State grantees ask how do we know if a RSAT program we fund or intent to fund in a jail or prison is evidence-based?

At first blush, there is an easy answer. Does the program utilize an evidence-based treatment program recognized by the U.S. Justice Department, Substance Abuse and Mental Health Services Administration (SAMHSA) and/or National Institute of Drug Abuse (NIDA). Check out, for example, http://nrepp.samhsa.gov/Index.aspx , SAMHSA's link to the national registry of evidence-based programs and practices. You will find, for example, the latest summary of research pertaining to M*odified Therapeutic Community for Persons With Co-Occurring Disorders.* The listing details the research behind this intervention, where it is used and for whom.

However, simply adopting an evidence-based program is only the beginning. The challenge is how that evidence-based program is *implemented* by the jail or prison. The institution must change its organizational structures and culture to enable the implementation of the evidence-based programs that we know otherwise work in reducing criminal behavior.

What does this means?[1]

First of all, it means the institution must jettison a lot of long standing traditions and practices based on those beliefs that are dearly held but antithetical to evidence-based practice. Perhaps heading the list is the belief that the most crucial job of corrections is to hold offenders accountable for their crimes. Holding offenders accountable without consistently providing skills, tools, and resources that science indicates are necessary to accomplish risk and recidivism reduction is a recipe for failure.

Second, the belief that we can rely on the experience and expertise of officials to predict the likelihood that an offender will commit another offense. Such clinical judgments consistently *under* predict rearrest rates when compared to empirically-based tools. Nor can we rely on the offender's current offense to dictate his or her risk. The offender's *characteristics* predict future offenses. For risk reduction, risk profile – rather than offense – should drive the intervention.

Third, the belief that the offender has got to want to change in order to change. This belief conveniently minimizes our role as correctional professionals, but has been proven wrong. Motivation is dynamic and can be influenced through effective engagement techniques to increase the likelihood that offenders will become motivated to change.

Fourth, the belief that lecturing, threatening and confronting inmates in the best way to influence their behavior. In fact, offenders are more likely to respond to positive reinforcement and

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[1] The content of this paper has been largely *adapted* from NIC, Implementing EBP in Community Corrections: The Principles of Effective Intervention, & Crime and Justice Institute, Implementing Evidence- Based Practices, Revised, Center for Effective Public Policy, 2010;Taxman, F. & S. Belenko, Implementing Evidence-Based Practices in Community Corrections and Addiction Treatment, 2012

incentives, often totally missing in our institutions. Similarly, the belief that it is best to "keep 'em guessing," keeping sanctions and consequences for rule breaking secret to keep offenders off-guard and fearful. Offenders are more likely to comply when they know the rules and consequences, and are less likely to resist the consequences when the rules are broken and a sanction is imposed.

Fifth, the belief that inmates do not pay attention to subtle messages they receive through their interactions with us or our interactions with other staff. To put it bluntly, if security staff and treatment staff don't respect each other in their interactions, both will be undermined in the eyes of RSAT inmates. Every interaction represents an opportunity to role-model for offenders, affirm pro-social values, and demonstrate disapproval for anti-social thinking/behavior.

Sixth, the belief that any evidence-based program will work for any inmate. Programs that are mismatched to offender traits can actually do harm. Programs must be appropriate based upon offenders' level of risk and criminogenic needs as well as recognize offender gender, culture and other responsivity factors.

What should we be looking for in evaluating a RSAT program or a proposal to establish a RSAT program?

We should look to see how they grapple with 8 fundamental key principles of evidence based practice:

1. Assess Actuarial Risk/Needs.
2. Enhance Intrinsic Motivation.
3. Target Interventions.
4. Provide Skill Train with Directed Practice
5. Increase Positive Reinforcement.
6. Engage Ongoing Support in Offender's Community
7. Measure Relevant Processes/Practices.
8. Provide Measurement Feedback

<u>Assess Actuarial Risk/Needs</u>

Is the staff trained to complete Reliable/Valid Offender Assessments, using tools that focus on dynamic and static risk factors, profile criminogenic needs, and have been validated for similar populations? Is offender assessment ongoing? Remember, case information that is gathered informally through routine interactions and observations with offenders is as important as formal assessment guided by Instruments.[2]

<u>Enhance Intrinsic Motivation</u>

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[2] **Andrews, et al, 1990; Andrews & Bonta, 1998; Gendreau, et al, 1996; Kropp, et al, 1995; Meehl, 1995; Clements,1996.**

Behavioral change is often an inside job, requiring a level of intrinsic motivation for lasting change. Research strongly suggests that motivational interviewing techniques, rather than persuasion tactics, more effectively enhance motivation for initiating and maintaining behavior changes.[3]

