outside the field of corrections—Norcross refers to what

he calls “responsiveness,” a cyclical, iterative phenomenon that occurs between client and treatment provider: “behavior that is affected by emerging context; it occurs on many levels, including choice of an overall treatment approach, case formulation, strategic use of particular techniques, and adjustments within interventions” (Norcross, 2002).

How is treatment different from what corrections professionals do?

Correctional treatment has much in common with probation and parole supervision, and roles and responsibilities can sometimes become muddled. They all are focused on high-quality, respectful relationships as the vehicle for offender influence and change; they believe in possibility of change even when the offender client does not; and they organize their professional interactions by the risk, needs, and responsivity principles. That said, there are key differences between what correctional professionals and treatment providers do, that must be understood to avoid duplication of effort and maximize the impact that both have on offenders.

Correctional treatment is not case management. It is not linkage or brokering services. The duration of a treatment episode is determined by the reduction of needs and symptoms, not by the length of a sentence or parole decision. Correctional treatment should not be confused with other valuable forms of correctional programming, such as community service, victim impact panels, and psychoeducational programming delivered in a non-clinical setting. While correctional treatment is relationship-driven, it should not be confused with the supervision and case management that probation and parole officers and other institutional case managers do, although it certainly supports corrections professionals in achieving the common goal of community safety. (See Appendix B: The Separate and Complementary Functions of Corrections and Treatment.)

Strengths-based intervention. Corrections professionals—and the treatment providers who work with offenders—admittedly have an ironic charge. They work with individuals who have violated societal norms, who are often verbally aggressive and lack interpersonal boundaries, and who can actively sabotage the very professional relationships charged with aiding and rehabilitating them. And yet, to be truly effective, corrections professionals and treatment providers must consistently take the high road in response to these predictable relational assaults. In keeping with the best practices in the field, practitioners are *role models* of the positive behaviors they wish to see in the offenders with whom they work. Being a positive role model does not preclude professionals from setting limits, correcting inappropriate behaviors, or advocating appropriately for sanctioning, but it does require them to do so with respect, civility, and objectivity.

Understanding successes and failures. While effective practice is informed by scientific knowledge, it also incorporates conceptual frameworks that facilitate the interpretation of offender problems, interventions, successes,

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and failures. Three important conceptual frameworks for working with clients in the criminal justice system are particularly helpful in critically thinking about and measuring offender success or failure: the strengths perspective, cultural competency, and harm reduction.

The strengths perspective. The strengths perspective is not a theory or model of intervention. It is a framework for understanding and interpreting client challenges that can be applied to many types of clinical and correctional practices. It evolved as an antidote to the problem-saturated medical model of understanding clients challenged by addiction and mental health problems (Poulin, 2005). That earlier model had an over-reliance on labeling—reducing clients to their diagnosis. Numerous researchers have demonstrated that diagnostic labeling can have adverse consequences for treatment outcomes:

1. Diagnostic labels—such as “Anti-social Personality Disorder” and “Borderline Personality Disorder,” among others—create negative expectations that may become self-fulfilling prophecies (Gambrill, 2006; Kinney, Haapala, & Booth, quoted in Poulin, 2005);
2. Diagnostic labels focus the practitioner’s attention on deficits and distract from resources and resiliencies (Poulin, 2005);
3. Diagnostic labels suggest that clients cannot change (Kinney, Haapala, & Booth, quoted in Poulin, 2005);
4. They inhibit clinician and client hopefulness, which reduces motivation (Rapp, 1998, quoted in Poulin, 2005).

It is important to note that, ideally, the field of corrections relies on models of classification—high-, medium-, and low-risk—that enable professionals to cost-effectively and prudently sort offenders into the appropriate array of services, whether that is the level of supervision, the level of facility security, or the dosage of treatment. Similarly, correctional treatment providers rely on diagnosis to formulate an individually tailored treatment plan. The strengths perspective does not promote abandoning these proven practices, but rather encourages professionals to view these labels within a balanced perspective, to think about their clients holistically, and to assign the appropriate weight to the diagnosis and risk classification.

At least in the case of addictions treatment, the medical model promoted an adversarial stance between provider and client, with the provider “confronting” the offender’s “denial” and systematically breaking down his tough exterior. This combative approach to client care has been shown to be ineffective (Miller & Rollnick, 2002).

Strengths-based practitioners believe that no matter how dismal the circumstances, people have possibilities, resiliencies, and capacities for

change and even transformation. They look for and even try to nurture the ‘gleam’ that is often hidden by misery, protective strategies, and the failure to achieve goals set by others (Van Wormer & Davis, 2003).

The strengths perspective is much broader than simply seeing client’s strengths. It also promotes listening closely to a client’s definition of “the problem” so that clients—even clients resistant to treatment—can be engaged collaboratively in their own change process (Miller & Rollnick, 2002; Poulin, 2005). For example, an offender may define the probation officer as the problem he wants to address. From his perspective, the intrusions that the probation officer represents in his life are the most noticeable problem he has. Rather than rebuff the offender’s view of his problem, the practitioner can agree that no one likes to be on probation and offer ideas that will help the offender satisfactorily complete his probation. The practitioner may suggest that once the offender demonstrates, through successful completion of treatment, that he has internalized self-control and relapse prevention skills, he will also be demonstrating that community supervision is no longer necessary. The practitioner can achieve a successful outcome while at the same time allowing the offender to define the problem as the offender sees it, thus increasing the client’s investment in treatment.

The strengths perspective eschews the use of the terms *resistance* and *denial* to describe clients who respond poorly to practitioner intervention (Poulin, 2005; Saleebey, 2006). Instead it promotes that clients will respond poorly when the practitioner’s interventions are inappropriate, ill-timed, or off-base, given the offender’s developmental phase in the change process. The strengths perspective sees offender change as “a process on a continuum that moves from a position of unwillingness to even consider making the change to acting on behaviors that will maintain the change. Relapse is regarded no longer as a personal failure but rather as an integral part of the change process” (van Wormer & Davis, 2003).

Cultural competence. The impact of culture, ethnicity, gender, and other social group memberships on treatment outcomes can be profound. Different cultures hold diverse beliefs about the nature of illness and helping. Culture can also influence behavioral norms that impact the development of the professional relationship: different levels of comfort around self-disclosure, non-verbal communication, eye contact, level of directiveness in the professional relationship, and confrontation (Boyle et al, 2008). “A challenge in delivering effective [treatment] to clients from other cultures is balancing clinical expertise and cultural relevance with the use of treatments that are informed by science” (Comas-Diaz, 2006).

Culturally relevant interventions are those acts made by the [clinician] that vary from minute social gestures, which can create barriers to relationship

formation, to very complex interactions initiated to solve problems, change behaviors, alleviate distress, and change thinking. These actions must be within the cultural framework of the ethnic minority person and must be experienced as culturally congruent (Leigh, 1998).

Lum (1999) has defined *cultural competence* as the knowledge, skills and abilities required by practitioners in order to assess and intervene effectively with multicultural clients. She breaks down cultural competence into four areas:

- *Cultural awareness* refers to the practitioner's ability to recognize and work with culturally specific beliefs, attitudes and behaviors that influence the treatment course.
- *Knowledge acquisition* refers to the practitioner's understanding of cultural variables, resources, and strengths.
- *Skill development* underscores the need for practitioners to adapt intervention strategies so that they are culturally congruent.
- *Inductive learning* emphasizes the need for practitioners, as "lifelong learners," to continually update their knowledge of different cultural and social groups, using individual clients as guides (Lum, 1999).

Most professional therapeutic organizations—including the American Psychological Association, the National Association of Social Workers, and the National Association of Alcohol and Drug Abuse Counselors—have clear guidelines on culturally competent practice, and there is considerable overlap and agreement in these guidelines.

The impact of gender. Similar to cultural and ethnic differences, being female profoundly impacts the assessment and intervention process. Many therapeutic models were developed, either implicitly or explicitly, with the expectation that clients would be males. Much research still lacks discussion about the differential impact of the intervention on males and females. And yet women's experiences and conditions are profoundly different from men's: 1. females are more likely to be physically and sexually victimized as children and to experience enduring psychological problems as a result (Boyd-Franklin & Bry, 2000); 2. as adults, women are ten times more likely than men to be abused by a partner, and six times more likely to be abused by a partner than by a stranger; 3. women are more likely to shoulder responsibilities for children and aging parents and other relatives, and more likely to be parenting alone; 3. seventy-five percent of people living in poverty are women or children, and there continues to be a significant wage gap between women and men (Carter & McGoldrick, 2005). Generally speaking, women are exposed to oppression on more fronts: physical and sexual violence; economic

inequities; and discrimination. Women's experience is generally considered to be more relational than men's, and treatment models need to incorporate attention to their relationship dynamics (Worden, 2001).

A developmental perspective. Closely aligned with the strengths perspective is the notion that offenders, like all people in recovery from chronic, serious health conditions, go through predictable stages in the change process. More important than assigning a static diagnostic label to a client, it behooves corrections professionals and treatment providers to assess and understand the offender's particular stage in the change process and to recall that the offender's statements and behaviors are representative of a stage in a dynamic change process. Tailoring interventions to that stage will increase the likelihood that the intervention will be successful. Carlo DiClemente (2003) defines the following five stages of change:

- *Precontemplation.* The offender has no overt or expressed intention of changing in the future. The practitioner's role is to develop awareness in the offender of the need for change, intensify concern regarding the offender's behavior, and facilitate the offender imaging a drug- and crime-free life. Interventions in this stage are largely cognitive and educational.
- *Contemplation.* The offender begins to develop *cognitive discrepancy*, an awareness that his behaviors lead to negative, ill-intended outcomes. The practitioner's role is to help the offender with the *decisional balance*, to analyze the costs and benefits of continuing the inappropriate behavior, to intensify the offender's ambivalence, thus intensifying the offender's intrinsic motivation to change. Interventions in this stage are cognitive, eliciting the offender's own cost benefit analysis of the behaviors in question.
- *Preparation.* The offender makes a decision to change the problem behavior and makes a plan to achieve that change. The practitioner's role is to solidify the offender's commitment, help develop a workable plan, rehearse and implement the change strategies. Interventions in this stage are to offer strategies and ideas.
- *Action.* The offender enacts the plan, experiences successes and failures, and adjusts and refines the plan in response to those failures. The practitioner's role is to facilitate developing a viable plan and to continue to instill hopefulness and confidence. Interventions in this stage are to refine and rehearse the plan, continue to express hopefulness in response to set-backs.
- *Maintenance.* The offender is able to maintain the changed behavior over an extended period of time. The changes become an

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integral part of the offender's lifestyle. The practitioner's role is to disengage and promote reliance on natural support systems.

While these stages of change appear linear, they are actually a crude depiction of a process that is more circular and circuitous. DiClemente's model is useful for reminding professionals that change is a dynamic, developmental process and that offenders are changeable individuals, regardless of their initial defiant or uncooperative presentation.

Harm Reduction. Thus far, correctional treatment has been defined through the lens of risk, need, and responsivity. The role of the treatment provider has been distinguished from the supervision and case management, and accountability practices of the correctional professional. The importance of the strengths perspective has been underscored, as has the advantage of viewing offenders from a developmental perspective, the "stages of change." Harm reduction is another key value that underscores effective correctional treatment, providing a philosophical and practical framework for thinking about offenders who struggle with chronic, relapsing conditions, such as addiction and serious and persistent mental illness.

According to Marlatt (2008), harm reduction "shift[s] the focus away from drug use itself to the *consequences* or *effects* of addictive behavior" (emphasis added, p. 50). Harm reduction may recognize abstinence as a treatment ideal, but it also promotes alternatives to abstinence that also reduce the harm to the individual and society. This philosophy of change appreciates when individuals who engage in extreme, chronic addictive and high-risk behaviors *decrease* the damaging consequences of their unhealthy behaviors. Harm reduction also promotes making services available to clients where they are at (e.g. clients who are homeless or living on the streets who refuse to come to office-based appointments), decreasing the stigma and shame (associated with the medical model of addiction) that can become barriers to clients seeking and engaging in treatment services, and proposing less unhealthy alternatives to illicit drug use (e.g. methadone). Harm reduction is a pragmatic philosophy that recognizes that many offenders will continue to engage in drug use and high-risk behaviors and that professionals will be more effective working with them in reducing their use (and therefore risk) than eliminating it outright altogether (Marlatt, 2002).

