When a Person Isn't a Data Point: Making Evidence-Based Practice Work[1]

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Some years ago my wife and I decided to become foster parents. We have had a number of children placed with us for short periods of time until permanent placement can be established. Most recently, we were asked to take a young girl whose entire family was enmeshed in the methamphetamine drug culture. We got to know this little girl fairly well fairly quickly. We learned about her upbringing, her family, and her life story. In spite of having a Ph.D. in criminal justice and having been a practitioner in the field for a number of years, hearing her story taught me quite a bit about the etiology and persistence of delinquency.

As I one day relayed this story to a friend he said, "…when people aren't data points their stories take on whole new meanings…" Being a realist can be painful. Doing what I do for a living gives me an educated guess what might happen to our little friend. I can also predict our criminal justice system response: "…to help you, we will send you to a cognitive-behavioral program and substance abuse treatment." Knowing what I have now seen firsthand and what I know about the field of corrections, I am led to the conclusion that our cookbook approach to corrections is only half right. More importantly, and disturbing, is the fact that the half that is wrong, is deeply and fatally wrong. When a person is not a data point, her story means something remarkably different and can help us understand things on a level we have not yet before. Evidence-based practice in any field calls for seeing the data point and the person. In this article, we argue that evidence-based practice in the field of corrections recognizes the data points but has been missing the person.

IN 1974, ROBERT MARTINSON published his now-classic essay in which he asked whether "nothing works" in offender treatment. The evidence he amassed gave what appeared to be a clear answer to this question: existing programs were largely ineffective. Other scholars, most notably Ted Palmer (1975), demonstrated that this conclusion was overstated and misled policymakers who were anxious to get tough on crime. Over the ensuing years, the "nothing works" doctrine did much to undermine efforts to create offender change. Still, in the long run, Martinson did corrections a service by arguing that rehabilitative interventions cannot be based only on good intentions; they also must be shown to work. Although he did not actually use the phrase, Martinson was suggesting that correctional interventions should be "evidence-based."

In response to Martinson, a number of scholars took up the challenge to demonstrate that offender treatment efforts could be effective. A key element of this movement was a more complete embrace of the idea that empirical data should guide the correctional enterprise as opposed to common sense, political rhetoric, or "feel good/pop culture." Fortunately, it is now clear that the age of evidence-based decision-making has arrived. Again, this approach, known as evidence-based practice (EBP), had its roots in the works of those defending offender rehabilitation from the nothing works doctrine, including Palmer (1965, 1973, 1975, 1991, 1994, 1995), Gendreau (1996), Gendreau & Ross (1979, 1987), Andrews & Kiessling (1980), Andrews et al. (1990a, 1990b), and others (see, e.g., MacKenzie, 2001, 2006). This concept has grown in popularity not only in the field of corrections but within other service professions as well.

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While we agree that the field of corrections has increased the quality of programming and services over the years (i.e., listening to the data points), we argue that the EBP movement in the field of corrections is widespread but exceedingly shallow (failing to see the person). This is problematic for two related reasons. First, on a practical level, any time an innovation is widespread but the implementation is shallow, it resembles a tree with widespread shallow roots, likely to topple over. Second, without driving this concept deep into the practices of front-line staff, we can never hope to achieve the results that make the work involved in implementing EBP worthwhile. In an effort to illustrate how we have missed the essence of EBP in corrections, we present the history of EBP in the medical field, our observations of EBP in the correctional system, and what must be done to effectively implement EBP and achieve the maximum results of this paradigm.[2]

Evidence-Based Practice: What Is It and Where Did It Come From?

The idea of evidence-based practice originated in the medical field. In the early 1800s, physicians in Europe began investigating how science—namely, research—could be used to better understand the outcomes of medical treatments. Many modern writers on EBP in the medical field recognized these early attempts as the beginning of this movement, while EBP as a concept in medicine didn't really materialize until the twentieth century (Goodman, 2002).

The last 30 years in the medical field have yielded considerable development in the area of EBP. There are a number of excellent definitions of EBP in medicine. See for example that which was offered by Sackett et al. (1996):

> Evidence-based medicine is the conscientious, explicit, and judicious use of current best evidence in making decisions about the care of individual patients. The practice of evidence-based medicine means integrating individual clinical expertise with the best available external clinical evidence from systematic research. By individual clinical expertise we mean the proficiency and judgment that individual clinicians acquire through clinical experience and clinical practice.

And Gray's (1997) definition:

> Evidence-based practice is an approach to decision making in which the clinician uses the best evidence available, in consultation with the patient, to decide upon the option which suits the patient best.

Note that both definitions, and likely any other definition one might find, emphasize a few concepts. Specifically, in the medical field, the use of evidence-based practice involves the intentional use of evidence, decision-making, and focus on the patient. EBP in medicine relies on evidence but posits that evidence alone is not sufficient to make decisions. EBP in medicine also relies on a hierarchy based on the strength of evidence, and interestingly enough the highest form of evidence is an N of 1 randomized controlled trial (Guyatt, Jaeschke, and McGinn, 2002). Why might this be? Among other things this allows for a very individualized approach to treating a particular health problem for a particular patient.