Target Interventions

The RSAT program should target high risk offenders and zero in on their criminogenic needs. To do this, however, they have to be *responsive* to temperament, learning style, motivation, culture, and gender of the inmates served. The treatment, the treatment provider, and the style and methods of communication must fit the offender and his or her stage of change readiness. Note: Cognitive-behavioral methodologies have consistently produced reductions in recidivism with offenders based on most rigorous research.[4] However, the quality of the *interpersonal relationship between staff and the offender,* along with the skills of staff, have been found to be as or more important to risk reduction than the specific programs in which offenders participate.[5]

No matter the methodology, the "dosage" has to be appropriate. The program should structure 40 to 70% of a high risk offender's time for three months to nine months. The treatment offered must be integrated into the full correctional environment. This is why modified therapeutic communities work in jail/prisons as they can approach 24/7 positive programming. Limiting RSAT "treatment" to specific counseling/group sessions risks inmates being overwhelmed by jail house culture and other negative influences. Also this explains why correctional officers must be an integral part of RSAT program as they remain on the tier long after counselors leave.

The ideal RSAT population? One suffering from dysfunctional family relations, anti-social/criminal peers, substance abuse, low self-control, and anti-social values/attitudes.[6]

Remember, there can be no "treatment effect" if the inmate is unlikely to reoffend anyway.

Skill Training and Directed Practice

The RSAT staff must understand *antisocial thinking*, *social learning*, and appropriate c*ommunication techniques*. Skills are not just taught to the offender, but are *practiced or role-played*. Pro-social attitudes and behaviors are *positively reinforced* by staff.[7]

Increased Positive Reinforcement

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[3] **Miller & Rollnick, 2002; Miller & Mount, 2001; Harper & Hardy, 2000; Ginsburg, et al, 2002; Ryan & Deci, 2000.**

[4] **Guerra, 1995; Miller & Rollnick, 1991; Gordon, 1970; Williams, et. al., 1995.**

[5] **Andrews, 2007; Andrews, 1980; Andrews & Bonta, 1998; Andrews & Carvell, 1998; Dowden & Andrews, 2004**

[6] **Gendreau, 1997; Andrews & Bonta, 1998; Harland, 1996; Sherman, et al, 1998; McGuire, 2001, 2002, Lipton, et al, 2000; Elliott, 2001; Harland, 1996.**

[7] **Mihalic, et al, 2001; Satchel, 2001; Miller & Rollnick, 2002; Lipton, et al, 2000; Lipsey, 1993; McGuire, 2001, 2002; Aos, 2002.**

Carrots over sticks, **the research suggests a ratio of 4 to 1 positive reinforcement is optimal for promoting behavior changes.[8] But, of course, this should not be at the expense of or undermining swift, certain, and real responses for negative and unacceptable behavior. The program must establish the order necessary to that inmates can think, reflect and learn. The tier should not reproduce the chaos of the street from where inmates mostly came.**

Engage Ongoing Support in Offender's Community

The successful RSAT program works to mobilize pro-social supports for offenders in their communities. Successful interventions with RSAT-like populations (e.g., inner city substance abusers, homeless, dual diagnosed) actively recruit and use family members, spouses, and supportive others in the offender's immediate environment to positively reinforce desired new behaviors. This is particularly challenging for programs located in prisons that may be far from where inmates will be released to. The worst, and mostly deadly alternative for RSAT grads is homeless shelters, often located in drug markets.

RSAT programs that do no link inmates up with programs, resources and treatment providers in the community before they are released are sacrificing much of the gains the inmates may have made while incarcerated in dealing with their addictions and criminal behavior.

Research indicates the efficacy of twelve step programs, religious and other activities that are geared towards improving bonds and ties to pro-social community members.[9] The research also validates the effectiveness of *medication assisted treatment*, severely underutilized in many treatment programs. See, e.g., a recent informational bulletin released by the National Institute of Health, SAMHSA, and the CDC: http://www.medicaid.gov/Federal-Policy-Guidance/downloads/CIB-07-11-2014.pdf.

Measure Relevant Processes/Practices

The RSAT program should document case information, including formal/valid mechanism for measuring outcomes, including routinely assessment of offender change in cognitive and skill development, and evaluation of recidivism of RSAT grads, *even though this is not required for BJA Program Performance Reports!* If a program does not know how its graduates do (or who is not completing the program), it does not know what it needs to do to improve.

Periodical staff performance evaluation achieves greater fidelity to program design, service delivery principles, and outcomes. Staff whose performance is not consistently monitored, measured,

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[8] Gendreau & Goggin, 1995; Meyers & Smith, 1995; Higgins & Silverman, 1999; Azrin, 1980; Bandura et al,1963;Bandura, 1996.