Abstinence—a zero tolerance approach to drug use—is one of the conditions of probation and parole supervision. Often it is also a stipulation for maintaining low-cost offender housing resources and for staying in residential addiction treatment. It's debatable whether a zero tolerance approach—essentially punishing and excluding offenders for exhibiting the very problems that these housing and treatment resources were intended to address—is effective; however, it can also be argued that trying to recover in an abstinence-based culture creates and maintains the *cognitive dissonance*

that offenders need to remain motivated to change. It creates accountability and a helpful, albeit coercive, pressure to change. Harm reduction strategies are widely employed within many treatment modalities and can be helpful in establishing realistic, achievable goals for offenders with chronic and persistent addiction and mental illness. While seemingly mutually contradictory, both belief systems potentially have a role in the recovery process for offenders—both can influence the change process positively—but they need to be utilized thoughtfully and ethically, weighing both the short-term and long-term consequences to the offender’s rehabilitation.

PART III: 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 research on brain development and healthy attachment.

What are Common Factors? As has been previously discussed, evidence-based practice is both a philosophy and standard of clinical intervention with clients. Some proponents of EBP have focused more heavily on the standardization of practice—that is, “model-driven, technical interventions and approaches” (Asay & Lambert, 1999); treatment manuals that prescribe a progression of themes and interventions from session to session; ongoing specialized training; psychometric instruments to evaluate provider adherence to models; and expert supervision for quality assurance. Professional organizations, such as the American Psychological Association, have published definitive guidelines of what their discipline considers the accepted menu of evidence-based models and techniques. These advocates tend to push models of treatment to the exclusion of recognizing what are called “common factors,” relationship qualities such as a positive alliance with the client, respect, empathy, and positive regard that cross over all treatment modalities and theories. In doing so, critics assert, these researchers are missing a critical component of what works: the potency of the therapeutic bond.

What’s missing? Another school of thinking has emerged which questions this emphasis on techniques and modalities. De-emphasizing modalities and techniques in favor of common factors, psychologists such as John C. Norcross promote what he calls “empirically supported therapeutic relationships.” He observes:

Although efficacy research has gone to considerable lengths to eliminate the individual therapist as a variable that might account for patient improvement, the inescapable fact is that the therapist as a person is a central agent of change. The curative contribution of the therapist is, arguably, as empirically validated as manualized treatment of psychotherapy methods (Norcross, 2002, page 4).

The researchers in this second camp are not adverse to scientific research and its role in clinical decision-making. “We are all committed to identifying, practicing, and promulgating those psychosocial treatments that

‘work’” (Norcross, 2002). But they do question this relative ignorance of more intangible factors such as the treatment provider’s ability to induct the client into a meaningful change process, and the provider’s interpersonal skills, emotional congruence, warmth, and enthusiasm.

In their influential book, *The Heart and Soul of Change: What Works in Therapy* (1999), Hubble, Duncan and Miller reject the notion that some models of treatment are more effective than others. The authors surveyed the vast array of therapeutic modalities and concluded:

[W]e found that the effectiveness of therapies resides not in the many variables that ostensibly distinguish one approach from another. Instead, it is principally found in the factors that all therapies share in common.

Asay and Lambert agree (same volume, 1999): “Most reviews conclude there is little evidence to indicate difference in effectiveness among the various schools” of treatment.

How are “common factors” relevant to correctional treatment? Since correctional treatments are one distinct stream of therapeutic endeavor, it is critical for any treatise on evidence-based correctional practices to factor in what is known about the “common factors.” Indeed, one of the challenges of correctional treatment, especially addiction treatment, has been its historic isolation from mainstream behavioral healthcare and a tendency to evolve its own standards and values, separate from community norms (Miller et al, 2006). Too often, instead, the standards and values of correctional treatment are heavily influenced by the reactivity, defensiveness, and disdain that characterize public discourse about the violence, addiction, and criminality that this class of clients represents to the public (White, 1998). This is an unfortunate obstacle for implementing effective, science-based practices in correctional treatment.

An analogy comes to mind: Offender clients go to the same dentists as law-abiding citizens, and those dentists use the same research-based interventions to ensure dental hygiene. There is no such thing as “correctional dentistry.” Similarly, the standards of therapeutic practice that apply to law-abiding citizens have some applicability to treatment of the correctional population. Of course, as there would be with any distinctive group of people, there must be adaptations to individualize any model of treatment to a unique client. Distinctive targets for intervention, unique to the sub-group of correctional clients, must be addressed as part of the treatment plan, such as anti-social thinking and behaviors, negative peer influences, and other risk factors. But there is no logical reason to ignore what is scientifically known about the common factors; in fact, the evidence suggests that neglecting them will weaken positive outcomes.

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What are the “common factors”? The articulation of the “common factors” is widely recognized as one of the most influential empirical findings in the treatment field in the last fifty years (Lebow, 2007). The “common factors” have been identified in several ways. Frank and Frank (1991) identify four elements that are common to all treatments, regardless of modality:

- an empathic, confiding relationship with a helping professional;
- a setting conducive to healing;
- “a rationale, conceptual scheme, or myth that provides a plausible explanation for the patient’s symptoms and prescribes a ritual or procedure for resolving them;” and
- the procedure or ritual itself, involving the client as active participant.

Along the same lines, Asay & Lambert (1999) identify the following therapeutic factors that account for a client’s improvement in treatment (see chart): client variables and extratherapeutic events; the quality of therapeutic relationship; placebo effects; and techniques or model factors. A well-known meta-analysis, reviewing all extant research studies of different treatment modalities, has been used to estimate the size of various treatment effects, including these common factors (see Figure 3). Its results will be included with the definitions below.

Client variables and extratherapeutic events. This component includes the client him- or herself and events that happen to them outside the treatment context; variables beyond the treatment provider’s control or influence; constitutional variables such as the severity of the client’s condition, the client’s motivation, emotional intelligence, self-efficacy, capacity for abstraction and insight, and other individual strengths; factors in the client’s natural environment such as a supportive spouse and family; and fortuitous events, like winning the lottery or moving to a safer neighborhood. According to Lambert’s review (1992), client variables and extratherapeutic events account for 40% of the improvement that clients experience while in therapy—the lion’s share of what contributes to change for people in any kind of treatment.

The quality of therapeutic relationship. Lambert’s research finds that the quality of therapeutic relationship accounts for 30% of the change that clients experience in treatment. Much of what is known about the quality of therapeutic relationship comes from the client-centered tradition: qualities such as empathy, warmth, enthusiasm, genuineness, and collaboration. In an interesting example relevant to correctional treatment, a study examining the impact of broad-spectrum behavioral therapies on problem drinkers also looked at the relationship between the therapist’s expression of empathy and

treatment outcomes. The study found a strong relationship between the practitioner's expression of empathy and positive outcomes for the client at six and nine months (Miller, Taylor, & West, 1980, as cited in Hubble, Duncan and Miller, 1999).

Consistent with these findings, Don Andrews (1994) emphasizes in his research that relationship factors are one of the key components of effective correctional practice. He found that it was critical for workers to be enthusiastic and engaged, able to handle their authority judiciously, and engage in healthy conflict with clients. Similarly, in their book *Criminal Conduct and Substance Abuse Treatment* (2004), Wanberg and Milkman observe:

There is a robust relationship between therapeutic alliance and improvement in treatment, regardless of the therapeutic orientation or treatment approach utilized by the treatment provider.... [S]tudies also indicate that client ratings of therapeutic alliance are more predictive of outcome than therapist ratings; therapeutic alliance scores tended to be higher for cognitive-behavioral sessions than for sessions conducted under a psychodynamic-interpersonal orientation; and the efficacy of therapeutic alliance is found across various therapeutic modalities (p. 45).

The same sentiments are echoed in the field of addictions treatment (Miller, 1999):

In a review of the literature on counselor characteristics associated with treatment effectiveness for substance users, researchers found that establishing a helping alliance and good interpersonal skills were more important than professional training or experience (p. 4).

More recent neuroscientific research confirms this data. Psychiatrist Daniel Siegel has written extensively about the impact of secure, positive attachments across the lifespan. His work has underscored that the brain remains plastic throughout life and subject to changes in response to lived experiences, including the availability of high-quality, consistent relationships. He notes that the basic elements of secure attachment include: collaboration; reflective dialogue; repair; coherent narratives; and emotional communication. These components resemble the key ingredients of an effective counseling relationship (Siegel, 2001). He observes:

Different therapeutic tools, including medications and specific psychotherapeutic techniques, may be useful at various times in helping patients achieve self-organization and live balanced and enriching lives. Whatever tools or techniques are used, the relationship between patient and therapist requires a deep

commitment on the therapist's part to understanding and resonating with the patient's experience. The therapist must always keep in mind that interpersonal experience shapes brain structure and function, from which the mind emerges (p. 300).

Placebo effects. Thus far, two common factors—extra therapeutic events and the quality of the therapeutic relationship—have been reviewed. The former lies completely outside professional influence and the latter lies completely within the practitioner's control. Together these two account for 70% of the positive changes that clients experience in treatment. Placebo effects are another source of the potency of treatment. According to *The American Heritage Dictionary*, a placebo is “a substance containing no medication and prescribed or given to reinforce a patient's expectation to get well” (Soukhanov, 1996). It has been more broadly applied to behavioral healthcare to refer to those self-healing capacities of the client that are activated by entering into the therapeutic relationship, if not simply the instillation of hope and the client's own expectation that he will improve. Lambert asserts that expectancy or placebo effects account for 15% of the variance in positive client outcomes. While seemingly outside the practitioner's control, placebo effects can conceivably be enhanced by the practitioner or referral source expressing optimism about the benefits of a particular type of behavioral healthcare. Conceivably placebo effects can also be intensified by example. As a case in point, this author once witnessed a counseling session in a prison between a drug-dependent inmate and an addictions counselor who was himself in recovery. Behind the counselor, facing the client, was a framed picture of the counselor as a younger man, in a prison uniform from his own days of incarceration. It was a powerful reminder of one's ability to recover and lead a meaningful, law-abiding life. While practitioners cannot control placebo effects, they can contribute to hopeful symbolism that is an important component of therapeutic success.

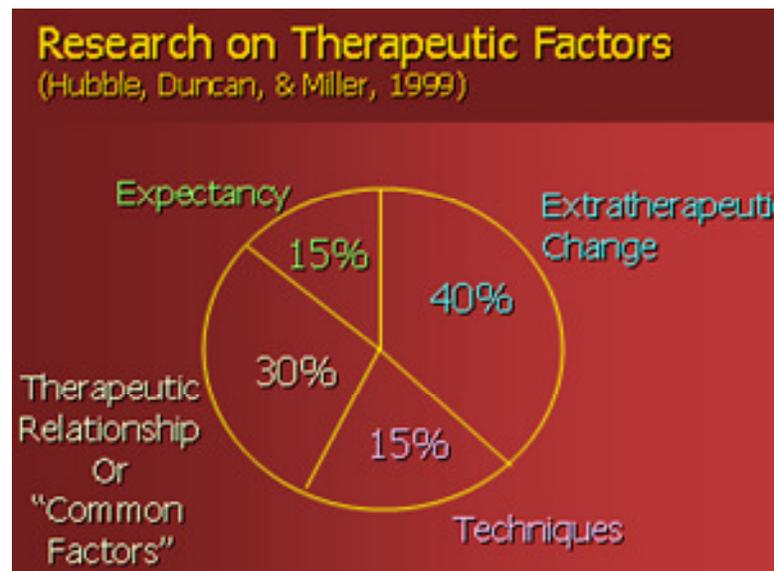
Techniques or model factors. While the vast majority of research on treatment has focused on the efficacy of different modalities—once called “the big guns of therapeutic change” (Asay & Lambert, 1999)—the empirical results have been, with a few exceptions, largely disappointing. “Specific techniques are estimated to account for only about 15% of the improvement” of clients in treatment (Hubble, Duncan & Miller, 1999). The researchers acknowledge that “specific techniques can never be offered in a context free of interpersonal meaning” (Asay & Lambert, 1999). The common factors are indivisible from the therapeutic modality, and most modalities acknowledge the importance of the clinical relationship.

