COMMUNITY CORRECTIONS REPORT™

On Law and Corrections Practice

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Hear No Evil, See No Evil, Speak No Evil: The Ethical Imperative of Evidence-Based Practices

by Frank Domurad

In medieval Japan, peasants practiced the ritual of "koshin." On the night of koshin, villagers would stay together in the fields, remaining awake until the first light of dawn. They prayed to Shuomen Kongo, a fierce god with six arms. They believed that if they made these devotions, their bad deeds would never be reported to this much-feared deity. As symbols of their faith, they carried statuettes of three monkeys—one with his hands over his ears, another with hands over his eyes, and the last with hands over his mouth. These monkeys acted as messengers to Shuomen Kongo and maintained the veil of ignorance that stretched over the peasants' evil deeds.

Modern-Day Koshin

In today's world, many correctional leaders and practitioners exercise their own form of koshin. While they do not stay awake all night in rice paddies, as did their rural predecessors, they do show signs of believing that ignorance will somehow protect them from negative consequences.

At the plenary session of the recent National Institute of Justice's Annual Conference on Criminal Justice Research and Evaluation, David Weisburd, Professor of Criminal Justice at Hebrew University and the University of Maryland, contended that "until we get a moral imperative that we have to do research to avoid harm, we will not get further along." To illustrate his point, Weisburd relayed to the audience the story of a correctional executive who told him that he was not interested in doing research because it would only bring bad news (National Institute of Justice, 2005).

The attitude of this executive toward knowledge and research, though not usually stated so boldly and publicly, is an unfortunate reality in our field of endeavor. One set of researchers stated that among the 200 or so correctional programs that they evaluated, most failed to collect data on recidivism and even fewer made public any evidence on success or failure using comparison groups. They concluded that systematic and thorough evaluation practices were virtually nonexistent in probation and parole (Gendreau et al., 2001). Another group of analysts cited data that "there continue to be many, both within and outside the corrections profession, who have failed to recognize the growing literature on effective treatment with offender populations" (Leschied et al., 2001, p. 4).

Good News About Treatment Interventions

Such apparent resistance to learning is all the more puzzling and disturbing given the fact that the news on the knowledge front is remarkably positive. Probation and parole have emerged from the long, dark night of "nothing works" to discover that they can be potent tools in the struggle to protect public safety. James McGuire found that across all meta-analyses of correctional treatment programs and interventions, recidivism was

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The Importance of the Hare Psychopathy Checklist-Revised

by Kimora, Ph.D.

A major challenge for criminal justice professionals is changing the antisocial behavior patterns that can prevent offenders from returning to society as productive citizens. Antisocial behaviors can keep offenders in the prison system longer and subject them to more negative consequences.

One significant predictor of antisocial behavior is the presence of either psychopathy or antisocial personality disorder (ASPD). Identifying individuals suffering from those conditions is therefore of the highest importance.

Over 20 years of research, Robert Hare (1991) developed the Hare Psychopathy Checklist (PCL) and its revised version, the Hare Psychopathy Checklist Revised (PCL-R). The scale measures a personality construct, psychopathy, implicated in antisocial and violent behavior. Hemphill et al. (1998) reviewed the PCL-R literature and concluded that the scale is a consistent predictor of general, violent, and sexual recidivism among criminal offenders and mentally ill patients.

Personality research has found the PCL/PCL-R (Hare, 1991) to be important markers for persistently violent behavior among inmates held in correctional and mental health settings (Hare, 1991; Hemphill et al., 1998). Understanding the individual differences in cognition and personality that are implicated in the unfolding of violent conflict is thus critical to assess-

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reduced on average by 9% to 10%. This figure climbed dramatically to 25% to 30% with the introduction of cognitive-behavioral technologies. It rose even further, to 40%, for serious and persistent young offenders when programs focused on interpersonal skill training, behavioral interventions, cognitive skills training, mentoring, and structured individual counseling. Recidivism reduction has even reached the astronomical height of 60% with the use of specialized techniques such as functional or behavioral family therapy, family empowerment, and multisystem therapy (McGuire, 2005; McGuire, 2001).