Consider the health problem of increased cholesterol levels and its relation to heart attack. If an individual goes to the doctor and finds out that he (or she) has high cholesterol, the doctor will suggest a treatment (e.g., change diet and begin exercising) based on a number of inputs, such as the presence of other risk factors for heart attack, family history, current lifestyle, and the patient's willingness to make changes in the areas of diet and exercise (Cleveland Clinic, 2012). The doctor will then have the patient return in several months to see if the prescribed treatment is working (Guyatt, Rennie, Meade, and Cook, 2008). If the first attempt at intervention does not appear to be working, the doctor will assign another treatment (maybe proceeding from diet and exercise, which is not working, to taking a statin). Both of these treatment trajectories are based on evidence; as such, they each make good potential choices at the outset, *depending on other risk factors and the magnitude of the problem* (see Smith et al., 2006, Pearson et al., 2002). Even so, neither one might work for any given individual. The doctor only knows that one treatment works when he or she actually has proof that blood cholesterol levels are going down. Please note that lowering the cholesterol level is really an *intermediate* target. The goal of reducing cholesterol is to cut the risk of heart and other vascular diseases (a longer-range target).

Our main point in this brief foray into medical history and treatment is this: In the medical field, evidence has shaped policy *and* individual practice. Doctors use evidence from studies of groups to develop a treatment, but they also use *patient-level evidence* to determine if a particular treatment is working for that patient. "What works" is a statement in terms of policy and general practice, but it becomes a question when it comes to applying practice to any given individual. It is this aspect of EBP—margining evidence-based practice with individual-level information—that we believe is largely missing from corrections.

Getting the Data Point but Missing the Person: Evidence-Based Practice in Corrections

The focus on adopting evidence-based practices has led to a number of positive strides in community corrections. The use of empirical data in the classification of clients is now a widely accepted practice. Supervision and services target the drivers of criminal behavior and are delivered in a mode supported by empirical research. Likewise, policies and practitioner publications are infused with the findings of quantitative and qualitative studies of community corrections programs. While we believe the adoption of evidence-based practices has been shallow, we don't ignore the advancements made with the proliferation of evidence-based policy and treatments in community corrections. The following paragraphs provide a brief summary of research and publications that support our optimism in this regard.

Calculating the likelihood of future criminal behavior has become the foundation of client supervision and an indicator of the adoption of evidence-based practices (Rhodes, 2010). The empirical science of risk assessment has allowed agencies to shift resources from low-risk offenders with low rates of recidivism to those with a higher probability of committing criminal acts (Andrews and Dowden, 2006). Adhering to the research has allowed agencies to avoid exposing low-risk offenders to factors that may increase client risk. In addition to shifting the focus to those

[2] Maruna and Barber (2011) have written a book chapter titled "Why can't criminology be more like medical research?: Be careful what you wish for." In this book chapter, they argue that the pool of research in the medical field has been tainted by the motives of those conducting the research, that there is an over-reliance on RCTs, and that research isn't always used properly. We acknowledge these issues and the fact that they might be present, to some degree, in corrections too. We nonetheless recommend that the field of corrections adopt the same *theoretical* model that has driven EBP in medicine. We should use evidence to guide the development of policy and an initial treatment plan after assessment, and we should seek offender-level evidence that assures us that the initial treatment plan is producing the expected effects.

most at risk, evidence-based practice has shifted the focus of supervision and services to the factors that are most likely to impact a client's involvement in criminal behavior. Instead of focusing on noncriminogenic factors, agencies are targeting antisocial thought patterns, peer associations, and other dynamic risk factors using approaches research has shown generally reduce the likelihood of future criminal behavior. Increased adherence to a model supported by evidence indicates the changes brought about by the adoption of evidence-based practices (Pew 2011a, 2011b, 2011c; for a review, see Andrews & Bonta, 2006; Andrews, Bonta, and Wormith 2006; Andrews & Dowden, 2005 & 2006).

Across the country, more informed policy makers and community corrections leaders are using evidence to formulate policies aimed at reducing recidivism (see for example Or. Rev. Stat. § 182.525 (West), 2003; Ark. Code § 16-93-104 (West), Public Safety Improvement Act 2011; S. C. Code Ann. § 24-21-10 (West); Ky. Rev. Stat. Ann. § 532.007 (West), Kentucky's Public Safety and Offender Accountability Act, 2011; 730 Ill. Comp. Stat. Ann. § 190/10 (West), Illinois' Crime Reduction Act, 2010; and Tex. Bus. & Com. Code Ann. § 501.092 (Vernon), 2009). In addition to changes in policies and day-to-day practice, practitioners are now working closely with researchers to measure and document the impact of newly adopted innovations (Hughes, 2011). The growth of evidence-based practice is also documented in monographs that define theoretical models of evidence-based practice, detail steps leaders should take to improve outcomes, or document practitioner experiences with adopting evidence-based practices (Crime and Justice Institute at Community Resources for Justice, 2009; Eisen & James, 2012; Pew, 2011b & 2011c). Finally, the picture of how evidence-based practice is being adopted in corrections is painted at professional conferences. The bi-annual workshops hosted by the American Probation and Parole Association (APPA), for example, offer a conference track specific to evidence-based practices. Similarly, for nearly 20 years, The International Community Corrections Association (ICCA) has offered an annual research conference featuring "What Works" in community corrections. Keynote addresses have articulated findings that highlight evidence-based practice in the field, and workshops focus on how to utilize evidence in a variety of topic areas.

From the early articles that challenged the findings of Martinson and introduced a new energy for rehabilitation, to the abundance of material that documents the changes in policy and details the results of practitioner efforts, the proliferation of the term "evidence-based practice" is undeniable. There is, however, an unsettling notion that we have somehow missed the mark. These are all great strides and we don't want to diminish them, but without correctional practitioners assessing and determining how an offender is responding to any given treatment and making adjustments where necessary, we have simply gone from one size fits all to another size fits all.

