What Works (What Doesn't Work): The Principles of Effective Correctional Treatment

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The "Nothing Works" Debate

It is doubtful that any single criminal justice issue has attracted as much attention during the past thirty years as has the "nothing works" debate. Readers who were professionally or academically active during the 1970s will remember the impact of Martinson's (1974) and Lipton, Martinson, and Wilks' (1975) research on criminal justice policies. After examining 231 treatment studies published between 1945 and 1967, Martinson (1974, p. 48) put the crux of the matter succinctly when he asked: "Do all of these studies lead irrevocably to the conclusion that *nothing works*, that we haven't the faintest clue about how to rehabilitate offenders and reduce recidivism?" Although Martinson was certainly not the first to despair of the futility of developing effective correctional treatment programs (see, e.g., Bailey, 1966; Cressey, 1958; Kirby, 1954), the social context during the 1970s meant that his message resonated with policy makers and readily became canon in schools of criminology (Cullen & Gendreau, 1989, 2000, 2001). Deterrence strategies (Wilks & Martinson, 1976), rather than rehabilitation, subsequently became the panacea in correctional circles in the United States; this was evidenced by the dramatic increase in the use of incarceration as well as intermediate sanctions in community corrections (Erwin, 1986; Mauer, 1999).

Reviving Rehabilitation

By the late 1970s, it appeared that the proponents of rehabilitation would not recover from the fatal blow they had been dealt. As it turned out, however, rehabilitation was only delivered a technical knockout. A few indefatigable, lonely voices in the United States persisted in advancing the notion that the rehabilitative agenda continued to have appreciable merit and that, at the very least, further research would uncover "which methods work best for which type of offender and under what conditions" (Palmer, 1975, p.150; see, also, Cullen & Gilbert, 1982). Shortly thereafter, Martinson (1979) moved closer to Palmer's position, although no one paid heed to his recantation at that time.

Some American psychologists also joined the battle (Emory & Marholin, 1977; Quay, 1977). They pointed out that the reason many correctional treatments failed was because they lacked therapeutic integrity, that treatment staff were poorly trained and did not adhere to the principles or techniques they were supposed to employ (Gendreau & Ross, 1979, p. 467).

Meanwhile, several Canadian psychologists—e.g., Andrews, Ross, and Gendreau—began reporting on demonstration projects and publishing a number of narrative literature reviews attesting to the utility of the rehabilitative ideal (for a publications list, see Gendreau, 1996b; Gendreau, Smith & Goggin, 2001, p. 243). The significant contribution emanating from their work was a look into the "black box" of treatment programs. In other words, unlike Martinson and his followers, Andrews, Ross, and Gendreau believe it is not sufficient just to sum across studies or file them into general categories. The salient question is what are the principles that distinguish between effective and ineffective programs?—what exactly was accomplished under the name of "employment"? By endorsing the perspective of opening the "black box," these authors have been able to generate a number of principles that characterize effective and ineffective programs (Gendreau, 1996b, p. 118).

From this viewpoint, these researchers (all with extensive field experience as clinicians) proffered a number of principles of effective

See *PRINCIPLES*, next page

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Frequently Used Terms in Correctional Rehabilitation

Criminogenic Need

There are two basic types of criminal risk factors: (1) static, which cannot be changed (e.g., criminal history, biological factors); and (2) dynamic, which are malleable. Dynamic risk factors are also known as criminogenic needs, which represent an offender's ways of thinking and behaving that support his/her offending behavior. Because they are amenable to change, dynamic risk factors are appropriate targets for intervention and case management. Some of the leading criminogenic needs are attitudes, feelings, and values favorable to law violation, antisocial peer associations, problems associated with substance abuse and lack of self-control, and self-management skills embedded in an antisocial mind set.

There are also needs that are non-criminogenic; that is, these factors have not been linked with criminal conduct. These are anxiety, low self-esteem, and vague emotional/personal complaints.

Intermediate Sanctions/ Community-Based "Get Tough" Programs

The programs that fall under the categories of intermediate sanctions/community-based and "get tough" programs are grounded in the belief that if an offender does not comply with the parole/probation conditions, then he/she is subjected to threats of impending dire consequences (e.g., immediate arrest, return to prison, harsher sentences, more surveillance), which will be enough to suppress criminal behavior. Intermediate sanctions either have stand-alone features such as electronic monitoring, drug testing, house arrest, restitution, and augmented surveillance checks in addition to that of regular probation, or various

See *TERMS*, next page

TERMS, from page 4

combinations therein. Scared-straight programs and boot camps are also occasionally part of intermediate sanctions.

Phenomenological and Psychodynamic Therapies

Within the theories of personality literature, these two conceptualizations of personality are quite distinct (Liebert & Spiegler, 1998). In corrections, one frequently encounters programs where these two are conjoined. Taken as a whole, these "talking" therapies involve establishing a good relationship with the client as the primary goal, fostering positive self-regard, promoting self-disclosure, insight, and self-actualization, unraveling the unconscious, and allowing for the externalization of blame and venting of anger.