Indeed, compared to the outcomes produced by punitive and retributive alternatives, the successes being achieved through the use of carefully crafted and implemented treatment interventions in the community with adults and juveniles who have run afoul of the law brook no competition. One study of the comparative effects on 398,300 offenders of longer and shorter terms of incarceration and brief periods of prison versus probation revealed that punitive sanctions actually increased recidivism on average by 2%. (Gendreau, et al., 2001, pp. 250-251). Preliminary findings from the Denver Youth Study, one of the nation's largest longitudinal investigations of youthful criminal careers, have led to similar conclusions for juveniles. In this case, analysis demonstrated that arrest and sanctions resulted either in the persistence of or an increase in delinquency. The more severe the sanction, the more likely the juvenile would engage in law-breaking activity (National Institute of Justice, 2005). The overwhelming majority of meta-analyses have concluded that "there is little evidence that punitive sanctions effectively deter criminal acts amongst adjudicated offenders: their effect as judged by large-scale reviews is either neutral or in some instances negative" (McGuire, 2001, p. 33).

One correctional executive said that he was not interested in doing research because it would only bring bad news.

A Preposterous Situation

Over the last 30 years, the expectation in human service professions has become that any intervention to solve human problems should rest on a firm foundation of evidence. A standard philosophy of evidence-based practice has arisen across these fields to consolidate and synthesize scientific knowledge. This philosophy has become the prerequisite for the design and delivery of services. In medicine, risk reductions around 10% have produced both a stampede to take an aspirin a day to prevent heart attacks and the expenditure of untold millions of dollars on heart bypass surgery to treat coronary disease.

However, in corrections, declines in recidivism of 20%, 30%, and even 60% are either

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routinely ignored or remain mired in unending dispute and controversy (McGuire, 2001). Although "doing what works, and not tolerating what doesn't work, should be the defining feature of our field....," writes Frank Porporino, former Director General of Research and Development with the Correctional Service of Canada, "few would suggest that what works has become the defining quality of the field, or even that it is the quality to which the field generally and decidedly aspires" (Porporino, 2005, p. 194).

How did we arrive in such a seemingly preposterous situation? What accounts for the fact that among all the human service professions, corrections seems most willing to turn its back on the opportunity for producing some of the richest outcomes in reducing risk to the public? Many practitioners would answer that it is primarily a question of resources. They simply do not have the money to train staff in clinical procedures or to hire researchers and analysts to evaluate what they are doing. Others contend, more cynically, that it is an unwillingness to accept accountability for any outcome of public value, least of all offender recidivism and crime prevention. Still others argue that any organizational change is a daunting and challenging process, especially in the case of a "what works" model, "a complex system of principles and programs that do not lend themselves well to piecemeal adoption, local tinkering or half-hearted efforts" (Burrell, 2005, p. 58). Given the multiple and often conflicting demands placed on correctional leaders and their staff, there is little time or room for them to marshal the effort required to do the job.

While each of these factors might be necessary elements in constructing an explanation of our current paralysis when it comes to evidence-based practices, in and of themselves they seem disturbingly insufficient. Other human service fields have confronted similar and even worse barriers to change and managed to overcome them.

A recent federal government study of the quality of health care in American hospitals revealed that doctors and hospitals routinely fail to take essential lifesaving steps in dealing with heart attacks, pneumonia, and heart failure, some of the most common causes of death. The treatments themselves are both simple and noncontroversial: aspirin and beta blockers for heart attacks, and immunizations and antibiotics for pneumonia. Patients who receive aspirin in the first 24 hours after a heart attack experience a 30% increase in their survival rate. Yet in the first half of 2004, more than 12,000 people, or one in every 16 victims, did not receive the appropriate therapy.

Some of the 3,500 hospitals included in the statistical review tried to argue that they did act properly but just did not document the fact, but a skeptical American Hospital Association would have none of it, commenting, "If the medications and tests are delivered and there's no documentation, that itself is a quality problem." Those hospitals that did the best owned up to their problems and immediately set out to fix them with checklists and patient-safety rounds. Their culture rested on an adamant refusal to do harm to their patients. As the administrator of quality care for Caritas St. Elizabeth Medical Center in Brighton, Massachusetts, one of the hospitals with a perfect therapeutic record, bluntly stated, "We have zero tolerance for people not meeting these objectives" (Fessenden, 2005).

some of the programs evaluated actually did harm and that we had no idea how many countless others were having the same negative and destructive consequences. He called for the discontinuance of ineffective programs and raised the specter that litigation was not far around the bend, as lawyers for adult offenders and juvenile delinquents began to sue because their clients had been placed into harmful programs. He concluded that our profession was confronting an ethical crisis by continuing to practice and fund unevaluated and unproven interventions (National Institute of Justice, 2005).