A couple caveats about this school of research. Some of the main researchers covered in this section have emphasized the importance of “empirically supported therapeutic relationships” over specific, evidence-

based treatment modalities. It should be noted that none of these researchers is specifically identified as having expertise with corrections clients; however, many of the modalities in which they do have expertise are known to be effective with offenders (for example, Motivational Interviewing, cognitive-behavioral treatments, etc.). To some extent, this controversy is semantic. Making a sharp distinction between the specific modalities and relationship factors is negligible. Most modalities—especially correctional models of treatment—advocate for practitioners to develop a positive, respectful, collaborative relationship as part of their intervention. None of them promises to be a “magic bullet.” Analogously, it is impossible to think about the automobile separate from the engine.

Much is yet to be learned about relationship factors with offender clients. Offenders can be challenging to relate to and arouse negative and even hostile feelings in practitioners and corrections professionals. Effectively managing those negative responses to offenders is a significant component of being a successful practitioner.

What we don't know. One of the most humbling aspects of engaging in evidence-based practices is the imperative both to own and to make transparent what is not scientifically known about treatment: the infamous “I don't know” factor. In spite of the staggering amount of research that has accumulated about effective psychotherapeutic practices, practitioners do not know with certainty how to treat all clients effectively. Science does not



provide the answer to all problems. Thus, the research on the common factors provides both a consolation and an alternative. It acknowledges that, although there is not a modality that fits every problem, the practitioner has recourse to

some actions that can benefit the client—the cultivation of a high-quality relationship, the instillation of hope and confidence, and, finally, belief in the client's own inherent ability to improve their situation, regardless whether they have professional assistance.

PART IV: SPECIFIC EVIDENCE-BASED MODALITIES FOR CRIMINAL JUSTICE CLIENTS

This section reviews specific modalities for treating clients affected by criminality, addiction and mental health problems; domestic violence perpetrators, adult female offenders, and sexual offenders. While the importance of common factors is accepted, as discussed in the previous section, it is also widely recognized that specific treatment protocols have been shown to have a demonstrated impact on particular client conditions (Aos, Miller & Drake, 2006; Lebow, 2007).

While this monograph can catalogue a number of practices that are currently considered to be effective, it can hardly be exhaustive. Individual offenders will present with myriad conditions underlying their criminal conduct, including addiction, a host of mental health conditions and personality disorders, family problems, and environmental vulnerabilities and perils. Multiple conditions overlap, not infrequently, which can compromise service delivery with fidelity to the design of the evidence-based practice. To truly engage in evidence-based practice, clinicians will often need to research and consult the best available evidence, which is increasingly accessible. They will be required to become “lifelong learners” (Gambrill, 2006).

What follows is a menu of select modalities for treating offenders affected by addiction and mental health problems, domestic violence perpetrators, adult female offenders, and sexual offenders. Within each review are catalogued the following information: 1. the major concepts associated with the modality; 2. examples of interventions; and 3. evidence of the modality’s effectiveness, particularly as it relates to criminal justice clients. When known, any criticisms of the modality, as they relate to criminal justice concerns, will also be described.

Models of clinical assessment. Clinical assessment is the starting point for any therapeutic intervention and the cornerstone of what is known as *responsivity* (matching offender clients to the correct type and dosage of a particular therapeutic intervention). Because there are many types and styles of clinical assessment, however, there is significant room for misunderstanding. Assessments involve both information-gathering and the clinical analysis of data, and there are important gradations of assessment: screening, biopsychosocial assessment, psychological testing, and forensic evaluation. Since assessment is a critical means of understanding the client’s condition, this section will attempt to clarify the types of clinical assessment and their application to offender clients.

Screening. At the most superficial end of the assessment continuum is *clinical screening*. Screenings are generally a brief series of questions designed to be administered in diverse settings, sometimes by non-clinical

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staff, to identify clients in need of more extensive clinical assessment and guide referral and placement decision-making. Since screenings are brief, they are appealing and cost-effective; however, their utility is *limited*. They cannot, for example, be used for diagnosis. Often they indicate the need for more extensive assessment (Titus & Dennis, 2003). Screenings are often used in prison and jail intake settings and hospital admissions to assess for particular conditions of concern, such as drug use or suicidality.

A number of empirically validated instruments exist for screening alcohol and drug use problems, including The Michigan Alcoholism Screening Test (MAST), the Drug Abuse Screening Test (DAST), the Addiction Severity Index (ASI), and the Drug Use Screening Inventory (DUSI) (Tarter, in Frances et al, 2005). The GAIN-Quick also has considerable empirical support as a screening tool (Dennis et al, 2006).

Biopsychosocial assessment. In the middle of the continuum is what is generally known as *biopsychosocial assessment*, psychosocial assessment, or the clinical interview. Generally, specially-trained masters-degreed social workers and counselors gather and analyze client data for the purpose of diagnosis, goal formulation, treatment planning, and to determine placement in the appropriate level of care (Murphy & Dillon, 2002). Biopsychosocial assessments are often unstructured and vary considerably depending on the individual clinician's style, theoretical orientation, and training. Thus, there is significant room for subjectivity and error. "Although the clinical interview is a powerful data-gathering approach, its lack of structure invites room for error in the hands of less experienced staff" (Dennis et al, 2006).

Because of the potential for bias and inconsistency, traditionally administered biopsychosocial assessments must generally be regarded with caution. This potential is magnified when dominant-culture clinicians gather and interpret data from minority and marginalized clients. Glicken (2003) cites several studies in which dominant culture or Caucasian clinicians demonstrated a tendency to misdiagnose, or diagnose with greater pathology, clients who came from different social, cultural, and ethnic groups. She cites, for example, the tendency of Caucasian clinicians to evaluate African-American clients as having paranoid features when the clients are in fact displaying what minority clinicians regard as a "healthy cultural suspicion" (Boyd-Franklin & Bry, 2000).

[T]he diagnostic process with African-American clients tends to discount the negative impact of racism, which leads to diagnostic judgments about black clients suggesting that they are more dysfunctional than they really are. This tendency to misdiagnose, or to diagnose a more serious condition than may be warranted, is what...is called 'pseudo-transference' and it has its origins in cultural stereotyping by clinicians who fail to understand the impact of racism (Glicken, 2003).

Similar studies have shown a clinical tendency to pathologize clients who appear to be of a lower socio-economic status (Robertson & Fitzgerald, 1990). Leigh (1998) offers an important caveat to the cross-cultural practitioner:

Assessments of minority clients are often limited because of a lack of cultural understanding, and social services to those clients are predicated on an incomplete knowledge of the minority client's circumstances, strengths, resources, motivations, and problems. Interventions based on such incomplete assessments will not be operative (p. 126).

An exception to this caveat is The Global Appraisal of Individual Needs (GAIN), an evidence-based, semi-structured biopsychosocial assessment that can be administered via computer software. Organized within a framework established by the American Society of Addiction Medicine (to be discussed later), the GAIN can be used with adults in all levels of programming, including outpatient, residential, therapeutic community, and correctional programming (Dennis, et al, 2006). Because it is semi-structured—i.e. questions are generally scripted, although what questions are asked depends on the client's presentation—the GAIN ensures that all clients are asked the same questions, in the same objective manner. The GAIN has been rigorously tested and found to deliver treatment recommendations that are both valid and reliable.

Studies with adults and adolescents have found good reliability in test/retest situations on days of use and symptom counts ($r=.7$ to $.8$) as well as diagnosis (kappa of $.5$ to $.7$).... Using discriminant analysis, the GAIN scales could also reliably predict independent and blind staff psychiatric diagnoses of co-occurring psychiatric disorders (ibid., p. 3).

Available in the public domain, the GAIN comes with guidelines for training, certification, and quality assurance of practitioners who administer it.

Psychological assessment. At the deep end of the continuum is *psychological assessment*. Psychological assessment encompasses a broad range of information-gathering practices, generally conducted by trained doctoral-level psychologists. It involves gathering and analyzing client data using myriad empirically validated and standardized psychometric instruments. Psychological testing and evaluation can be used to assess intelligence, psychiatric conditions, personality disorders, and neuropsychological conditions (psychological challenges correlated with certain brain structure impairments). The types of objective testing used by psychologists are too numerous to mention, but include generally known

personality tests such as the Minnesota Multiphasic Personality Inventory (Millon, 1994) and the Beck Depression Inventory (Beck & Steer, 1996), both empirically validated instruments.

Forensic evaluation. A sub-specialty of psychological assessment, particular to offenders, is known as forensic evaluation, which is done at the behest of judges or attorneys, often to address specific issues pertinent to a legal outcome, such as impairments that might interfere with an offender's competency to stand trial, dangerousness, insanity, or fitness to parent. Forensic evaluations are less geared to guide treatment placement, dosage, and interventions than to inform the court's thinking about a legal outcome (Melton et al, 1997). Forensic evaluations typically include empirically validated psychometric tools, such as The Psychopathy Checklist—Revised, The Competency to Stand Trial Test, or the Rogers Criminal Responsibility Assessment Scales, to name only a few (Melton et al, 1997).

Specific Intervention Strategies. Once a client has been comprehensively assessed and their condition is clear, the treatment provider can make an informed choice about appropriate intervention strategies. After discussing the overarching importance of addressing criminal thinking and behaviors in any treatment of clients in the criminal justice system, a number of evidence-based practices will be reviewed: Cognitive-Behavioral Treatment, Motivational Interviewing, Contingency Management, effective psychopharmacology, family therapies, Twelve Step meetings and Twelve Step Facilitation, Integrated Treatment for Dual Disorders, gender-specific treatment for women, and treatment models targeting domestic violence and sex offending behaviors.

Treating Criminality. Without addressing criminal thinking and behaviors, any treatment of an offender client will fail. The hallmark of correctional treatment is that, as part of any rehabilitative episode, anti-social attitudes and behaviors receive rigorous intervention (Bonta, 2006; NIDA, 2006; Wanberg & Milkman, 2004).

'Criminal thinking' is a combination of the attitudes and beliefs that support a criminal lifestyle and criminal behavior. These can include feeling entitled to have things one's own way; feeling that one's criminal behavior is justified; failing to be responsible for one's actions; and consistently failing to anticipate or appreciate the consequences of one's behavior. This pattern of thinking often contributes to drug use and criminal behavior (NIDA, 2006).

Intervention into this component of an offender's condition should go hand-in-hand with interventions to address addiction, mental health, and other psychosocial challenges. Indeed, many interventions for interrupting criminal thinking and behavior, such as cognitive-behavioral intervention, are also

commonly utilized in treating addictions, mental health problems, sexual offending, and will also be discussed in this section.

Cognitive-behavioral treatment for criminality. Cognitive-behavioral treatment (CBT) has been well tested and shown to demonstrate a positive impact on both addiction and criminality (Aos, Miller, & Drake, 2006). In the most recent meta-analytic review, posted on the Campbell Collaboration, Lipsey & Landenberger (2006) define cognitive-behavioral treatments (CBT) as interventions

... designed to correct these dysfunctional and criminogenic thinking patterns. They employ systematic training regimens aimed at ‘cognitive restructuring’ such that offenders develop more adaptive patterns of reasoning and reacting in situations that trigger their criminal behavior.

CBT may focus on anger management, assuming personal responsibility for behavior, ... taking a moral and empathetic perspective on interpersonal behavior (e.g., victim impact awareness), problem solving, life skill development, setting goals, or any combination of these themes.