Reinforcement

Reinforcement increases prosocial behavior so that it will be repeated in the future. Behavior therapists emphasize the use of positive reinforcement of which there are three general types of reinforcers:

- Tangible, e.g., money or material goods;
- Activities, e.g., sports, music, TV, shopping, socialization; and
- Social, e.g., attention, approval, praise.

In contrast, punishment, which, albeit effective, is less often used for a variety of technical and ethical reasons (Gendreau, 1996b), attempts to suppress behavior through the use of unpleasant or harmful consequences to antisocial behavior.

Relapse Prevention

Relapse prevention trains clients to anticipate problem situations and rehearse and practice alternative prosocial responses to cope with difficult situations in their environment that may lead to conflicts. Significant others are trained to offer support, and the opportunity is made available for offenders to return to the program to relearn/reinforce the necessary skills.

Responsivity

There are two kinds of responsivity, general and specific. General responsivity refers to behavioral treatments of the sort noted above. Specific responsivity pertains to the interaction between the style of service delivery and offender and therapist characteristics. There are three ways in which this occurs with a behavioral program:

- The style of service delivery is congruent with the learning style/personality of the offender;
- Offender characteristics are matched with those of the therapist; and
- Therapist methods of teaching and relating are compatible with the program service delivery components.]

Examples of each of these responsivity elements can be found in Gendreau (1996b, p. 123).

Treatment/Behavioral Treatments

Within the rehabilitative context, treatment is usually referred to as a planned intervention that targets aspects of an offender's attitudes, behaviors, and life circumstances that contribute to his/her criminality. Interventions are meant to increase prosocial behaviors. Rehabilitation does not include get tough strategies (e.g., boot camp) that are designed to suppress criminal behavior.

Those emphasizing behavioral treatments stress that the therapeutic relationship is based upon openness, warmth, and empathy, with a firm yet fair application of reinforcement contingencies. There are three general classes of behavioral treatments, the techniques of which overlap, particularly with regard to social learning and cognitive therapies. Behavior therapists often incorporate techniques from each of the following (a recommended strategy in our view):

Operant Conditioning. Radical behavioral treatments are based on the principle of operant conditioning, whereby prosocial behavior is immediately reinforced (sometimes called "contingency management") using positive reinforcers. Token economies are typical of this genre. The offender earns points for achieving specified prosocial goals. The points can then be used to obtain items from a menu of reinforcers.

Social Learning. Social learning programs rely extensively on modeling of appropriate behavior and then having the offender engage in repeated behavioral rehearsal to develop a sense of self-efficacy in mastering the necessary prosocial skills. Assertion training is also a part of social learning programs.

Cognitive Behavior. Cognitive behavioral techniques endeavor to change the offender's cognitions that maintain the undesirable behavior. Cognitive behavior therapists utilize cognitive restructuring, problem solving, structured learning, reasoning, and self-control techniques (see Spiegler & Guevremont, 1998, for a description of the different "schools" of cognitive therapy, as well as for a good overview of all forms of behavior therapies). ■

PRINCIPLES, from page 4

treatment. The most important among these principles is that behaviorally oriented therapies should target the criminogenic needs of those assessed at high risk of reoffending (see sidebar for descriptions of frequently used terms in the treatment literature).

The Meta-Analytic Revolution

Depending on one's point of view, the narrative reviews of Andrews, Ross, and Gendreau were either convincing or greeted with skepticism. For cynics of rehabilitation—and they were in the majority—these revisionist claims could be largely dismissed because of the biases inherent in the narrative review process (e.g., subtly selecting and emphasizing studies favoring a rehabilitative ideology). Another frustrating facet of narrative summaries was that they were maddeningly imprecise. As Gendreau, Goggin, and Smith (2000) remarked, re-reading some of the most cited testimonials to rehabilitation (e.g., Gendreau & Ross, 1987) was an exercise in futility. No detailed summaries of the numerical magnitude of the effects of various treatments were ever provided outside of simple-minded box score summaries to the effect that "10 studies favor this treatment versus 7 for another" or "the results seem promising," etc.

Coding Studies. Fortunately, quantitative approaches to summarizing large bodies of literature appeared in medicine and psychology about 20 years ago (see Hunt, 1997) and belatedly found their way into criminology. This methodology, called meta-analysis, is an exercise similar to assessing all attributes of an individual using a psychological test, but in this case, the focus is on the treatment study itself. Studies are coded on a variety of dimensions, such as the:

- Type of setting;
- Nature of subjects;
- Type or dosage of treatment;
- Quality of the research design; and
- Effect of the treatment (compared to a comparison group) on the outcome of interest.