Evidence-based practice research has clearly demonstrated what actions we routinely take as practitioners in community corrections that might produce harm for our clients, their victims, and the public. In terms of interventions, meta-analyses have found no effect size for such common tools of our trade as intermediate sanctions, "smart sentencing," deterrence-based interventions, "scared straight," intensive supervision, arrest, restitution, boot camps, drug testing, and electronic monitoring—with the last six items even marginally increasing recidivism (McGuire, 2005, pp. 72-80).

Gendreau and his colleagues found that 70% of all programs assessed "failed" to make the grade.

It is the recognition and acceptance of the possibility and reality of injuring, maiming, and even killing patients that has propelled medicine and health care into the arms of evidence-based practices. In corrections, a similar set of concerns can now be seen cresting the horizon among an increasingly worried community of researchers and analysts. When Deborah Sheetz, a Policy Advisor from the federal Bureau of Justice Assistance, characterized the previously mentioned National Institute of Justice (NIJ) researchers' conference on evidence-based practice to an audience of over 200 probation and parole practitioners, she emphasized that it had focused on "doing harm" (American Probation and Parole Association, 2005). Indeed, at the NIJ conference itself one presenter after another outlined ways in which the well-intentioned efforts of practitioners to do good in terms of preventing crime had actually made matters worse—in some instances, much worse.

The litany of bad news culminated with the luncheon speech of Delbert Elliott, the Director of the Center for the Study and Prevention of Violence at the University of Colorado in Boulder. He observed that there were no evaluations for most criminal justice programs in the United States. At best, only 35 to 40 programs had been rigorously assessed and were known to be effective. Of even greater concern was the fact that

In terms of risk factors as targets of behavioral change as part of the supervision of adults and juveniles, harmful practices include the following:

- Focusing on ill-defined emotional or personal problems;
- Emphasizing individual self-esteem;
- Promoting physical activity as an end in itself;
- Increasing cohesiveness among antisocial peers; and
- Showing respect for offenders' antisocial thinking.

Placing an emphasis on any of these targets in working with correctional clients "is associated, on average, with increases in recidivism, which in some instances are not small" (McGuire, 2005, p. 79).

Finally, there is the thorny problem of program implementation. Even well-designed interventions may do little good or even have deleterious effects on the level of criminal behavior if the quality of the delivery is poor (McGuire, 2005, pp. 72-80). As Porporino suc-

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cinctly summarized the situation, "corrections clearly should not be comfortable in behaving 'iatrogenically,' a medical term referring to the kind of disease created in the process of treating the disease" (Porporino, 2005, p. 193).

Failures in Implementing Correctional Treatment Programs

The magnitude of the problem confronting probation and parole can best be illustrated in Paul Gendreau's summary of three large-scale reviews of the quality of correctional treatment programs using the Correctional Program Assessment Inventory. Gendreau and his colleagues found that 70% of all programs assessed "failed" to make the grade in terms of effective implementation. The list of major programming deficits would convince even the most hardened skeptic that the medieval Japanese practice of koshin is alive and well in community corrections:

- Program directors and staff were "unfamiliar with the treatment literature in their field," leading to a pattern of decision making that "followed hunches," repeated the mistakes of others, and constantly chased the latest panacea.
- Despite everything written about the efficacy of actuarial risk assessment, "the traditional clinical subjective/intuitive format persists."
- There remains confusion on which dynamic or criminogenic risk factors to appraise, with continuing focus being placed on self-esteem, anxiety, or depression.
- In some cases, "it was found that the most frequently used interventions were empirically established failures."
- Staff had large gaps in their knowledge of criminal behavior and offender treatment, with much of the cognitive-behavioral therapy being practiced functioning as little more than nondirective "chats," where there was not any guarantee "that prosocial behaviour is being reinforced and that antisocial behaviour is not..." (Gendreau, 2001, pp. 260-263).