At the center of the evidence-based paradigm is an implied commitment to understanding the individual and using the strategy that provides the best option for achieving the desired result. Many corrections agencies, however, have reduced the message of evidence-based practice to a "this worked for most, so it should work for you" approach that expects all offenders to respond to a mode of service delivery that works for some (data points rather than people). This approach amounts to a one-size-fits-all or cookbook approach that ignores the individual offender's characteristics and runs the risk of labeling "unresponsive" clients as resistant or unwilling to change. Likewise, this approach strips a truly evidence-based approach of its most powerful asset—offender-level evidence.

Many offenders present with similar risk factors, but their individual differences require varied treatment responses (for a discussion of this issue, see Andrews et al.'s 1990 discussion of specific responsivity). Often offenders present with the same set of criminogenic needs, which on the surface would indicate that they need the same intervention. Accounting for responsivity requires that the agency vary treatment delivery depending on other (perhaps non-criminogenic) factors, commonly framed as "barriers" to treatment. Responsivity considerations are wide and varied—which is perhaps part of the reason why agencies have by and large not implemented responsivity-based processes and strategies. Language barriers, IQ, motivation, anxiety, race, and gender may all play a part in developing a plan for responsivity, which will of course require the agency to be flexible and progressive and have the capacity to evolve—rapidly if necessary (something called for below). And of course, relational style is a part of responsivity as well. Perhaps at its most basic, responsivity is about creating strategies to formulate the best response on the part of the offender (i.e., the way they respond to supervision, treatment programming, court-ordered requirements, and the like). We are at the beginning of addressing relational style, and the relationship itself, as these concepts interface with and influence officer/offender interaction, with implications for responsivity and treatment engagement.

For example, most agencies recognize the need to target the anti-social thought patterns of offenders. Most agencies, however, fail to recognize that a generic cognitive-behavioral program may not be the answer for an offender with issues specific to domestic violence, drug abuse, or employment. Or even more generally, agencies may fail to recognize that different offenders might respond differentially to Moral Reconation Training (Little and Robinson, 1988), Reasoning and Rehabilitation (Ross and Fabiano, 1991), Thinking for a Change (Bush, Glick, Taymans, 2011), or Strategies for Self Improvement and Change (Wanberg and Milkman, 1998). The failure to recognize the need for more than one "treatment" has often left agencies scratching their heads and wondering what to do when the first treatment does not seem to work. How can this problem be combatted? In the next section we offer some practical approaches to correcting this troubling trend.

Getting the Point and the Person: Maximizing Effects under Correctional EBP

What, then, does evidence-based practice look like in corrections? Based on Guyatt et al. (2008), there are some identifiable steps that are followed in the medical field that we in corrections should follow too. First, conduct an assessment. Second, define the clinical problem (or in the case of corrections, the criminogenic need). Third, develop a question that guides the retrieval of research and evidence. Fourth, obtain the research and appraise its applicability to the person in front of you. Fifth, craft a response based on the results of earlier studies and apply that response. Sixth, reassess each client to see if the treatment is actually working as well as it is expected to work for the given individual.

One thing we must realize in corrections is the same realization that has emerged in the medical field: Just because a random controlled trial generates a clear answer about the efficacy of a certain treatment, that does not mean that this treatment will work for everyone! That is, as Guyatt et al. (2002:276) point

out, ". . . just because a treatment showed a positive effect in a group of other patients does not mean that the patient before us necessarily will benefit." We need to stop pretending that this statement is not true.

Therefore, true EBP in corrections means that correctional professionals should create individualized intervention plans for offenders based on the results of the research conducted on groups of offenders (this may often be done to some degree already). However, each correctional professional needs to be open to the idea, and on the lookout for signs, that what works based on group data may not work for the individual in front of him or her. If that is the case—that there are no clear signs that the intervention is working for the offender at hand—then the correctional professional needs to adjust the intervention plan to include more intense treatment, a different curricula, or a different treatment approach all together.

What are some solutions that will assist the field of corrections in implementing EBP in a way that is true to the concept and maximizes the effectiveness of this paradigm? First, we need to understand the term EBP and recognize what it is and what it is not. We cannot move further as a system until we stop equating evidence-based practice with potentially—or actually—effective treatments. We need to see EBP as a process of assigning treatment interventions that are based on evidence and then using offender-level evidence to evaluate how well those interventions are working for the individual in front of us (we provide an example of this in the following paragraphs). Second, we need to stop engaging in imitation-based practices (IBP) in which we gravitate toward interventions and practices that are trendy and of political interest or because we see a nearby jurisdiction using the intervention and "liking" it (doing so is not EBP). Third, we need to have access to an array of programs and multiple options within each program type. Fourth, we need to regularly reassess offenders' criminogenic needs to ensure that their risk is going down. That is, we need to regularly "run a blood test" to ensure that the client is responding to the intervention we have prescribed. We now turn to a discussion of the third and fourth issues presented above.

One of the aspects of evidence-based medicine that is clear is the notion that the results of group studies are limited. Although the evidence provided by empirical group evaluations gives medical professionals direction on how to proceed, what was found effective for the group may not work for any given person. Therefore, multiple evidence-based treatments need to be available so that a doctor can try other evidence-supported interventions if the first one fails to bring about desired results.

The availability of more than one empirically supported treatment in corrections is certainly a foreign idea. However, the comments we are making are based on our own experiences in evaluating correctional programs. Most programs and agencies select one cognitive-behavioral curriculum as their "evidence-based practice" and expect that every offender assessed as being in need of cognitive-behavioral treatment should respond to the program. We advocate that correctional programs use cognitive-behavioral curricula, but that they have more than one available and make placements to the differing curricula (and possibly to different facilitators) based on how an offender is responding to a curriculum. That is, if we place an offender in "Thinking for a Change" and no change in thought or behavior can be identified after several sessions, perhaps that offender would be better served by one of the other cognitive curricula available. It is even possible that the offender would be better served by some other bona fide treatment aside from CBT! But alas, we have stopped considering these options and seem pleased to make final policy and individual-level decisions based on group data—regardless of the rest of the evidence (like offender relapse or failure to move into a decreased risk category).