CBT can be used with individuals, but is more commonly used in groups of offenders. Numerous manual-based CBT curricula exist, including The Reasoning and Rehabilitation program (Ross & Fabiano, 1985); Moral Reconciliation Therapy (Little & Robinson, 1988); Aggression Replacement Training (Goldstein & Glick, 1987); The Thinking for a Change curriculum (Bush, Glick & Taymans, 1997); and Strategies for Self-Improvement and Change (Wanberg & Milkman, 2004).

Results from several recent meta-analyses of the effectiveness of cognitive-behavioral treatment for criminal conduct are encouraging. Summarizing the existing research for the Campbell Collaboration’s Crime and Justice Group, Lipsey & Landenberger (2006) catalogue the following studies:

1. A meta-analysis of twenty studies of group-oriented CBT found that the approach was effective for reducing recidivism by 20-30%, compared to untreated control groups (Wilson, Allen, & MacKenzie, in press).
2. Pearson et al. (2002) found that CBT was more effective in reducing recidivism than solely behavioral programs, with a mean recidivism reduction of about 30% for offenders who received group treatment.
3. Lipsey & Landenberger’s own meta-analysis of fourteen studies of CBT’s effectiveness showed that the odds of recidivating for treated offenders were about 55%, compared to offenders in the

control groups. Significantly, they found that CBT was more effective with offenders on community supervision than those who were incarcerated (2006). This finding was also found in a meta-analysis done by Aos, Miller, & Drake (2006).³

Andrews (1994) famously noted that supportive, praising statements to offender clients need to outnumber confrontation or disapproval of criminality by an optimal ratio of 4:1. (While this ratio appears logical from a behaviorist perspective, it is not scientifically proven.) He highlights the need for immediate feedback to criminal thinking and behavior, within the context of a caring and respectful relationship, including:

1. firm and emphatic statements of disapproval and disagreement;
2. modeling anti-criminal attitudes by discussing the reasons for disapproval;
3. being able to “switch gears” quickly to introduce approval when the client expresses pro-social attitudes and behaviors;
4. generally attending with interest, concern, and positive support to the client’s pro-social thinking and behavior (Andrews, 1994).

In addition to being an effective intervention for criminal conduct, cognitive-behavioral treatment has applications as well to treating addictions, mental health problems, and sexual offending behaviors, which will be discussed.

Treating Addiction. In the last twenty years there has been a renaissance of research into “what works” in the treatment of addiction and a significant advancement of scientific knowledge. A surge of research interest in motivational and cognitive-behavioral approaches to treating addiction has upset more traditionally informed approaches to recovery, which tended to be confrontational and grounded in the twelve-step philosophy (Rotgers et al, 2003). A broad menu of services now exists for offenders with addictions, although some researchers have acknowledged that these evidence-based modalities have not been fully embraced by the addictions field (Miller et al, 2006).

American Society of Addiction Medicine (ASAM) Patient Placement Criteria. As previously mentioned, *responsivity* means matching the dosage and intensity of treatment to the client’s individual condition. Mee-Lee developed an assessment protocol, known as the ASAM Patient Placement Criteria, that allows clinicians to tailor treatment recommendations to the needs of individuals with substance abuse problems, using six common

³ This difference might be attributed to the ability of probationers and parolees to have “real world” practice with the new skills they are learning.

dimensions for information gathering: acute detoxification and/or withdrawal potential; biomedical conditions and complications; emotional, behavioral or cognitive conditions and complications; readiness to change; relapse, continued use or continued problem potential; and recovery/living environment (Mee-Lee, 2001). For improved matching, Mee-Lee's Patient Placement Criteria also clearly defines the five levels of addiction treatment, from least intensive to most: early intervention; outpatient; intensive outpatient/partial hospitalization; residential/inpatient; and medically managed intensive inpatient treatment.

The ASAM Patient Placement Criteria has been extensively tested and shown to reduce under-treatment that leads to treatment failure and to prevent over-treatment which is both costly and overly restrictive. More studies are needed on placing clients with co-occurring mental health conditions. ASAM Patient Placement Criteria sometimes conflict with court and probation recommendations for offenders, either the level of care or the length of treatment episode. Providers are encouraged to make reasonable efforts to have the referral source revise its orders in these situations (Mee-Lee, et al, 2001).

Cognitive-behavioral treatment for addiction. In addition to impacting criminality, CBT has been shown to be effective in reducing relapse from substance use problems. Cognitive-behavioral treatment targets four core processes that underlie addiction: 1. *self-efficacy*, or "the individual's perceived ability to deal with events that lead to substance abuse," such as problem-solving and social skills; 2. *attributions*, or the rationalizations that addicted offenders offer for engaging in maladaptive behaviors; 3. *outcome expectancies*, or the individual's short-sighted and maladaptive perception of the benefit of substance use and criminal conduct; 4. *decision-making processes*, or the unconscious and seemingly "automatic" choice of maladaptive thinking and behaviors, which can be replaced through this treatment with more conscious, intentional, and pro-social choices (Wanberg & Milkman, 2004; Gorski, 1996).

Rotgers et al (2003) note that there is considerable scientific evidence, through controlled clinical trials, that CBT is effective treatment for problem drug and alcohol users. He also notes that CBT has been found to be particularly effective with clients struggling with both addiction and criminal conduct. Walsh (2006) writes that one of the advantages of CBT is that it is not only effective with addiction and criminal conduct, but its effectiveness has been demonstrated through fourteen meta-analyses also to be effective in treating depression, generalized anxiety, panic disorders, social phobias—all conditions that are also seen in the offender population.

Motivational interviewing. Considered the "gold standard" in addiction treatment, Motivational Interviewing (MI) focuses on resolving the ambivalence that is core to most addicted individuals. Developed as an

Considered the "gold standard" in addiction treatment, Motivational Interviewing (MI) focuses on resolving the ambivalence that is core to most addicted individuals.

alternative to earlier “denial busting” approaches that had been shown to be ineffective, this directive, client-centered method is designed to elicit the client’s intrinsic motivation to change. Strategic techniques help to minimize power struggles and defensiveness and to mobilize the parts of the client geared toward positive, pro-social change (Miller & Rollnick, 2002). Some of MI’s characteristics include:

1. The practitioner elicits the client’s goals, values, and motivations to change;
2. The practitioner engages the client in a collaborative cost/benefit analysis of continued substance use;
3. The client’s readiness to change is understood, not as the individual client’s condition, but as a product of the interaction between client and practitioner;
4. “Resistance” signifies the need for the practitioner to adapt their intervention to the client’s developmental stage in the change process, rather than the offender’s pathological stubbornness.

The efficacy of MI in resolving substance abuse problems has been abundantly demonstrated through numerous randomized, controlled trials (Burke et al, in Miller & Rollnick, 2002). Compared to CBT and Twelve-step Facilitation groups, MI was found to have comparable positive impacts, albeit appreciatively in a significantly shorter time period (Walsh, 2006; Project MATCH Research Group, 1998).

In general, adaptations of Motivational Interviewing (AMI) have proven superior to no-treatment control groups and less credible alternatives, and equal to viable comparison treatment. AMIs have often done as well as other viable treatment that were two or three times longer (Burke et al, in Miller & Rollnick, 2002).

In a meta-analysis of 72 randomized controlled trials of MI, it was found that MI was effective in improving a broad range of behaviors related to physical and psychological problems, including smoking cessation, weight loss, asthma and diabetes. A positive effect was demonstrated in 74% of the randomized controlled trials, and there were no adverse impacts (Rubak et al, 2005). Other benefits of MI include its ability to be used by non-clinicians, such as probation and parole officers and other corrections professionals, in very short time frames (e.g. fifteen-minute interactions).

While MI can be inconsistent with the sometimes adversarial and punitive cultures that develop in jails and prisons and the coercive context within which many offenders arrive at drug treatment, its adoption can be seen

as part of an important sea-change in these settings (Ginsburg et al, in Miller & Rollnick, 2002).

Contingency management. The objective of this modality, a form of operant behavioral conditioning, is to strengthen the client's commitment to abstinence and to weaken his/her drug use through a systematic use of rewards and punishers in response to desired and undesired behaviors.

Community reinforcement and contingency management involves arranging a client's environment so as to use the social, recreational, family, and other community reinforcers to facilitate and reinforce change (Wanberg and Milkman, 2004, p. 31).

Examples of positive reinforcers include "vouchers/tokens exchangeable for retail items, methadone take-home privileges, access to affordable housing, and increased opportunity to win a prize" (Budney et al, in Rotgers, Morgenstern, & Walters, 2003). Examples of negative reinforcers include increased probation/parole supervision, increased counseling sessions, sanctions, and incarceration (ibid.).

Contingency Management (CM) has been scientifically demonstrated through a number of clinical trials to enhance motivation and retention for individuals in addiction treatment (Marlatt & Donovan, 2008). A series of recent studies showed CM to be effective in retaining patients in treatment and reducing substance use. Positive impacts have been shown with clients dependent on cannabis, nicotine, alcohol, opioids, benzodiazepines, and polysubstance abuse (Petry, 2002). Excellent effects have been demonstrated for CM when combined with CBT in clients with cocaine and opioid addictions (Marlatt & Donovan, 2008).

Psychopharmacology. While talk therapy is generally recognized as the treatment of choice for problem substance use, in the case of certain drug problems it is being combined with psychopharmacology with positive impacts. Medications can be used effectively to help with detoxification (e.g. benzodiazepines to manage the symptoms of alcohol withdrawal), stabilization and maintenance (e.g. methadone maintenance), antagonist and other behaviorally oriented medications (e.g. naltrexone, which effectively blocks the effects of opioids), and the treatment of co-existing psychiatric disorders (Carroll, in Rotgers et al, 2003).

The bulk of the evidence suggests that pharmacotherapies can be very effective treatment adjuncts, but in most cases the effects of pharmacotherapies can be broadened, enhanced, and extended by the addition of psychotherapy (Carroll, in Rotgers et al, 2003).

Comas-Diaz offers the following cautionary note with respect to psychopharmacology with individuals from non-dominant social and cultural subgroups: “There is growing empirical evidence that ethnicity is a central variable in an individual’s response to psychotropic medications.” She cites ethnic differences in the genetic structure of certain enzymes that metabolize medications, variations of body size and composition across ethnic groups, and culturally specific behaviors and beliefs related to diet, lifestyle, and healthcare that also affect how individuals consume and metabolize medications (2006).

Family Therapy. Familial engagement—enhancing affection, supervision, and positive communication—is recognized as a criminogenic need that is key to effective correctional treatment (Bonta, 2006). A small but growing body of research literature recommends the inclusion of family therapy for the treatment of substance use problems (CSAT, 2004). Generally speaking, family therapies involve all members of the family in treatment for an individual’s problem substance use. These approaches explore ways in which the family context supports or precludes substance use problems and examines and suggests ways that all family members must change their thinking, behaviors, and interactions to help a family member achieve abstinence (CSAT, 2004).

Treatment must engage the client’s significant others and the client’s primary social unit. Treatment needs to enlist the support, understanding, and reinforcement power of the family and significant others in the person’s efforts to make change” (Wanberg and Milkman, 2004).

O’Farrell & Fals-Stewart (2006) elaborate on the critical influence that family members have on the recovery process.

Family members are seen as reacting to the substance abuser with characteristic behavior patterns, such as enabling the addiction by protecting the substance abuser from the negative consequences of drinking or drug taking...often called ‘codependence’ (p. 4).

Family therapies excavate and build on family strengths and are particularly useful in working with women, who are more relationally inclined, and members of non-dominant social and cultural groups, which are known to be more communitarian in their beliefs (CSAT, 2004; Walsh, 2006; Boyd-Franklin & Bry, 2000). There are numerous schools of family therapy—e.g. Functional Family Therapy, Structural and Strategic Family Therapy, Multi-dimensional Family Therapy, and Cognitive and Behavioral Family and Couples Therapy—which makes generalizing the effectiveness of these approaches challenging.