Faults in the Corrections Culture

So why has knowledge of the harm that we might commit not overcome the practical barriers confronting us and launched our profession into evidence-based practices as it has medicine, health care, and other human service fields? The answer is that three deeply embedded cultural factors have conspired to paralyze our profession in a state of drift and uncertainty.

Porporino labeled the first of these factors the "fix-it" culture, "seeing what works as simply the application of a set of methods or techniques to fix offenders." Such an orientation concentrates more on efficient processing than the achievement of outcomes, on imposing or mandating behavioral change than on motivating the client to grasp and internalize opportunities for improvement. It is a mechanistic approach to supervision. It assumes that the offender is "broken" and that the officer needs only to find the right parts to overcome "deficits" and make things whole.

In this framework, the officer can only do "good"; it is the client's refusal to be held accountable and embrace the prescribed treatment that causes "harm." When the probationer or parolee does not respond as desired, he or she is written off as noncompliant and uncooperative, violated, and sent back to court, and then remanded to the punishing environment of jail or prison. Such a retributive approach is considered both rational and appropriate in dealing with someone who now represents a clear danger to public safety (Porporino, 2005, pp. 200-201).

Second, this "fix-it" model is in turn supported by an outdated conception of what it means to be a professional. William Solesbury argues that the "new interest among professionals in bringing impartial evidence to bear on their practice is related to the loss of public confidence that most have suffered in recent years." Previously, professionals functioned like priests. They relied on and demanded from their clients unquestioning compliance. They trusted their own experience and judgment as the primary source of knowledge.

However, in today's world, patients, parents, students, and other recipients of human services are better informed and less likely to accept blindly the dictates of experts. They want to understand whether what is being done to and for them is the best way possible. They insist on knowing which hospitals are not "killing" their patients by failing to administer aspirin after a heart attack. Such clients are aware that the equation of human services involves the possibility of harm, and they want a provider to prove that he or she will be doing good for them (Solesbury, 2001).

In contrast, the old notion of a professional priesthood remains alive and well in community corrections. Correctional leaders have successfully isolated their managers and staff from the glare of public scrutiny by refusing to evaluate what their organizations do and to hold themselves accountable to standards based on empirical evidence. The result has been an incubator for future generations of correctional "priests" committed to the veracity of a "fix-it" culture and for whom "doing harm" cannot be an ethical possibility. Such true believers in the efficacy of their own personal experience and judgment are often misled in two ways: they either accept as efficacious "useless or even harmful therapies" or they reject "as ineffectual therapies that, in reality, offer benefits" (Davies, 1999, p. 9). The third, and possibly the most important, cultural impediment blocking community corrections' road to evidence-based practice pertains to what psychologists refer to as "sensemaking." In its crudest terms, aligning practice with scientific evidence simply does not "make sense" to priestly professionals mired in a culture of "fixing" offenders. And until it does, they will simply reject its premises. As Porporino argues, "staff will not change 'practice' simply because they are encouraged to do so, regardless of whether that encouragement is subtle, forceful, or even enthusiastic, and visionary." Ways must be found to change not only how staff members do things (behavioral change), but also how they think about doing those things (cognitive change). Unless this transformation occurs and the "sensemaking of staff is not acknowledged and dealt with along the way," any attempt "to implement any thoughtful and integrated what works agenda may be futile..." (Porporino, 2005, p. 220).

The difficulty for community corrections in following such sage advice is the nature of sensemaking itself. Karl Weick, Professor of Organizational Behavior and Psychology at the University of Michigan, contends that sensemaking "is about plausibility, coherence, and reasonableness." It is about accounts of situations and circumstances that are "socially acceptable and credible." When people encounter an event so implausible that they fear reporting it to others because they will not be believed, they "think to themselves, it can't be, therefore, it isn't" (Weick, 1995, pp. 1, 61). This response was the case for so many years with medical professionals in terms of acknowledging the possibility of a battered-child syndrome, and it is now the response of correctional professionals in terms of "doing harm."

Lessons From the Health Care Industry

Two decades ago, medicine and health care stood on the same slippery cultural ground now occupied by community corrections. Therapeutic arrogance dominated. Doctors and other professionals lorded over their patients, commanding behavioral change and expecting obedience. When harm occurred, it was not the fault of accepted practice but the result of ignorant and resistant clients.