At this point we do wish to re-emphasize that we are not calling for a complete "reshuffling" of the correctional deck, nor are we calling for the field to go back to the time when programming that clearly lacked evidence was implemented carte blanche. The massive and growing body of correctional intervention literature (much of which is cited above) without question provides strong clues as to what we need to be doing in our field to create and sustain offender change. Further, evidence exists about programming and interventions that probably should be dismissed out of hand (at least as far as creating long-term offender behavioral change goes). Rather, we are calling for a more intensified application of what is currently available (in some cases—depending on the individual evidence!), and we are calling for more widely varied options to move away from the "one CBT program fits all" approach, for example. At the same time, we are also calling for continuing research, controlled innovation, and interdisciplinary projects that may drive our field forward.

What else are we suggesting? If adding other cognitive curricula and other treatment modalities sounds complex, there is more. We are also suggesting that correctional practitioners gather evidence on a regular basis about the offenders they are working with to ensure that the empirically supported practice (based on group research) is actually evidence-based for the individual offender in front of them.

What does this look like? Often correctional practitioners report procedures that involve reassessment using the same risk assessment that was used at intake. This might or might not be acceptable depending on the assessment. Most assessments, even dynamic ones, are not sensitive enough to pick up slight changes in risk that are observed over short periods of time. One exception is the Dynamic Risk Assessment for Offender Reentry (DRAOR), which assesses an offender's stable and acute risk factors as well as strengths (Serin, Mailloux, & Wilson, 2010). The assessment of acute factors is done in an effort to guide changes in supervision and/or treatment—again, using evidence at the individual level to ensure that the empirically supported (those based on group data) practices are working to reduce the offender's risk. We might also suggest that correctional practitioners begin having conversations with offenders about relevant risk factors and begin assessing the offender's progress—in a criminogenic need area—each time they interact with the offender. The conversation on the next page is an example of an audio-recorded interaction between an officer and an offender.

There are several features of this conversation that should be noted; however, some background as to how this conversation occurred is in order. First, this offender came into the probation department and was assessed as a high-risk offender with maladaptive cognitions. The officer considered the clinical question (What is the best way to correct maladaptive cognitions for a high-risk offender?) and then tracked the empirical research that bears on this question. The research indicated that the offender should be referred to a cognitive behavioral curriculum and given specialized supervision that targets his maladaptive cognitions. The offender was referred to these treatments. Next, the officer began engaging in conversations with the offender about ways that he has been able to use what

Example of an Audio-Recorded Interaction Between an Officer and an Offender

Officer: Before I turned on the tape we talked about a more recent situation that happened to you. Can you talk about it? What is the external event?

Offender: I went to an AA meeting and I ran into the guy who helped set me up.

Officer: So . . . you ran into what we might call the "snitch." What were your thoughts at the time?

Offender:

1. Man I'd like to beat his [expletive] head in.
2. I could probably get away with it.
3. Ain't nobody gonna know.
4. He might tell on me again, but at least I get to feel better.
5. Does this piece of [expletive] even recognize who I am [this comes out later]?

But then my thoughts were

1. Man, is it really worth going back to prison for putting hands on this person?
2. My sobriety and stuff is way better than that.
3. I enjoy my freedom way too much.
4. Best bet is to just sit down and finish out my meeting.

I even thought about leaving the meeting early, but thought this person ain't worth my time.

Officer: So what I hear you saying is that your commitment to your sobriety has become . . . [offender interrupts him]

Offender: . . . more important.

Officer: How does that feel?

Offender: Feels good—I'm free, I ain't got somebody telling me when I can go [use the bathroom] or when I can eat, I can be me. I'll be able to be a better person to my kids and my father.

he is learning in group sessions and individual interactions with the officer. The conversation above is *evidence* that the offender: (1) acquired the skills being taught to him; (2) can identify situations that are appropriate for the application of those skills; (3) is motivated to use the skills; and (4) sees value in the continued use of the skills. All of this is evidence that the evidence-based treatment is working for this person. Put simply, this whole scenario is how evidence-based practice works. It should be pointed out that the interaction between officer and client transcribed above may well be rare in form and content.

We should use evidence-based treatments (based on the analysis of groups of data) and then make sure there is evidence that any given treatment is working for any given individual. How does someone have the types of conversations listed above? We put forth that the types of conversations listed above increase our ability to truly practice EBP and are also contingent upon the relationship between the corrections professional and the offender. We turn to this topic briefly to highlight such relationships' necessity—yet insufficiency—in bringing about offender change.

Relationship: What's Old Is New Again

Several authors have investigated the competing roles that many have assumed community supervision officers have (see, e.g., Clear & Latessa, 1991; Whetzel, Paparozzi, Alexander & Lowenkamp, 2011; Purkiss, Kifer, Hemmens, & Burton, 2003). These competing roles are often cited as some version of "law enforcement" versus "social worker," which in essence (and in theory) pits the importance of rule following and accountability against human service delivery and rehabilitation. While authors continue to study the existence and/or effect of role conflict (Lambert, Hogan, & Tucker, 2009), what may matter most is how the officers see their own role in the landscape of offender intervention.