In a recent monograph, the Center for Substance Abuse Treatment (2004) cites a growing body of research demonstrating the effectiveness of family therapy in treating addiction. While much of the most rigorous research focuses on adolescent substance abusers, they cite several studies that point to its effectiveness in helping adults to achieve abstinence and more stable relationships:

- Liddle and Dakof (1995) reviewed controlled treatment outcome research and reported that family therapy can improve clients' engagement and ongoing participation in treatment, enhance family functioning, and help prevent relapse. Although they note methodological limitations in the research, they suggest that family treatment is more effective than counseling that excludes family members.
- O'Farrell and Fals-Stewart (2000) found that behavioral couples therapy reduced the incidence of relapse, enhanced relationship functioning and stability, and decreased the incidence of domestic violence and divorce.
- Shapiro (1999) reported on an intensive, family-based treatment program, La Bodega de la Familia, which effectively reduced relapse and recidivism rates among released inmates, noting a drop in the re-arrest rate from 50 to 35 percent 18 months post-release.
- Stanton and Shadish (1997) did a comparative study of family and non-family treatments for addiction and also concluded that family therapy improved the retention and engagement of substance abusers in treatment.

Behavioral Couples Therapy (BCT). Behavioral Couples Therapy has been shown through research to be the most effective family treatment for achieving abstinence, improving family and marital functioning, and reducing the incidences of separation and divorce. These results have been shown to be consistent for both male and female clients (O'Farrell & Fals-Stewart, 2006).

Behavioral Couples Therapy has four main objectives: engagement of both members of the couple in treatment; achieving abstinence; improving the quality of the relationship; and helping the couple to generalize the changes they achieve to their life after treatment ends. BCT supports involvement in 12-Step recovery groups, helps the couple develop a behaviorally oriented "recovery contract" (including urine screens, 12-Step attendance, and sometimes medication), and concrete interventions to improve communication (O'Farrell & Fals-Stewart, 2006).

A cautionary note about Twelve Step meetings. In some jurisdictions, treatment for addiction is limited to participation in Twelve Step self-help groups. The effectiveness of Twelve Step and other self-help groups in

helping individuals achieve abstinence is inconclusive. The Cochrane Library, an online database devoted to systematic reviews of health care interventions, did a recent review of research on the effectiveness of Twelve Step Groups and concluded: “The available experimental studies did not demonstrate the effectiveness of AA or other 12-step approaches in reducing alcohol use and achieving abstinence compared with other treatments, but there were some limitations with these studies.” One study did indicate that AA combined with other interventions may help clients accept and stay in treatment, more so than alternative approaches, but that study was quite small (Ferri, Amato, & Davoli, 2006).

Twelve Step Facilitation. In contrast to solely attending Twelve Step meetings, Twelve Step Facilitation (TSF) therapy is a brief, structured, manual-driven form of treatment aimed at increasing a client’s active participation in Twelve Step meetings. It combines professional interventions with Twelve Step attendance. Several researchers have documented that Twelve Step Facilitation therapy for helping clients with low psychiatric severity engage in pro-social affiliations and achieve abstinence, although these studies were not specific to corrections clients (Miller, Meyers, & Tonigan, 1999; Nowinski, 2000; Ouimette, Finney, & Moos, 1997).

All Twelve Step Groups are clear that they are not run by professionals, and that, to a large extent, is what they claim is the source of their potency. Since they are not a “profession,” their literature and mission lack the extensive knowledge base, mechanisms of quality control, vision, and quality of motivation that are characteristic of professionals and professions (Netting and Kettner, 2004). According to their official literature, Twelve Step Groups do not do research on their outcomes. They do not diagnose or seek to motivate individuals with alcohol and drug problems. They do not monitor compliance with treatment recommendations (Alcoholics Anonymous, 2006).

Twelve Step meetings are designed as self-help groups, led by lay people with the same problems, and they should not be considered professional treatment or clinical intervention. Different from Twelve Step Meeting involvement, when someone enters treatment, they enter a professional relationship with someone with a specialized knowledge base who can advise them on the best course to improve their condition. There is an individualized treatment plan followed by interventions informed by scientific research. Therefore, in terms of effectiveness, any comparison of Twelve Step meetings and any form of treatment, correctional or otherwise, is unfair.

Given the importance of corrections clients finding pro-social peers, it would be ill-advised to discount Twelve Step meetings as a resource for some clients. A recent article in *The New York Times* quotes Thomas G. Brown, PhD, from McGill University: “Although the randomized controlled trial is

the gold-standard methodology in comparing between conditions, it washes out a factor that may be important in potentiating AA's benefits, namely patient choice and preference" (Bakalar, 2006). This comment aligns with one of the philosophical hallmarks of evidence-based practice, which is that honoring the client's preferences in treatment approach enhances the success of the intervention.

Treatment for serious mental health disorders. For the purposes of this monograph, mental health disorders refer to chronic psychiatric problems, often biochemical in nature, that have a profound and persistent impact on an individual's functioning, including the individual's ability to take care of himself, to work, and to have meaningful interpersonal relationships. Disorders that fall into this category include bipolar disorder, anxiety disorders, schizoaffective disorders, and schizophrenia. The most extensive research looking at the coincidence of these disorders and substance abuse found that clients with serious mental health disorders "were significantly more likely to have a substance use disorder than individuals with no psychiatric illness" (Mueser et al, 2003).

The current state of the art in treating clients with both serious mental health problems and substance addiction is known as *integrated treatment* for dual disorders. Integrated treatment is an evolution from earlier approaches to treating these complicated individuals: *sequential treatment* promoted first treating either addiction or mental health, whichever was considered primary, while *parallel treatment* advocated simultaneous treatments by professionals with two different specialties. Both sequential and parallel treatments have been shown to be ineffective (Mueser et al, 2003). According to Mueser, Noordsy, Drake, & Fox (2003), Integrated Treatment has the following seven key characteristics:

- *Integration of services.* One clinician with dual expertise treats the individual with co-occurring disorders, in order to avoid gaps and conflict in service delivery;
- *Comprehensiveness.* In a wraparound approach, treatment addresses the broad range of areas impacted by dual disorders, including housing and vocational assistance, psychoeducation, and family therapy;
- *Assertiveness.* Integrated treatment is not an office-bound model of therapy but promotes clinicians doing active, home- and community-based outreach to clients. When necessary, clinicians leverage mandates from the legal system to coerce treatment;
- *Reduction of negative consequences.* Because of the chronic and spiraling nature of these disorders, clinicians embrace the philosophy of Harm Reduction;

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- *Long-term involvement.* Given that these disorders are never fully cured, services are not time-limited. Clinicians strive to keep clients in less restrictive settings for their care whenever possible;
 - *Motivation-based treatment.* Treatment is collaborative and focused on the client's goals for recovery, embracing the principles of Motivational Interviewing;
 - *Multiple psychotherapeutic modalities.* Integrated treatment includes individual, group, and family interventions, as well as psychopharmacology.

Because minority clients have demonstrated poorer outcomes in treatment, Drake et al (2001) emphasize the importance of cultural competence of service delivery

These principles are consistent with evidence-based practice guidelines developed by the University of Pennsylvania Center for Mental Health Policy and Services Research (Minkoff, 2001). Because minority clients have demonstrated poorer outcomes in treatment, Drake et al (2001) emphasize the importance of *cultural competence* of service delivery, including situating programming within the client's native community, hiring clinicians who come from the same cultural and ethnic background as clients, and ensuring that clinicians remain "lifelong learners" about issues of intercultural sensitivity.

Psychopharmacology. Because most serious mental health disorders are biochemical in origin, psychopharmacology has a significant role in the improvement of the client's condition; however, most researchers agree that psychotropic medications are most effective when offered in tandem with psychosocial interventions. Busch, Weiss, & Najvits (in Frances et al, 2005) provide a helpful summary of recent research on specific psychopharmacological interventions for a range of psychiatric conditions, including major depression, bipolar disorder, schizophrenia, anxiety disorders, and attention-deficit/hyperactivity disorders. In addition to looking at the effectiveness of individual psychotropic medications, they discuss controversies associated with prescribing medication for clients with pre-existing drug addictions, cautionary notes about drugs with addictive potential, and the hazards of prescribing to clients whose illicit drug use is ongoing (pp. 271 – 302).

Treating adult female offenders. As noted in part two, women's experiences differ profoundly from men's, and their treatment needs are subsequently different. Women are more likely to have experienced childhood physical and sexual trauma; to contend with lingering post-traumatic stress symptoms from those events; to have experienced victimizations as adults, often at the hands of intimate partners; and to experience social and economic oppressions correlated with gender bias and sexism (Carter & McGoldrick, 2005). Women involved in correctional systems are more likely to suffer from polysubstance abuse and co-occurring mental health disorder, particularly depression and Post-Traumatic Stress

Disorder, as well as medical conditions related to their criminal lifestyle, such as HIV/AIDS, and child welfare involvement (Field, 1998).

Characteristics of gender-specific programming. To be effective, any treatment model needs to take into account the unique challenges faced by women and to adapt interventions to accommodate those needs. Those adaptations include: 1. recognizing the diverse, overlapping needs that women bring into treatment, including mental health, medical, family-friendly housing, employment, and child welfare; 2. working in a collaborative, empowering fashion toward goals that are meaningful to women offenders; 3. having access to treatments that are relational and trauma-informed (see below); and 4. having services from different entities coordinated.

DBT and Seeking Safety. Two innovative treatments in particular hold out particular promise for women in criminal justice systems. Linehan developed Dialectical Behavioral Therapy (DBT) for women diagnosed with Borderline Personality Disorder (BPD). DBT is known as a mindfulness-based cognitive-behavioral program, combining intensive case management, individual counseling, and psychosocial skills training. It has been shown to be highly effective in women with BPD in randomized controlled trials (Linehan, 1993). Najvits developed a less intensive group psychoeducational curriculum called *Seeking Safety*, a trauma-informed, relational treatment model for women struggling with addiction and trauma issues. While there has been only one randomized controlled trial for *Seeking Safety*, its results were promising, with one hundred low-income female participants demonstrating reduced substance use and PTSD symptoms. One smaller scale study showed promising results for women in prison (Najvits, 2002).

Treatments for Special Populations. Offenders struggling with domestic violence and sex offending behaviors present a unique challenge to clinicians because their primary condition is a criminal justice, as opposed to a healthcare, problem. Partly due to the vast heterogeneity of these two criminal justice sub-groups, the research on specialized modalities for treating them is not extensive. The philosophy of evidence-based practice compels practitioners working with these two groups to be acutely cognizant of the “I don’t know” factor and to work closely with correctional professionals to safeguard community safety while these offenders are treated. In particular, the assessment of risk takes on critical importance when working with domestic violence perpetrators, since higher risk offenders are less likely to benefit from treatment without recidivating.

Treating Domestic Violence. Perpetrators of domestic violence are a highly heterogeneous group, making the investigation of effective treatment interventions both complex and difficult to generalize across this criminal subgroup. It is difficult to discuss treatment for domestic violence separate from substance abuse. Summarizing existing data in a treatment improvement monograph, SAMSHA (1997) reports:

Researchers have found that one fourth to one half of men who commit acts of domestic violence also have substance abuse problems.... and that a sizable percentage of convicted batterers were raised by parents who abused drugs or alcohol.... Studies also show that women who abuse alcohol and other drugs are more likely to be victims of domestic violence.

While psychoeducational groups for male perpetrators have been ubiquitous, there is to date no specific clinical modality for treating the perpetrators of domestic violence that has been shown to have strong research support for its effectiveness (Murphy and Eckhardt, 2005; Dutton and Sonkin, 2002). In a systematic review, Aos, Miller, & Drake (2006) found that programs for domestic violence offenders did not achieve a statistically significant change in recidivism compared with non-specialized treatment approaches. Dutton and Sonkin (2002) concur: “At present, there is no one ‘treatment of choice’ in working with physically abusive clients” (p. 4).