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Then came wave after wave of disastrous reports. In 1991, the prestigious *British Medical Journal* contended that only 15% to 20% of medical interventions in the United Kingdom were supported by solid scientific evidence. A few years later, research demonstrated that it took up to 10 years for even incontrovertible and indisputable evidence to become standard practice in doctors' offices, clinics, and hospitals.

The culminating point in this litany of woe came in 1999 with the Institute of Medicine's report that errors in hospitals killed anywhere from 44,000 to 98,000 people every year in the United States. (Domurad, 2005). Suddenly, a once confident medical and health care profession was confronted with the fact that its previously existing world no longer "made sense." It could not deny any longer the tremendous harm that was occurring in its midst. Events that had once seemed so implausible now could no longer be ignored. The sensemaking dissonance between what they thought to be true and what actually existed had simply grown too strong to be cognitively relegated to oblivion. Practitioners at all levels confronted a simple ethical choice: should they continue to adhere to the deaf, dumb, and blind monkeys of ignorance, in the hope that the fierce six-armed god Shuomen Kongo would continue to pass them by, or should they embrace evidence-based practices for the health and well-being of their patients?

The health care industry chose the latter option and took three important steps to ensure its behavioral, cognitive, and organizational institutionalization.

Adjusting the Old Occupational Model. The first step was to destroy the stranglehold of the old occupational model of professional priesthood by:

- Revamping curricula in medical schools to include courses on ethical practice, the role of patients in therapeutic planning, and what might be called "responsivity" or the motivational human relationship between doctor and client;
- Giving new life to the old Hippocratic Oath in a modernized form. Many graduating medical students now swear to "respect the hard-won scientific gains of those physicians in whose steps I walk" and to "apply, for the benefit of the sick, all measures which are required, avoiding those twin traps of overtreatment and therapeutic nihilism." They "will not be ashamed to say 'I know not,' nor will I fail to call in my colleagues when the skills of another are needed for a patient's recovery." They recognize that "I do not treat a fever chart, a cancerous growth, but a sick human being, whose illness may affect the person's family and economic stability" (Hippocratic Oath, 2005);
- Eliminating any tolerance for the ill-informed and uninformed practice of "experts" by systematically and routinely uncovering "harm" through the use of adverse incident reports for hospitals and other *public* reporting mechanisms.

Destroying the Consequences of the "Fix-It" Culture. The second step taken by health care on its path to evidence-based practices has been the implementation of an ethical decision-making process designed to destroy the destructive consequences of a "fix-it" culture. Health care executives are now being taught that "the decisions made and actions taken in response to ethical questions are critical because of their direct impact on the quality of care." The approach being used is based on the concept of procedural justice, a structured deliberative process that fosters fairness by understanding all the competing values inherent in ethical conflicts. The challenge in any ethical conflict, be it the closing of a neighborhood clinic or a decision about maintaining life support for a patient in a vegetative state, is choosing among potential options that involves prioritizing values. While there can never be an "objective" answer in determining such rankings, a clear sense of the fundamental purpose of health care organizations and practice, namely quality patient care, is able to produce a list where patients or the population served come first, clinicians and staff second, and the organization itself third. In this context, the relevant question becomes "when, if ever, we are justified in not giving patient care first priority." It is at this point that evidence-based practices necessarily guide the discussion by ensuring that any decision taken against placing patient concerns above all others does not create "harm" either in the present or in the future (Nelson, 2005, pp. 9-10).

The Process of Sensemaking. Health care has become actively engaged in the process of sensemaking. Health care organizations are striving to become high-reliability organizations based on a culture of safety. Such organizations embrace the potential for failure and harm. They comprehend and accept that the context in which they function is rapidly changing, ambiguous, unpredictable, and often without structure. They are willing to declare, as a coalition of hospitals, doctors, nurses, insurance companies, and patient advocates recently did in response to the Institute of Medicine's report mentioned above, that "one serious medical error was one too many" (Domurad, 2005, p. 49). They seek to abandon a cognitive attitude and posture known as "mindlessness."