In light of the importance of the role or mission of supervision officers, increasing attention has been paid to the interactions between officer and client. With increasing caseload size, particularly in recent decades, the amount of time each meeting takes has been of concern. While the field of community supervision moved beyond the "casework era" and into the "brokerage era" (which was followed by the "justice model era"), the emphasis of the officer/offender interaction became rule-oriented. In other words, whether offenders were following all the legal and extra-legal stipulations of their supervision was of primary focus philosophically as well as out of necessity (due to presumed time/resource constraints). As such, when officers met with offenders, they tended to ask questions and gather information that pertained solely to the requirements of supervision (e.g., drug testing, contact with law enforcement, gathering restitution payments, address changes, and the like). This continued despite the widespread dissemination of "Evidence-Based Practices" and the "What Works!" literature and related research that largely reveals, globally, what the most effective strategies for long-term behavioral change are. In short, the importance of the interaction between offender and officer was diminished, at least as far as the promise for behavioral change was concerned. The conventional wisdom dictated that officers were spread too thin to conduct any meaningful interaction. Further, "treatment" and behavioral change were largely viewed as resting in the hands of treatment practitioners—that is, programming of some kind, which until recently has been viewed as separate from the act of "supervision." Even if officers were inclined to harken back to a "casework" or "social work" era, the short amount of actual time spent with offenders was viewed as insufficient to evoke any real change and better spent on the "administrative" functions of supervision, briefly noted above.

The prevailing view toward the use of officer/offender interaction (specifically regarding the prospect of long-term behavioral change) took a turn when efforts were made to take

an even closer look (beyond just "amount of time") at what officers spent their time on. In an effort to look inside the "black box" of correctional supervision, Bonta, Rugge, Scott, Bourgon, and Yessine (2008) rigorously analyzed the subject matter that officers covered, as well as some aspects of the qualities of the interactions with their clients. Overall, Bonta et al. found much room for improvement in the extent to which officers covered criminogenic needs as part of their officer/client interaction. However, they did find evidence that recidivism may decrease the more criminogenic needs become the central focus of client meetings and discussion. In a somewhat related piece, Andrews, Bonta, and Wormith (2011) examined the Risk Need Responsivity (RNR) model alongside the Good Lives model (GLM) of officer/client interaction. The RNR model emphasizes the need for supervision to utilize the risk and need principles, while being responsive to individualized needs of the offender. The GLM model emphasizes relational style (among other things) when it comes to the tone and tenor of the officer/client meeting. In actuality, the RNR model appears to offer everything the GLM model does; however, RNR remains rooted in evidence-based practices and by definition incorporates the principle of responsivity, which emphasizes attention to relational style.

On an international level, many training curricula for correctional practitioners have been developed [for example, STICS (Bonta et al., 2008), EPICS II (Lowenkamp, Lowenkamp & Robinson, 2010), Working with Involuntary Clients (Trotter, 2006), and IBIS (Lowenkamp, Koutsenok & Lowenkamp, 2011)] with additional, well-thought-out, discourse on this important topic (see Burnett & McNeill, 2005; McNeill, Batchelor, Burnett, & Knox, 2005; and McNeill, 2009). These curricula and writings in part focus on resolving the seemingly contradictory aspects of the correctional practitioners' dual role and establishing trusting and functional relationships with the offenders they work with. They also focus on increasing the motivation of offenders to make desired changes and identifying what officers need to assist offenders in making changes once the offender is motivated to change.

The qualities of the officer/offender interaction were further examined by an evaluation of the Staff Training Aimed at Reducing Re-Arrest (STARR) model of supervision, currently in use in the federal probation system (Robinson et al., 2012). The STARR model is based largely on RNR—requiring the officer to observe and incorporate risk, address criminogenic needs, and incorporate responsivity considerations into their interactions with the offender. In addition, officers trained in STARR utilized techniques designed to increase motivation and identify (and address) criminogenic cognitions in an active manner. The evaluation found that clients of officers trained in STARR recidivated at lower rates than those of officers who had not been trained in STARR (Robinson et al., 2012). An extension of this study using a 24-month follow-up period demonstrated that offenders supervised by STARR-trained officers had better outcomes than those supervised by untrained officers. Further, high-risk offenders had the best outcomes when supervised by an officer trained in motivational interviewing *and* STARR (Lowenkamp, Holsinger, Robinson, & Alexander, 2012). Other similar evaluations of officers applying RNR in their one-on-one interactions with offenders have produced similar results (for example, see, Bonta et al., 2008; Trotter, 1996; Taxman, 2008).

The above examples represent a tremendous shift in community corrections. Perhaps most obviously, the content of the officer/client interaction is examined in both pieces of research. There may be real benefit in moving away from "rule enforcement" toward a concentration on crime-producing factors. In addition, the qualities of the officer-offender interaction were of concern in both of the above examples. Support was shown for a warm, motivating tone when interacting with probation clients. The most radical shift, however, may come in considering the officer as an agent of change. The "casework era" mentioned above may have been a period when the probation officer likewise was viewed as an agent of change, and at least in some small way responsible for the offender's behavior (recidivism). Community corrections in the U.S. moved away from this idea of "officer as agent of change" due to a number of factors, in favor of a more "administrative" function for community supervision officers. As mentioned above, treatment was viewed as the purview of counselors and programming personnel, not the probation officer. Adhering to this "administrative" perspective may limit effectiveness, however.

While there may be real promise in shifting to a criminogenic needs-based framework for interacting with clients, and promise as well in creating a more warm and motivating communicative environment, we would like to go at least a bit further, in keeping with the purpose of the current paper. Specifically, there may be additional benefit in proposing the need for community supervision officers to establish real and meaningful relationships with their clientele. What we mean by relationship is a palpable bond between officer and client, where each recognizes the other as an important part of their "professional" world (professional, at least, on the part of the officer—for the offender, the viewpoint may be something different). Clearly there are risks inherent in establishing any sort of relationship with a client—chief among them being the power differential that is inherent in a probation officer/probationer dyad. On a similar note, we are advocating for a complete and uncompromised preservation of professionalism and boundaries when it comes to human interaction. Nonetheless, the current article is about seeing the person—the human being—behind the data that pertains to so much of our field of study. Recognizing and respecting the human-ness of probationers through a palpable relationship may hold promise if our objective is to reduce the likelihood of recidivism.