Given the limitations of the research in the field—and recognizing the climate of uncertainty that surrounds this sub-specialty—Murphy and Eckhardt (2005) offer a research informed model to address domestic violence. Emphasizing the heterogeneity of domestic violence perpetrators, they advocate for an *individualized case formulation approach*, based on research informed targets for intervention. The hallmarks of their model include: 1. a functional (behaviorist) assessment of the abusive behavior; 2. building working alliances with family and community supports that are committed to non-violence; 3. building a collaborative working alliance with the offender; and 4. using motivational interviewing to increase the commitment to change.

During this empirically-informed treatment, treatment targets include: *cognitive factors* (the attitudes and beliefs favoring violence that precede physical and emotional abuse; selective attention to situational cues; maladaptive interpretation of interpersonal and social interactions; faulty externalizing attributions for one’s aggressive behaviors); *substance use and abuse*, considered one of the most empirically robust correlates of domestic violence; and *relationship-behavioral factors* (chronically distressed relationships, poor interactional skills, and power struggles) (Murphy and Eckhardt, 2005).

Risk assessment. Given the context of empirical uncertainty that surrounds this treatment sub-specialty, it is ethically imperative for practitioners to be aware of the degree of risk that these offenders pose to their families and communities. Murphy and Eckhardt emphasize the critical importance of specialized risk assessment:

Objective, actuarial methods of violence prediction have routinely outperformed clinical judgment in study after study, and clinicians would be wise to rely on such methods, rather than intuition, when trying to predict dangerousness in their clients (ibid., p. 75).

The authors call attention to three actuarial instruments.

- The Danger Assessment Instrument (DAI), typically administered to female victims, is a short, 15-item instrument that covers risk factors empirically correlated with spousal homicide (Campbell, 1995).
- The Spousal Assault Risk Assessment Guide (SARA), based on both clinical interview and case file review, is a 20-item checklist that covers past criminal history and violence factors as well as variables specific to spousal violence. The SARA “has been shown to discriminate between recidivistic and nonrecidivistic spouse abusers at the completion of their probationary term” (Kropp & Hart, 2000).
- The Partner Assault Prognostic Scale (PAPS), based on interviews with both offender and victim, is unique in that it does not have to be administered by a clinician or specially trained professional. It is a 17-item scale that combines components of several existing screening tools, including the DAI (Murphy et al, 2003). “Initial findings revealed significant prediction of postcounseling physical assault, severe violence, and criminal recidivism,” but more conclusive research is still needed (Murphy and Eckhardt, 2005).

In the spirit of evidence-based practice, these scientist-practitioners openly acknowledge the empirical limits of their treatment approach and actively call for more research in this field, including a rigorous methodology that differentiates typologies of domestic violence perpetrators.

Treating Sexual Offending Behaviors. Similar to research on domestic violence offenders, scientists generally agree that it is difficult to make any definitive conclusions about the effectiveness of sex offender treatment programs because the term “sex offender” encompasses such a broad and heterogeneous group (CSOM, 2006); however, understandings of the effectiveness of specialized sex offender treatment protocols have evolved dramatically in the past five years.

A 2003 review published by The Cochrane Library was tentative about its effectiveness:

Some evidence suggests that CBT may decrease re-offending at a year, however the general approach may contribute to re-arrest levels up to ten

years later. This review shows that evaluative studies are possible in this difficult area, and further ones are urgently needed to resolve persisting uncertainties (Kentworthy et al, 2003).

A 2006 systematic review by Aos, Miller, & Drake was more optimistic. In their review of 5 prison based cognitive-behavioral programs (inmates) and 6 community-based cognitive-behavioral programs (probationers), the authors found that such specialized sex offender treatment protocols could achieve, on average, statistically significant 14.9% and 31.2% reductions in rates of recidivism, respectively. The authors emphasize the importance of these protocols utilizing cognitive-behavioral interventions (Aos, Miller, & Drake, 2006).

Most recently, the Center for Sex Offender Management issued a 2006 review of the most recent research and types of treatment for this sub-group of offenders, concluding that:

... [A] treatment effect does in fact exist for specialized treatment programs for sex offenders, particularly when programs utilize more contemporary approaches to treatment, such as cognitive-behavioral and relapse prevention models (CSOM, 2006).

The CSOM review notes generally that sex offenders who participate in sex-offender specific treatment are less likely to recidivate than non-treated counterparts. The review further differentiates four different typologies of sex offenders, to facilitate more individualized interventions: 1. avoidant-passive offenders wish to refrain from sex offending but lack replacement skills to enable them to realize this desire; 2. avoidant-active offenders also want to refrain from sex offending, but utilize skills and strategies that actually increase their likelihood to sexually re-offend; 3. approach-automatic offenders desire to sexually offend but do so impulsively and opportunistically, rather than consciously planning to create abuse opportunities; and 4. approach-explicit offenders are more sociopathic and overtly desire to offend sexually, actively grooming potential victims and establishing circumstances to avoid detection (CSOM, 2006).

Common targets for programming. Most specialized treatment programs utilize cognitive-behavioral and relapse prevention modalities, including motivational interviewing to enhance commitment to change. CSOM emphasizes the importance of utilizing strength-based frameworks and motivational interviewing strategies. There is also an emphasis on interventions that target the following four core target areas, empirically correlated with risk to engage in sexual offending behaviors: emotional dysregulation; isolation and relationship dysfunction; cognitive distortions supporting both anti-social and sexually deviant behaviors; deviant sexual

fantasies and associated schema for interpreting sexual encounters (ibid., p. 6). CSOM emphasizes the need for holistic treatment:

[A]dults who have committed sex offenses may also have a range of intervention needs in the psychiatric, healthcare, family, peer, substance abuse, vocational, or educational domains, and if these additional issues are left unaddressed, their ability to lead a stable and productive life may be understandably hampered (CSOM, 2006).

Risk assessments for sex offenders. Reid Meloy (2000) has done a useful summary of different actuarial instruments used to assess risk in violent male offenders, including sex offenders. He calls attention to four well-known and accepted instruments: the Violence Risk Appraisal Guide (VRAG), normed largely on violent offenders with personality disorders, classifies offenders with an accuracy rate of 74%. It has been rigorously tested. The Sex Offender Risk Appraisal Guide (SORAG), based on Hanson and Bussiere's meta-analysis of studies involving over 20,000 sex offenders, incorporates many of the same variables, but includes physical arousal to sexually deviant stimuli. It is not applicable to exhibitionists and offenders who commit non-contact sexual offenses. Two other instruments—the Minnesota Sex Offender Screening Tool—Revised and The Static-99—have been cross-validated and are in the public domain.

CONCLUSION: WHAT HAVE WE LOST?

Many practitioners have complained that EBPs have restricted their professional discretion, confining them to a prescribed course of highly choreographed interventions outlined in a treatment manual, or scripting all of their interactions with clients according to a narrow model of intervention. Others wonder if EBP can be implemented with offenders embedded within the restrictive settings of the criminal justice system with appropriate fidelity to their research-based design. Still others have questioned the applicability of EBPs to offenders from non-dominant cultural groups, especially if there are no clear and compelling data that the intervention has benefited clients with those backgrounds.

The manner of conceptualizing EBP presented within this monograph attempts to define EBP as a philosophy and process of ethical and clinical decision-making that puts a premium on practitioners thinking objectively and rigorously about why they are doing what they are doing with offenders. Professional discretion is not lost, but it must be continually honed by the use of up-to-date research, by practitioners who are lifelong learners, who are providing thoughtful assessment and listening carefully to both the referral course and the offender's statements about what they need to be better citizens. Within this conceptualization of EBP, it behooves practitioners to cultivate an openness to expert consultation and quality assurance, as well to discovering new and emerging science-backed models of intervention.

Ultimately treatment manuals don't make decisions that affect human lives. A well-referenced article on effective treatment will not tell a professional exactly what to do with an offender who is sitting in front of them—or, just as likely—on the run from them. The stakes for not practicing what is known to work effectively with offenders are exceptionally high. Rather than subtract from professional discretion, the introduction of EBP has intensified the importance of rigorous critical thinking in making life-altering decisions about what will make the most positive difference for offenders in the criminal justice system.

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APPENDIX A: CONFIDENTIALITY IN CORRECTIONAL TREATMENT

Definition of the problem. Few issues are as tricky and nuanced within the multidisciplinary partnership required for effective correctional treatment as confidentiality. On the one hand, free and open information-sharing is an essential ingredient for a trusting relationship between professionals. It helps anticipate and solve problems and contributes to effective team work. On the other hand, confidentiality is one of the hallmarks of the therapeutic relationship, one source of its potency and effectiveness, and many clinicians are reluctant to compromise it in treatment of the general population. “Fear that a confidence will not be kept may affect what is told to the professional, thereby limiting a diagnosis or treatment plan” (Dickson, 1998). Clients in treatment need to be free to disclose embarrassing, stigmatizing, and even incriminating information, so that a clinician has a full understanding of the challenges they face. The benefits of such confidential and uninhibited disclosure have been demonstrated (The Menninger Foundation, 1996, as cited in Dickson, 1998). The National Association of Social Workers’ Code of Ethics contains eighteen provisions related to the confidentiality of the therapist/client relationship, and the American Psychological Association’s Code of Ethics contains ten such provisions (Dickson, 1998, p. 6). The American Counseling Association and the American Association of Marital and Family Therapists also contain clear guidelines that promote confidentiality in clinical practice.

Exceptions to confidentiality. Confidentiality is an ideal and rarely absolute. The extent of client/practitioner confidentiality varies depending on the context, client characteristics, and the type of information shared (Parsons, 2001). Ethical practitioners have an obligation to clearly inform clients about the extent of confidentiality in the therapeutic relationship. Generally, clients must sign a waiver of confidentiality to allow these disclosures; however, confidentiality can be breached under certain circumstances (for example, child abuse, an imminent threat to harm another person, or a suicidal client) (Gelman et al, 1999). Because their treatment is mandated by the courts, offenders are generally required, as a condition of receiving correctional treatment, to sign a waiver to release clinical information to the courts, but this information is generally limited to reports on their attendance, progress, and discharge or completion. Wanberg and Milkman (2004) note that treatment providers “should not make a commitment to keep secrets about anything the sponsoring agency or supervisory personnel need to know. Assurance should be provided, however, that treatment details will be used appropriately and in context” (p. 136). When information is disclosed that the provider believes should be made known to the corrections professional,

whenever possible the provider needs to work with the offender to have them report that information, ideally with the provider present to confirm the accuracy of the relevant details.

The operant phrases here are “need to know,” “appropriately” and “in context.” There is no one recipe for what should be disclosed and no common agreement on what should be shared between treatment and corrections professionals. The general rule of thumb is that treatment providers should report generally on progress and compliance issues. Exceptional circumstances need to weigh the ethical and clinical ramifications of disclosure to someone outside the treatment relationship, balancing the harm to society and long-term damage to the therapeutic relationship.

The duty to warn. Of particular relevance to the provider of correctional treatment is the now famous 1976 case *Tarasoff v. The Regents of the University of California*, in which the courts ruled that a clinician had an obligation to warn and protect potential victims:

When a therapist determines, or pursuant to the standards of his profession should determine, that his [client] presents a serious danger of violence to another he incurs an obligation to use reasonable care to protect the intended victim against such danger. The discharge of this duty may require the therapist to take one or more of various steps, depending upon the nature of the case. Thus it may call for him to warn the intended victim or others likely to apprise the victim of danger, to notify the police, or to take whatever other steps are reasonably necessary under the circumstances (*Tarsoff*, 131, Cal. Rptr. At 20).

At least fifteen states have enacted statutes in accord with the Tarasoff ruling, and others have upheld its spirit. Several other courts have made similar rulings supporting the duty to warn (Parsons, 2002). But the ruling is not, it should be noted, adhered to universally.

Child abuse and neglect. Also of considerable importance to providers of correctional treatment, The Child Abuse Prevention and Treatment Act of 1974 set out the standards for identifying child neglect and maltreatment and mandated that clinicians report known or suspected abuse and/or neglect to the appropriate authorities. Both clinicians and peace officers are mandated reporters of child abuse and neglect. “By 1997 all states had enacted mandatory reporting laws which take precedence over statutory privilege or confidentiality” (Dickson, 1998).