[9] Azrin, & Besalel, 1980; Emrick et al, 1993; Higgins & Silverman, 1999; Meyers & Smith, 1997; Wallace, 1989; Project MATCH Research Group, 1997; Bonta et al, 2002; O'Connor & Perryclear, 2003; Ricks, 1974; Clear & Sumter; 2003; Meyers et al, 2002

and subsequently reinforced work less cohesively, more frequently at cross-purposes and provides less support to the agency mission.[10]

Provide Measurement Feedback

Both inmates and staff need feedback.[11]

Organizational change is not easy nor for the uncommitted. Must efforts to change organizations fail[12] and correctional institutions are as resistant as any to change. To succeed the RSAT program needs steadfast and dedicated commitment to change by managers, line staff, and everyone in between. The change cannot be "owned" by just a few, or units within an organization, or even by a single agency within the jurisdiction. Successful offender reentry depends on full alignment within and among criminal justice and partner organizations.[13]

Changing the status quo takes clarity of purpose, the courage to challenge the status quo, and a fundamental willingness to do things differently. Effective implementation of EBP cannot simply be adding it or exchanging piecemeal one past practice for a new one. Evidence-based practice requires a comprehensive review of vision, mission, policies, practices, attitudes and skills, and a thoughtful transition from what has been to what will be.

Research demonstrates that the strategic use of public funds can significantly reduce recidivism. Collecting and analyzing performance data, making performance data available to others, and holding ourselves accountable for improvements in public safety are key components of evidence-based practice.

Some final questions we need to ask about the specific treatment program utilized by the RSAT program.

Is the Evidence Based Program (EBP) transferable to local setting?
Was the research of the EBP based on a program that served equivalent population and setting?
Can the EBP be implemented with fidelity?
Does the organization have the resources and capacity to implement the EBP?
Does the staff perceive the utility of the EBP?

Remember, the new EBP must be aligned with existing process and procedures which will require either adaptation of the EBP or modification of the existing procedures. The staff, both

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[10]Henggeler et al, 1997; Milhalic & Irwin, 2003; Miller, 1988; Meyers et al, 1995; Azrin, 1982; Meyers, 2002; Hanson & Harris, 1998; Waltz et al, 1993; Hogue et al, 1998; Miller & Mount, 2001; Gendreau et al, 1996; Dilulio, 1993.
[11]Miller, 1988; Project Match Research Group, 1997; Agostinelli et al, 1995; Alvero et al, 2001; Baer et al, 1992; Decker, 1983; Luderman, 1991; Miller, 1995; Zemke, 2001; Elliott, 1980
[12] Rogers, Wellins, and Connor, 2002, The Power of Realization: Building Competitive Advantage by Maximizing Human Resource Initiatives.
[13] Rogers, Wellins, & Connor, 2002

treatment and security, needs the knowledge and skills to use the EBP. And a feedback loop needs to be instituted so we know if the program is working as implemented.

To assist state grantees in evaluating RSAT applications or existing programs, a brief checklist is provided in the Appendix that includes both evidence-based treatment and correctional programming principles for effective substance abuse treatment.

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Appendix: <u>Principles of Effective Substance Abuse Treatment*</u>

Key Principles	Compliant	Partially Compliant	Non-compliant
1. Use collaborate approach involving treatment and custody staff			
2. Target the population for treatment services			
3. Assess inmate's substance use disorder history and prior treatment history			
4. Include substance abuse counseling groups (BJA funding requirement)			
5. Make multi-modal treatment services available			
6. Monitor drug use (BJA funding requirement)			
7. Ensure adequate treatment period (90 days for county institution and 6 months for prisons are BJA funding requirements)			
8. Establish continuity of care upon release			
9. Include cognitive behavioral therapy and social skills training			
10. Isolate treatment unit from general population (required BJA funding requirement, although recognition that some jails may not be able to comply totally)			
11. Primary focus on recidivism reduction			
12. Require treatment, recognizing that treatment need not be voluntary to be effective			
13. Provide integrated treatment for inmates also suffering from mental illness and trauma			
14. Develop a clear code of conduct communicated to all inmates/staff			
15. Graduated sanctions for non-compliant behavior			
16. Incentives provided for positive behavior			
17. Develop measures to insure staff accountability to program objectives			
18. Correctional administrators committed to support the treatment program			

*Identified in research conducted by Peters, R.H. (1993). *Drug treatment in jails and Detention Settings*. In J.A.Inciardi (ed.), Drug Treatment and Criminal Justice, 44-80. Newbury Park: Sage Publications. (1993), Taxman, F.S. (1998). *Reducing Recidivism Through a Seamless System of Care: Components of Effective Treatment, Supervision, and Transition Services in the Community.* Office of National Drug Control Policy, and National Institute on Drug Abuse. (1999). *Principles of Drug Addiction Treatment: A Research-Based Guide*. Washington, DC: National Institutes of Health compiled by Rocheleau, A.,

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