Generally, the greater the amount of pro-social social support an offender has, the better off they should be (Cullen, 1994). Skeem, Louden, Manchak, Vidal, and Haddad (2009) put the amount of social support to the test when working with probationers with co-occurring (substance abuse and mental illness) disorders. Skeem et al. (2009) demonstrated that the more pro-social support an offender had, the better the offender's outcome when measured as recidivism. It should be noted that the main relationships that mattered were those with the clinicians; however, the relationship that a dually-diagnosed probationer had with an officer mattered as well when predicting perceived coercion, adhering to the treatment model, and future technical violations of supervision (Skeem et al., 2007; see also Skeem et al., 2003; and Kennealy, Skeem, Manchak & Eno Louden, 2012). Higher-quality relationships (as assessed by the strength of the bond and the degree of emotional warmth) mattered when predicting failure. Likewise, drug court participants performed better when they experienced a pro-social bond with the presiding judge (Gottfredson, Kearley, Najaka, & Rocah, 2007). The authors speculate that the clients did well because they did not want to "let the judge down" due to the bond they had.

What does it mean to have a high-quality relationship between a community supervision officer and a probationer? There is no single answer to this question; however, a place to start might be by acknowledging the complexities inherent in any human being's life. Vogelvang (2012) points out many of these complexities, and the need to learn about, empathize with, and incorporate them into the officer/client dyad. When we fail to acknowledge these complexities, the "view of the offender as an authentic and autonomous person, with his own intentions and initiatives, is lost" (Vogelvang, 2012, p. 3). One way to begin acknowledging human complexities might be through having the wherewithal to put ourselves in another person's position in an effort to truly understand that person and his or her motivation. To put ourselves in the position of another, we would have to be willing to enter the offender's world, at least proximally, in order to see everything that shapes that person. Understanding the offender's world requires taking a risk—not grave risk, but risk nonetheless, as doing so is certain to cut against the grain of the status quo.

Are "warmth" and "genuineness" wrapped in "ethics" something that can be taught? Certainly some skills can be taught in the context of a training that would increase the likelihood of an officer doing a better job of interacting with and relating to a client. The larger challenge is probably at the organizational level. There should not be any need to revise any fraternization rules that exist in agencies today. We are not calling for any "hug-a-thug" programs that compromise the authority or integrity of the agency. Likewise we are not calling for any approval of criminal behavior. We are, however, calling for an understanding *of* that behavior and a willingness to see the person as a person, separate from the behavior they may have engaged in.

When the offender feels as though his or her officer truly cares about the outcome, the offender may be more likely to invest emotionally in the officer. This in turn may help the offender to comply with rules and engage in treatment opportunities. When the officer feels as though the offender really needs the officer and looks to him or her for guidance and help, the officer may feel an added sense of responsibility that encourages him or her to remain engaged with the offender. Clearly, more research is needed in this area; however, two meta-analyses from the psychological literature may help inform this issue. When examining the effectiveness of various psychotherapeutic interventions, Wampold et al. (1997) and Miller, Wampold, and Varhely (2008) found essentially no difference in effectiveness between the varying modalities. On the surface, this result might suggest that, when it comes to psychotherapy, the specific style doesn't matter; the outcome will be the same. This does not make intuitive sense in an age (at least in the field of corrections) where we are currently struggling to find more effective treatment modalities. Why might a multitude of methods render an overall effect size of "0" regarding treatment effectiveness? There are a number of plausible explanations; one viable one might be that the skill of the therapist mattered more than the method employed. This in turn would suggest that the quality of the one-on-one relationship between psychologist and client was very important. Perhaps the same is true for the community supervision officer and the client relationship. Perhaps it is even more important in light of the paucity of social support most offenders in the United State have.

Putting the Individual and the Evidence in EBP

There should be little argument that EBP has penetrated the professional practice of corrections both in the community and institutionally. Perhaps most notably, the extent to which EBP vocabulary and practice have spread throughout the U.S. and other countries may have permanently put to rest any debate over the potential efficacy of rehabilitative efforts. The research highlighted above and the body from which it came demonstrates the futility of punishment by itself if long-term behavioral change is the goal, and further demonstrates some treatment practices that show promise. Please note, however, that we are yet dealing with "potential" and "promise," compared to where we believe the field could go. As such, much of what we have shared above leads us to believe that at least two general changes need to be made in order for the field to truly realize the promise of EBP. First, practitioners need to do what they are currently doing under the EBP umbrella better. Second, practitioners need to add skills and practices to their professional arsenal. What follows are some recommendations for the field of correctional practice.

The formation and use of an "offender case plan" is by no means a new practice in corrections. However, we are calling for a re-examination of the case plan, its purpose, and most importantly its implementation. In a word, case planning needs to become more individualized, in keeping with the very nature and theme of this entire article. Case plans, of course, need to use existing/archival information from the offender's files, as well as current, relevant, and dynamic information from actuarial risk/need assessments. However, too often the entire assessment process relies too much on just one comprehensive risk/need assessment, which may largely if not entirely ignore the domain of responsivity. Anyone who has experience in training, implementing, and/or validating assessment tools of any sort should appreciate what a herculean undertaking it can be, organizationally, just to implement one existing tool! Nonetheless, while the function of offender assessment has come a long way, more work needs to be done. Agencies should no longer be satisfied with the use of one comprehensive risk/need tool, but should instead treat that tool as a starting point in a "graduated assessment process."