The Threat of Mindlessness

In their book on high-reliability organizations, Karl Weick and Kathleen Sutcliffe define mindlessness as a mental attempt to conceal problems that are worsening. "It is a style of mental functioning in which people follow recipes, impose old categories to classify what they see, act with some rigidity, operate on automatic pilot, and mislabel unfamiliar new contexts as familiar old ones" (Weick & Sutclifffe, 2001, p. 92). An organization that tolerates mindlessness among its leaders and staff "knows little about itself, may not realize that its knowledge is impoverished, and persists in doing traditional monitoring that produces few updates" (Weick & Sutcliffe, 2001, p. 94).

"Mindfulness," in contrast, is a cognitive approach where people make sense of situations by always doubting that the current picture is complete and by being willing to remove those doubts through a constant updating of their awareness of what is going on. It forms the foundation of a safety culture where, in the words of human factors researcher James Reason, "those who manage and operate the system have current knowledge about the human, technical, organizational, and environmental factors that determine the safety of the system as a whole." In short, it is a cognitive recipe for doing evidence-based practices (Weick & Sutcliffe, 2001, pp. 92-94, 128-129).

How far community corrections remains from "making sense" of its present situation and achieving such a culture of safety is best illustrated in its attitude toward treatment program completion rates. As Porporino noted, one of the most consistent findings in "what works" research is that offenders who leave programs before completion reoffend at much higher rates than either those who finish the program or those in comparison groups. He found that dropout rates typically ranged between 30% to 50%. Those who did leave were generally higher-risk, younger offenders, the very populations that posed the greatest threat to public safety. Yet correctional professionals not only tolerated such failure, but in many instances even welcomed it, because they now no longer had to deal with those elements of their caseload who refused to be "fixed." Porporino concluded, with some amazement, that "it seems silly to allow our programs to be delivered in such a way that only the `good risks' survive" (Porporino, 2005, pp. 208-209).

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New Jersey Law Authorizes Satellite-Based Monitoring of Certain Sex Offenders

New Jersey was the first state to enact a "Megan's Law," which allowed authorities to alert residents when a sex offender moves into a neighborhood. New Jersey legislators have now taken the next step by enacting a new law that uses satellite technology to keep track of the state's most dangerous sex offenders.

The devices use global positioning technology and will allow officers to know the precise whereabouts of the offenders.

Senate Bill 1889, enacted as Public Law 2005, Chapter 189, was signed by Acting Governor Richard Codey on August 11, 2005. The new law establishes a pilot program for satellite-based monitoring of certain sex offenders and requires those certain sex offenders to submit to an annual polygraph. Three million dollars was appropriated for the program. The actions of the New Jersey legislature and acting governor make the state the third in the nation to use this type of monitoring technology, joining Florida and Tennessee.

Ed Bray, a spokesman for the state's parole board, stated that the two-year pilot program would have its first offenders in ankle bracelets within three months. The program will hire an additional 20 parole officers by early next year, when the Board expects about 55 paroled sex offenders considered to be the most potentially dangerous to be wearing the tracking devices. Eight of the latter will be those deemed to be sexually violent predators. There are currently 2,900 sex offenders under supervision for life by the state's parole officers. The program allows a maximum of 250 offenders to be monitored.

The devices use global positioning technology and will allow officers to know the precise whereabouts of the offenders. Any offender who fails to comply with the program or tampers with the equipment would be guilty of a crime punishable by up to five years in prison and $15,000 in fines.

After the program runs its course, the chairman of the state parole board must submit an evaluative report within 90 days of that date. The report will recommend whether the pilot program should be continued as a statewide program. ■

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Conclusion

So what choices will community corrections make as it stands at the same ethical crossroads once occupied by medicine and health care some two decades ago? There were then and are now still but two options. We can continue the medieval peasant practice of koshin accompanied by the three monkeys of willful ignorance, or we can follow the precedent of our colleagues in other human services in becoming accountable for our actions.

Ask any probation executive, manager, or line officer, and he or she will tell you that we do our jobs to protect public safety. Yet we continually engage in activities that produce harm rather than good. We cut budgets for training, refuse to create research and analytical capabilities in our organizations, use unproven methods and programs with our clients, and tolerate a priestly, "fix-it" culture in our ranks. When all is said and done, we still refuse to ask, or, even better stated, simply do not understand that we must always ask the question "when, if ever, are we justified in not giving public safety first priority?" It is a query that we cannot answer without doing evidence-based practices first.

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