The functional importance of confidentiality. Federal and state laws abound with elaborate prescriptions concerning the sharing of personal health information. While the concept of confidentiality can lead to bureaucratic debates about what the law/statute/rule does and does not allow, it is important to remember that confidentiality has a *functional importance* for effective clinical practice. In order to understand that function, however, it is

important first to define three interrelated terms: confidentiality, privilege, and privacy.

Confidentiality. Confidentiality refers to the ethical guideline, common to most addictions and mental health professionals, to withhold and safeguard personal information disclosed to them by clients in the course of treatment. Both treatment providers and lawyers consider their relationships with clients to be confidential and believe that this characteristic allows them to be effective in assisting their clients.

Privilege. Privilege “refers to the right to withhold confidential information in a court of law. Privilege is conferred by the legislature of the courts” (Stein, 2004, as cited in Dickson, 1998). It is a special status afforded to certain types of professional relationships. Most states extend privilege to most types of clinicians (psychologists, social workers, and psychiatrists), physicians, and lawyers. Confidentiality is an ethical obligation, while privilege is a legal concept.

Privacy. Privacy, on the other hand, is a much broader concept, a right guaranteed within the Constitution under the first, fourth, and fourteenth amendments. Alderman and Kennedy (1995) state:

[Privacy] protects the solitude necessary for creative thought. It allows us the independence that is part of raising a family. It protects our right to be secure in our own homes and possessions, assured that the government cannot come barging. Privacy also encompasses our right to self-determination and to define who we are..... The right to privacy, it seems, is what makes us civilized.

The functional role of confidentiality. It is important to understand the rationale—from both an ethical and research perspective—for allowing any confidentiality at all within a therapeutic relationship with anyone, regardless whether they are involved in the criminal justice system. Most beliefs about confidentiality are rooted in personal and professional values, history, and statutory and administrative requirements; however, there is empirical data that connects confidentiality to positive treatment outcomes:

1. In a comprehensive review of the literature of its time, Roback and Shelton (1995) found that “perceived confidentiality limitations will deter people from seeking therapy and will inhibit self-disclosures once they are in treatment.”
2. A line of research stretching from 1970 to 1993 supports the view that confidentiality is indeed essential. In a review of several studies that met rigorous methodological criteria, Roback and Shelton (1995) conclude: “... most ‘potential patients’ 1) assume that information divulged in psychotherapy is confidential, 2)

- report that they will not talk about unprotected topics, and 3) may not enter treatment when apprised of limited confidentiality.”
3. Client worries about confidentiality breaches are related to content of information disclosed, recipient of the disclosure, and the level of care that the client is receiving (i.e. clients in higher levels of care have more concerns because of increased stigma). Meyer and Willage (1990, as cited in Dickson, 1998) found that “[non-therapy] subjects were most influenced by confidentiality concerns when they were asked to report very personal information. The more private the information sought, the stronger the effect of the degree of perceived confidentiality.”
 4. In 1996 decision [*Jaffee vs. Redmond*, 135 L.Ed.2d 337, 345], informed by empirical data supplied by the Menninger Foundation, the Supreme Court ruled that effective treatment “depends upon an atmosphere of confidence and trust in which the patient is willing to make frank and complete disclosure of facts, emotions, memories, and fears....The mere possibility of disclosure may impede development of the confidential relationship necessary for successful treatment” (in D. Dickson’s *Confidentiality and Privacy in Social Work* [1998], pp. 5-6).
 5. At least five research articles cited by Roback and Shelton (1995) reported that both clients and treatment providers had rudimentary and sometimes unclear understanding about confidentiality rules.

A recent report by the Surgeon General (CSAT, 1997) concludes:

[A]vailable research supports the conclusion that strong confidentiality laws are critical in creating assurances for individuals seeking mental health treatment and thereby increasing willingness to participate in treatment to the degree necessary to achieve successful outcomes. However, the present legal framework does not provide strong, consistent protection of confidentiality in many instances.

Finding the Balance. Within the often adversarial context of the legal and judicial systems, knowledge is power. Because offenders are mandated to attend and successfully complete treatment, often as the condition of a sentence or supervision, the court has an understandable need to know pertinent information about the offender’s progress in treatment. In working with offenders, finding a balance—what is sometimes called *limited confidentiality*—is key to avoiding road blocks within a multidisciplinary partnership. Clinicians need to release enough information so that corrections professionals know whether offenders are in compliance with court mandates, but corrections professionals need to respect that clinicians will withhold personal details disclosed within the treatment relationship. Otherwise, the

clinical relationship loses one of its most potent and defining characteristics. At the same time, clinicians need to clearly inform offenders about the extent that their information will be kept confidential and to have them sign a waiver to release information that is relevant to their conditions of probation or their sentence. The recently enacted Health Insurance Portability and Accountability Act (HIPAA) uses the “minimally necessary” standard as the guideline for what information clinicians release, although corrections professionals and treatment providers can debate the parameters of “minimally necessary.”

Avoidance of self-incrimination. Treatment generally and optimally occurs after the conviction and sentencing processes, so that the offender is relieved of fears about whatever consequences follow his criminal activity. In some cases, sentencing is deferred pending a successful treatment outcome. This deferment often provides a meaningful incentive for treatment completion. In either circumstance, it is important for the treatment provider and the corrections professional to have a unified understanding of what actions will be taken in response to any disclosure of past criminal activity. This understanding needs to be made transparent to the offender from the beginning of treatment, ideally as part of a signed understanding of their rights and responsibilities. Often it is impossible to make a single rule that will fit all the myriad types of past crimes an offender might disclose. In these circumstances, it is important for the clinician to weigh the short- and long-term ethical and clinical ramifications of the decision to disclose information about past criminal activity and to involve the offender, as much as appropriate, in the final decision.

Drug courts have done pioneering work to articulate thoughtful strategies to balance the need to maintain client confidentiality, which enhances treatment progress, with the court and correctional professionals’ need to monitor treatment progress as part of conditions of community supervision. Sample policies and forms are available in the monograph “Federal Confidentiality Laws and How They Affect Drug Court Practitioners” (Tauber et al, 1999), which is also available online.

APPENDIX B: THE SEPARATE AND COMPLEMENTARY FUNCTIONS OF CORRECTIONS AND TREATMENT

[T]he therapist...essentially states: 'I confront you with you; I confront you with what you say you want and the contradictions in your thinking, emotions, and behaviors which violate your own needs and goals. The correctional treatment specialist states: 'I confront you with me; I represent the external world that you have violated and I confront you with the values and laws of society and I expect you to change' (Wanberg and Milkman, 2004).

According to the Center for Effective Public Policy (2005), "Justice 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." Corrections and treatment professionals play different roles in the lives of individuals in the criminal justice system.⁴ They are both important members of a multidisciplinary response to criminal activity, including factors like addiction and mental health problems, which, when untreated, contribute significantly to recidivism. The roles and functions of corrections and treatment professionals have some areas of overlap, but some areas that are distinctly different. *Synergy*, it is recalled, refers to "the interaction of two or more agents or forces so that their *combined effect* is greater than the sum of their individual effects."

Because offenders are being treated for both criminality and other conditions, corrections professionals play a significant role in the overall effectiveness of treatment. They help create a surveillant context in which offenders can be praised for making pro-social choices and receive consequences for engaging in criminal behaviors. Like treatment providers, they also form high-quality, pro-social relationships with offenders.

With the respective roles of corrections and treatment, the effect on offenders can be either positive or harmful, depending on whether different professionals accept and understand their differences and how those differences create that positive end effect. This information was compiled to help clarify the similarities and distinctions.

⁴ "Corrections professionals" refer to probation and parole officers and officers in jail and prison systems charged with monitoring the activities of offenders, protecting community safety, and assisting offenders in their rehabilitation. "Treatment professionals" refer to specially trained providers of therapeutic services for alcohol and drug and mental health problems, including interventions specific to domestic violence and sex offender treatment.

Similarities between Corrections and Treatment Functions

Corrections Professional	Treatment Professional
Upholds community safety as an important value and works to reduce recidivism	Upholds community safety as an important value and works to reduce recidivism
Provides services (such as linkage and case management) for offenders to maximize positive outcomes for the community, the victim and the offender	Provides services (such as specialized treatment) for offenders to maximize positive outcomes for the community, the victim and the offender
Believes in behavior change	Believes in behavior change
Sees offender’s strengths and competencies	Sees offender’s strengths and competencies
Models pro-social behavior and confront anti-social behavior	Models pro-social behavior and confront anti-social behavior

Differences between Corrections and Treatment Functions

Corrections Professional	Treatment Professional
<p>ETHICAL DECISION-MAKING</p> <ul style="list-style-type: none"> Ethical decisions tend more to be uniform and consistent across all offenders, oriented by common conditions of supervision 	<p>ETHICAL DECISION-MAKING</p> <ul style="list-style-type: none"> Ethical decisions tend more to be individualized, taking into account contextual variables
<p>ACCOUNTABILITY (External/ “visible”)</p> <ul style="list-style-type: none"> Holds offender accountable to general and specific <i>conditions of supervision</i> (rules that apply to everyone in a particular sub-group, i.e. probationers or sex offenders) Is accountable to the courts and community 	<p>ACCOUNTABILITY (Internal/ “invisible”)</p> <ul style="list-style-type: none"> Holds offender (and sometimes family members) accountable to signed <i>treatment plan</i>, developed in collaboration with the offender and the referral source (usually the corrections professional) Is accountable to a referral source but extent of information sharing is determined by authorizations to release information Is accountable to ethics and

Corrections Professional	Treatment Professional
	licensing boards, and sometimes health insurance funders or contracting agencies
<p>INFORMATION SHARING</p> <ul style="list-style-type: none"> • Some criminal information is public information • Public information and controlled information, guided by local correctional policies • Case information is entered into a state-wide system and available to criminal justice personnel throughout the state 	<p>INFORMATION SHARING</p> <ul style="list-style-type: none"> • A & D and mental health information is <i>confidential</i> unless appropriate releases are signed • Clinical records are generally kept in a locked file behind two locked doors • Only information that needs to be shared should be shared (e.g. treatment compliance, clinical recommendations, discharge summary and discharge recommendations) • Any other information that is shared should be explicitly negotiated with the offender client • Harm to self or others is not confidential
<p>CASE PLAN</p> <ul style="list-style-type: none"> • Investigates and adjudicates • Based on assessment of criminogenic factors • Individualized plan to address strengths and <i>criminogenic factors</i> 	<p>TREATMENT PLAN</p> <ul style="list-style-type: none"> • Clinically assesses • Individualized plan to address behaviors that interfere with adaptation, based on biopsychosocial assessment
<p>DURATION OF INVOLVEMENT</p> <ul style="list-style-type: none"> • Broader and longer term • Length of community supervision is determined by court, dependent on crime of conviction • Number of contacts is determined by assessed <i>risk</i> to community 	<p>DURATION OF INVOLVEMENT</p> <ul style="list-style-type: none"> • Limited to a specific episode of care (coordination of treatment services and other services needed to complete treatment plan) • Length of and intensity of treatment is determined by client <i>need</i> and completion of treatment plan goals • Medically/clinically determined discharge from services

Corrections Professional	Treatment Professional
	<ul style="list-style-type: none"> • Number of contacts determined by need
<p>ABSTINENCE</p> <ul style="list-style-type: none"> • Represents the “abstinence-based world” to the offender • Ultimately conditions of supervision require offender to abstain from substances (even though most corrections professionals understand principles of harm reduction) 	<p>HARM REDUCTION</p> <ul style="list-style-type: none"> • Treatment professionals let clients know that “relapse happens” and plan for how to handle it, even while helping the client adapt to living in an “abstinence-based world”
<p>MONITORS COMPLIANCE</p> <ul style="list-style-type: none"> • Represents the court’s authority to the offender • Is an arbiter of right and wrong for the offender • Monitors conditions of supervision • Holds offender accountable to rules that apply to everyone 	<p>THERAPEUTIC NEUTRALITY</p> <ul style="list-style-type: none"> • Correctional treatment is still “client centered” • Some of the power of the therapeutic relationship derives from the treatment provider maintaining reasonable neutrality about choices, good or bad, that offenders make. However, treatment providers are not neutral about violent or criminal behavior, harm to self or others
<p>DETERMINES SANCTIONS</p> <ul style="list-style-type: none"> • Determines appropriate sanctions for non-compliance based on graduated sanctions 	<p>MAY CONSULT ON CONSEQUENCES AT TIMES</p> <ul style="list-style-type: none"> • Must stay out of the business of “consequencing”

APPENDIX C: COERCED TREATMENT

As Shakespeare's Hamlet reminds us, "The readiness is all." One of the defining features of correctional treatment is that it is coerced or mandated. Offenders are forced to go into treatment as a condition of their incarceration, probation, or parole. Coerced treatment has at times aroused controversy. To understand that controversy, it is important to look at it from two perspectives: the values inherent to the therapeutic relationship generally as well as the science of effective correctional treatment. Both perspectives, ultimately, need to be reconciled.