Specifically, processes should be in place that allow for additional valid assessment tools that dig deeper into specific criminogenic domains once they are identified using the first global "triage" assessment. For example, most comprehensive third-generation risk/need assessments have the capacity to identify the existence of criminogenic cognitions. Identifying and recognizing criminal thought processes is an important first step in assessment and in turn case planning. But how many agencies then administer a more in-depth process to assess and analyze criminogenic thinking on its own? If an agency intends to address a specific criminogenic domain, particularly via rehabilitative intervention, a more in-depth analysis of each criminogenic domain should be conducted, beyond the initial global assessments that are commonly found in use today. We recognize that this task may represent a tremendous burden, as new assessment tools mean additional training, piloting, and validation, all the while making any number of adjustments in processing and policy over the long term. This additional assessment information will lay the foundation for making the case planning process more individualized as mentioned above, but even this is just a start.

In addition to using more assessment tools in a graduated fashion, the case plan needs to become a "living document" that truly records and responds to offender change as they engage in supervision and programming. As noted above, a truly effective intervention

process will involve knowledge of what the literature says will be effective, along with observation and measurement of the subject, which includes feedback *from the subject*. Correctional practitioners will need to engage offenders more; they will have to know how to solicit the kind of feedback necessary to gauge progress from the offender's perspective, as well as from their own (in conjunction with the additional assessment processes referred to above). Gleaning this type of feedback through practitioner-offender interaction will allow for an individualized case-planning process that assesses progress on a "micro," ongoing level, allowing for adjustments along the way in order to maximize effectiveness. Put plainly, this sort of case planning based on a much broader array of information and processes will allow practitioners to know "what works" and what does not, *for the individual*.

Along with changes in information gathering and case planning processes should come a willingness to create and value real relationships with clients. Again, we wish to reiterate that we are not recommending doing away with or even altering ethical rules and codes of conduct that relate to and govern the professional-client dyad. However, based on the evidence that shows the results that can be produced by changing the content of the practitioner-offender interaction, as well as the tone and tenor of the interaction/relationship, a discussion of "relationship" appears warranted. We are referring specifically to the need to create something resembling an emotional investment in the offender's progress and ultimate success (and vice versa). It might be true that most practitioners "want," in theory, all their clients to succeed, simply because it might seem odd (or perhaps not in some isolated cases!) to hope for a negative outcome. However, if practitioners are on some level truly and emotionally invested in their clients' success, some of the other changes we are suggesting might come a little easier (e.g., the individualized case planning process, soliciting offender feedback, and the like).

In order to facilitate the creation of a professional practitioner-client relationship, processes should be put in place so that supervising officers receive esteem from the progress their clients make, including of course long-term success. Central to this sort of emotional investment is the ability and willingness to empathize, if not sympathize, with offenders. A true understanding of criminogenic behavior should also include knowledge that environmental factors beyond an individual's control contribute—greatly in some instances—to the making of a criminal. That being so, the practitioner should recognize on some level that he or she might also have taken on a preponderance of antisocial thinking and behaviors if born into different circumstances.

One of the themes that we hope is evident throughout this article is the assertion that there needs to be a revival of the idea that supervision officers and correctional workers can be change agents, playing an active role in shaping behavior in small and incremental or even large ways. We fully acknowledge that officers have for many years been "change *facilitators*," playing an administrative role in case management, case planning, making recommendations, and keeping track of (again) the "administrative" side of probation/correctional work. These tasks have come to dominate how we have "done" corrections and supervision for the last 20 years. We are not arguing that officers should become change agents to the *exclusion* of being officers. However, we are arguing that while officers should never lose their officer role, they should not be officers to the exclusion of being change agents as well. We are calling for the field of corrections—administrators, practitioners, and researchers—to work on finding ways we can blend these two roles. More research is needed regarding 1) what the "relationship," the "emotional investment," and "empathy" should look like, 2) how to teach the skills necessary to implement these themes, and 3) how to put them into practice. The last quality—empathy—may be the most important key. Of course, empathy by itself does not have much of an effect on recidivism (Trotter, 2006). But without empathy, it is difficult to have meaningful interactions. Empathy on the part of supervision officers and correctional workers may indeed provide the conduit to help offenders change if they choose to do so.

In order to facilitate the recommendations noted above, correctional agencies need to start hiring staff—all staff—based in large part on relational style, interpersonal skills, and personality. Once attained, this information should be used to match offenders to specific officers, and to treatment personnel as well. Further, we recommend that agencies have formal mechanisms for assessing these particular attributes. Traits such as a lack of empathy could be used to screen people out of the hiring pool, better insuring that new staff begin their jobs with the skills that the agency is looking for. At the very least, agencies should be able to articulate and show evidence of the ways in which they screen for relational style (specifically within the context of the officer-client interaction), interpersonal skills, and personality.

While the hiring of the "right" staff is an important part of the discussion that surrounds agency transformation, we also wish to re-emphasize the need for training existing (and new) staff. In other words, it is not just about hiring the right staff, but also (and perhaps more importantly) having training available that can transfer necessary skills and characteristics to existing and new staff that are hired. We have mentioned training several times; however, we wish to highlight the necessity for patience when staff are expected to acquire new skills, use them effectively, and make them part of the broader agency's mission and procedures. We are calling for realism about how long it can take for even new vocabulary to become part of an organization's lexicon (consider, for example, that NIC's "What Works!" curriculum and the generations of EBP curricula that followed have been around for 20 years so far, and we have just now reached the point where the "vocabulary" is prominent among correctional workers in general—for better, and perhaps for worse in cases of "over-familiarity"!). In brief, agencies must determine what skill sets and characteristics their staff should have, and hire accordingly. Simultaneously, agencies should pay particular attention to the need to make available good training that will transfer the skills, knowledge, and characteristics that the agency desires to affect change in the offenders they work with. Good training is rarely (if ever) a one-shot course or series of courses. For example, skill acquisition, just like good cognitive-behavioral programming, requires active learning, modeling, testing, time for "real-world" practice, re-testing, re-training, and certification.

Once hired, staff should be considered to be in a probationary period themselves, during which their interactions with the offender will be observed and assessed by trained professionals/supervisors. Interactions should be assessed and rated (with regular and frequent feedback provided to the professional) on the content and form of the professional/client interaction—things like warmth, focusing on criminogenic needs and targets, use of real-life examples to identify and correct thinking,

refraining from the use of shame, learning about the offender's life outside of the justice system, and establishing a palpable relationship—should all be part of observation/feedback processes. Use of these skills and others should be part of the professional's performance assessment during and beyond the probationary period, with promotion and pay incentives tied to their mastery.

Most if not all of the recommendations outlined above rest on another necessary change within corrections: more programmatic options. As noted above, agencies often make great progress when they go from using no assessment tools (or an outdated/invalid assessment tool) to using a comprehensive third-generation assessment tool. While the use of these sorts of tools represents positive change, it is not enough—hence our recommendation for a "graduated assessment" tool procedure. The same can be said for the use of curricula—specifically cognitive-behavioral curricula. For example, positive (EBP-based) change can be observed on the program level when an agency replaces an ineffective treatment model or curriculum with a cognitive curriculum (such as "Thinking for a Change"), particularly when the agency also takes steps to utilize behavioral change techniques alongside or integrated within the curriculum itself. However, one curriculum is unlikely to be "enough" for any agency/program; in fact, in light of our call for a more individualized approach to correctional intervention, just one curriculum cannot be enough. In short, to allow for a more individualized approach to intervention, an agency's EBP toolbox should contain many different tools, in the form of different curricula.

Conclusion and Recommendations

We are calling for a renewed commitment to and an intensified application of several things that began (or began again) with the EBP movement. We are not quibbling with the progress that has been made—clearly the field has been transformed. However, as a discipline we may be missing the mark by concentrating on implementing specific procedures and strategies, at the expense of concentrating on the individual offender. When we force ourselves to see the person behind the "data point," recognizing that person's humanity and our shared experiences, we will be much more likely to behave in ways that should better ensure long-term behavioral change and success. In sum, we believe the evidence that exists—evidence that shows the promise in several strategies—supports the following recommendations that may move our field forward:

- Case planning needs to go far beyond identifying "goals," "objectives," "completion criteria," and "who is responsible." Case planning needs to be born out of the creation of a living document that is supported by actuarial assessment, professional discretion, real offender input, and consistent re-evaluation leading to the adjustment of treatment and supervision trajectories. Moreover, agencies and offenders may benefit from case planning that captures the true essence of the individual and allows for important variation to inform and influence intervention.
- Agencies need to assess for responsivity, and use the information not just in the case planning process, but also to plan for and implement necessary changes. As noted above, responsivity can cover a number of different factors and undoubtedly requires the use of any number of various assessment processes that in turn will require additional training and expense. Regardless of the effort and expense, the time has come to move far beyond what currently amounts to agency-level lip-service when it comes to addressing the responsivity concerns at work in the individual offender's life.
- Agencies need to use a "graduated assessment" process whereby a comprehensive/global risk/need assessment instrument serves as just the first step. Once specific criminogenic areas or domains are identified, additional, more specific and more sensitive assessments should be utilized that "drill deeper" into the various criminogenic areas that were identified through the comprehensive risk/need assessment tool. This enhanced assessment information can then facilitate the assessment of progress, the individualization of the case plan, and the transformation of the case planning document into a "living" document.
- Agencies and practitioners should begin discussing the role of "relationship" in correctional practice and take steps to implement ways in which practitioners can truly invest in an offender's progress and fate. This discussion will almost certainly reveal the need for training and adjustments to policy, and may in turn identify the need for changes in the way offender progress is measured, as well as in the way practitioners are evaluated.
- Correctional agency hiring practices should always include the assessment of personality characteristics and relational styles that facilitate the changes recommended above. Clearly, working with the offender population is not for everyone—not everyone has the skill set necessary to become an agent of change, having a real, palpable, and positive effect on an offender's life. Unfortunately, "corrections work" in many venues may be viewed as a "last resort" vocational option or one that "traps" an individual in a low-paying government-funded agency where the earliest-possible retirement becomes the goal, rather than more humane objectives. As a result, the profession may currently have a tendency to attract people for whom pro-social offender change is not a central part of their professional purpose. While we do not have an easy solution to the issues surrounding what may be lower-than-average salaries, we do believe that when people are paid more, more can be expected of them.
- All staff in a correctional environment, once hired, should undergo a probationary period where they are required to demonstrate all the skills we are advocating here before being removed from probation. This will of course require that the staff member's skills be observed and assessed by a trained and qualified supervisor, if not (or in addition to) a clinical supervisor. In addition, once a staff member is removed from this probationary period, he or she should be subject to periodic and rigorous reassessment, evaluation, and feedback regarding the use of these and other skills related to creating pro-social offender change.
- Last but not least, correctional agencies simply need more options, as noted above. If we are correct in our advocacy for individualizing the correctional supervision and treatment process, agencies need to have the capacity to do so with integrity. Moving beyond a "one size fits all" model, by definition, will require that an agency have many more "sizes."

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