Coerced treatment has existed for nearly a century and has been a long-standing weapon in the "war on drugs." James A. Inciardi (in Leukefeld & Tims, 1988) writes:

The philosophical basis of civil commitment and other forms of compulsory treatment for drug abuse seems to have considerable logic. The theory of civil commitment holds that, of the numerous types of...substance abusers, some are motivated, but most are not. Therefore there must be some lever for structuring treatment for those who ordinarily do not seek assistance on a voluntary basis (p. 126).

The science behind coerced treatment is clear, unequivocal, and substantiated by two decades of correctional research: *coercion does not interfere with treatment effectiveness*. In fact, coerced treatment enhances therapeutic outcomes, leading to increased retention (CSAT, Treatment Improvement Protocol 17; Brecht, Anglin, & Jung-Chi, 1993; Gerstein and Hardwood, 1990; Hubbard et al, 1988; Wanberg & Milkman, 2004). Hubbard et al (1988) report that clients who are mandated to treatment have significantly better outcomes than non-mandated clients and have a better chance at treatment completion. Anglin (in Leukefeld & Tims, 1988) clarifies that the legal mandate is only one component of criminal justice system pressures, which also include community supervision and regular urinalysis.

Then why is there controversy? From the perspective of mainstream therapeutic values, however, coerced treatment can sometimes be problematic. Ethically, clinicians are trained to respect client self-determination regarding their medical and behavioral healthcare. Informed consent—the conscious, willing choice that a patient makes to pursue a particular course of treatment—is the hallmark of ethical clinical practice. Coerced treatment can appear to contradict that clinical and ethical imperative.

The quasi-voluntary client. Several experts have commented on the particular quandary of clients mandated to correctional treatment. Wanberg and Milkman (2004) observe that correctional clients are "quasi-voluntary."

Newman notes that “there are only voluntary patients and those others punished for failing to volunteer, but no involuntary patients” (1973). He expands upon this distinction:

The voluntary character of the [therapist/client] relationship is by no means precluded by the existence of outside pressures on the patient. Rather the word ‘voluntary’ implies the exercise of one’s free choice or will, whether or not external influences are at work. The difficulty, of course, is determining what constitutes ‘free choice.’ However unappealing the alternative presented, the addict nevertheless always retains the option of choosing the sanction associated with *not* entering a treatment program.... Such an argument, however, ignores the loss of freedom we feel when coerced into choosing between two disagreeable courses of action. To avoid this sterile conclusion *it is necessary to define voluntarism pragmatically in terms of the relationship which exists between patient and practitioner* [my italics].

Within this framework, the coercion or mandate exists between the courts and the offender, in the same way it might exist for a non-offender client who is pressured into treatment by family members upset by his addiction. If that judicial mandate is ignored, the courts are the entity that imposes a consequence or sanction. Newman makes reference to “the loss of freedom we feel when coerced into choosing between two disagreeable courses of action.” That loss of freedom is in some senses universal. Many healthcare consumers feel “backed up against a wall” by life-threatening, debilitating physical conditions, such as cancer, and must choose between the untreated condition, which can kill them, and a painful, prescribed treatment course, such as radiation or chemotherapy. At a certain point “coerced treatment” becomes simply unfortunate luck.

In some ways, practitioners of correctional treatment represent that bridge between extrinsic motivation, personified by the legal and correctional systems, and the intrinsic motivation of the offender who can make a commitment to prosocial behavioral change. Their function is to elicit and enhance client motivation. The developers of *Motivational Interviewing*, Miller and Rollnick note:

[M]any different external motivators may cajole or coerce clients into treatment, including a spouse, an employer, a physician, or family and criminal courts. Although extrinsic motivators can be useful in bringing a client into treatment and increasing retention, self- or intrinsic motivation is important for substantive and abiding change (2002, p. 84).

Leveraging a legal mandate to optimize clinical outcomes requires some conceptual sophistication, both on the part of the practitioner as well as the corrections professional. Strategically, effective treatment providers will intentionally identify themselves as separate from the criminal justice system.

They will distance themselves from its restrictions and mandates, albeit while openly, with the client's consent, maintaining a line of communication with the referral source. This distance does not mean that treatment providers pretend that the treatment mandate does not exist. They may need to engage the offender client in thoughtful dialogue about what the mandate means and what will result if it is defied. This distance also does not mean that treatment providers are “soft” on offender clients. But, in order to be effective, treatment providers must clarify that they themselves are not in the business of mandating, supervising, and sanctioning. These functions, while necessary for rehabilitation, can interfere with the development of an appropriately therapeutic relationship.

The semblance of choice, even if it is in some senses illusory, is an important component of correctional treatment. “Giving clients a sense of choice and control is essential when working with those who are mandated into treatment” (Berg & Shafer, in Strausner, ed. 2004). Clinicians working with offenders can use many creative, well-accepted strategies for working with offenders, including emphasizing choices they can make throughout the process; informing them about what treatment entails; contracting with them collaboratively regarding treatment goals; and promoting their active participation throughout treatment.

Redefining “resistance.” Within the field of psychology, “resistance” was conceived in terms of an individual’s maladaptive defenses: “a process in which the ego opposes the conscious recall of unpleasant experiences” (Soukhanov, ed., 1996). Resistance was pathologized; it was an individual’s stubborn defense against the practitioner’s reasonable and well-intentioned entreaties. “Resistance was an inherent, unconscious striving to avoid thoughts and feelings that caused discomfort” (Beutler et al, in Norcross, 2002). Undoubtedly this manner of conceptualizing client’s struggles caused harm to them. Indeed, for offenders in treatment, this way of conceptualizing resistance can lead to sanctions and imprisonment.

Most contemporary practitioners find it unhelpful to think about therapeutic stalemate in this pathologizing, individualizing manner. The current thinking understands resistance as a systemic phenomenon, in which both the client and the practitioner play some part. The developers of Motivational Interviewing have done significant work to transform our therapeutic understanding of resistance, moving it from a static position assumed by one putatively stubborn individual to a dynamic relational phenomenon, in which both the client and the treatment provider contribute to the stalemate. Miller (2002) writes:

[W]e decided to retain the concept of resistance and to rehabilitate it. Resistance is something that occurs only within the context of a relationship or system.... A difficulty is that within the context of psychotherapy, resistance is usually used to describe the behavior of only one person, the

client. Although transference has its countertransference in psychoanalysis, there is no corresponding concept of counterresistance to describe the counselor's role in evoking and maintaining this interaction (p. 45).

Berg and Shaffer (in Straussner, ed., 2004) comment that mandated clients are often, unfortunately, imprinted with the language of the criminal justice system, which is very different from the language of treatment. That imprinting can sometimes hinder their progress in treatment and needs to be shed. The authors observe:

Words such as *mandated*, *involuntary*, or *criminal justice* elicit certain preconceived notions in clinicians, such as difficult, resistant, oppositional, or defiant, as well as other commonly used descriptions of clients as 'in denial' or as 'minimizing the seriousness of the problem' (p. 83).

Ultimately, corrections professionals and treatment providers have different schemas for understanding how clients engage in rehabilitative processes. Within the context of the legal system, corrections professionals conceive of the offender's level of participation in terms of right and wrong. They can therefore apply pressure when clients go awry of legal expectations. Within the therapeutic realm, treatment providers conceive of the offender's level of participation in terms of cognitive distortions, manageable conflict in the professional relationship, and maladaptive knowledge about their condition. Neither schema is wrong. Both, when used strategically, are necessary levers of a dynamic change process.

APPENDIX D: QUALITY ASSURANCE

Appropriate quality assurance is widely recognized as an important component of effective clinical practice (Powell, 1993, Campbell, 2006) and particularly in the field of correctional treatment where there has been an emphasis on therapeutic integrity (Andrews and Bonta, 1994) and program integrity (Lowenkamp, Latessa, & Smith, 2006). Quality assurance encompasses a range of different activities that assess, monitor, evaluate, and regulate the effectiveness of behavioral healthcare practices, including:

- program accreditation and outside quality reviews;
- clinical practice guidelines and treatment manuals;
- credentialing standards in specific modalities;
- ongoing outside evaluation of performance outcomes; and
- systematic evaluation, defined as “methods or instruments that begin with a construct and seek to operationalize that construct in ways that can be scrutinized, validated, and replicated by others in similar circumstances” (Goodheart, et al, 2006), including objectively determined fidelity and adherence measures for specific practices.

In terms of correctional treatment, for example, the maintenance of therapeutic integrity includes the following components: manualized interventions, based on specific, tested theoretical models that link the intervention to reduced recidivism; trained staff; and clinical supervision (Andrews, 1994). Increasingly, a number of evidence-based practices are encouraging practitioners to be supervised by specially trained clinical supervisors, with specific therapeutic adherence measures, including Motivational Interviewing (Martino et al, 2006), the Global Appraisal of Individual Needs (Dennis et al, 2006), and Dialectical Behavioral Therapy (Linehan, 1993), to name only a few.

Correctional Program Assessment Inventory. Lowenkamp & Latessa (2006) have written extensively about the Correctional Program Assessment Inventory (CPAI), a survey that can be applied to correctional treatment programs that assesses the degree of fidelity to the most promising, evidence-based strategies for reducing recidivism. The CPAI reviews such core program characteristics as client assessment, characteristics of the program and staff, and strategies for program evaluation. In addition to using the CPAI to measure program integrity, agencies are encouraged to evaluate the outcome of their programming, using different indicators (e.g. new arrests, new convictions, types of new criminal activity [felonies, misdemeanors, or technical violations], and treatment completion, etc.)

Clinical supervision. Clinical supervision is unique to behavioral healthcare practitioners and can be difficult to understand from outside those professions. There are several definitions of clinical supervision:

Clinical supervision is a disciplined, tutorial process wherein principles are transformed into practical skills, with four overlapping foci: administrative, evaluative, clinical, and supportive (Powell, 1993).

[T]he primary purpose of clinical supervision is to review practitioner's work to increase their skills and help them solve problems in order to provide clients the optimal quality service possible and prevent any harm from occurring....[I]t is a teaching and training tool as well as a monitoring function (Campbell, 2006).

Thus, in treatment provision, clinical supervision is one of the primary modes of ongoing quality assurance and program integrity. Clinical supervisors have both an ethical and a legal obligation to know the quality of their supervisee's work and to prevent harm to clients. In the case of corrections clients, that responsibility is magnified to include the duty to protect others who may be impacted by the offender's behavior. Clinical supervisors can be held liable ("vicarious liability") for malpractice committed by their supervisees (Campbell, 2006).

In addition to regular, often weekly, meetings with a clinical supervisor, in both individual and team formats, it is becoming increasingly recommended for clinical supervisors to occasionally accompany supervisees to appointments with clients for first-hand exposure to their work, to require the regular submission of audio- and videotapes of sessions, and to thoroughly and routinely review case notes (Campbell, 2006).

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