See *PRINCIPLES*, next page

PRINCIPLES, from page 5

Deriving Effect Size. The end result of a meta-analysis is that a precise estimate of the effect of the treatment, called an "effect size," is derived. To better gain an appreciation of the way in which researchers report their results, we might draw upon an election poll example. Imagine that in a forthcoming gubernatorial election in your state, pollsters reported that, on the basis of a survey of 2,000 citizens, 48% of respondents supported candidate Z and the 95% confidence interval (*CI*) was 44% to 52%. (The confidence interval is calculated to mean that the probability is .95 that this interval contains the true population value. The *CI* estimates the margin of error when only a sample of the citizens were surveyed. Of course, if all of the citizens were polled [a practical impossibility] and the results stayed the same, there would be no need to provide the *CI*. The exact result would be 48%.)

Pearson Correlation Coefficient. One of the statistics often used to estimate treatment effects or the effect size is the Pearson correlation coefficient (r) and its confidence interval. Thus, in the corrections treatment literature, the reader will encounter statements such as the following: "Programs that follow the principles of effective treatment produce an effect of $r = .26$ with a 95% *CI* of .21 to .31." This means that recidivism was reduced by 26% ($r = .26$) in contrast to a comparison group(s) and that the probability is .95 that the *CI* of 21% to 31% includes the true population value of the treatment effect. In addition, the researcher can also estimate changes in the magnitude of the effect depending upon the type of offender, treatment dosage, and quality of the research design. From a policy perspective, the meta-analytic process provides more definitive conclusions than typical narrative reviews, in which vague and sometimes contradictory conclusions are often the order of the day (Gendreau, Goggin & Smith, 2000).

Far More Informative Than Narrative Reviews. Although meta-analyses are not foolproof—both the choice of variables for coding and the accuracy of coding are subjective, not to mention that the inadequacies of individual level studies always pose problems of varying degrees—meta-analytic reviews have been found to be far more informative than narrative reviews with regard to adequately describing studies (e.g., study description, procedures, methods, and the magnitude of the treatment effect; Beaman, 1991). Finally, one can replicate a meta-analysis (the conclusions from meta-analyses are much more consistent) and extend it by gathering more studies in the future. Imagine the difficulties in replicating narrative reviews in which the biases are often subtle and covert, and which are often so large in number that the mind simply cannot systematically process the myriad outcomes and study characteristics in a reliable fashion.

"Do all of these studies lead irrevocably to the conclusion that nothing works, that we haven't the faintest clue about how to rehabilitate offenders and reduce recidivism?"

Applying Meta-Analyses. What better way, then, to test the emerging literature on the principles of effective treatment than by applying meta-analytic techniques. The first meta-analyses appeared in the mid-1980s (Davidson et al., 1984; Garrett, 1985; Ross & Fabiano, 1985; for a review, see Gendreau & Ross, 1987, pp. 391–394). For the most part, these pioneering attempts at quantitative synthesis of this literature were prescient. The many meta-analyses that followed, by either the Canadian group or others, confirmed the general thrust of earlier meta-analytic reports (Andrews, 2001; Lipsey, 1992; Redondo et al., 1999; see McGuire, 2002, for a summary of 34 meta-analyses). More importantly, these meta-analyses essentially endorsed the narrative reviews of 10 to 15 years earlier (Gendreau & Andrews, 1990). Correctional treatment does work, on average, and recidivism is reduced by approximately 10% and by two to four times more if combinations of various strategies (e.g., behavioral programs targeting criminogenic needs) are employed. We do not want to mislead the reader into believing that the issues are all neatly resolved in this area. Complexities abound, and certainly more studies are needed to refine and extend the conclusions from meta-analysis (Andrews & Bonta, 2003). For the purposes of this paper, however, we now turn to our exposition of the principles of effective treatment. We also wish to recommend to our reader other informative presentations that express the principles within a somewhat different framework (see Andrews, 1995, 2001).

Principles of Effective Intervention

Determining the Principles. The following eight principles of effective intervention are founded on:

- Meta-analytic and narrative reviews of the offender treatment literature;
- Individual studies of a seminal nature; and
- The clinical wisdom accumulated from the practical experience of colleagues who have conducted successful programs.

Undoubtedly, some of these principles will undergo modest revisions in the future, particularly principles #1, #2, and #7, because they are based upon limited evidence, much of it from case studies.

Some Exemplary Studies. We also recommend that readers consult some of what we consider to be exemplary studies cited by Gendreau (1996b, pp. 119–120). Programs of more recent vintage that are commendable are the:

- Functional Family Therapy Model, which promotes family cohesion and affection (Alexander et al., 1998; Gordon et al., 1995);
- Equip or Teaching Youths to Think and Act Responsibly Peer-Helping Program (Gibbs et al., 1995);
- Prepare Curriculum Program (Goldstein, 1999);
- Multisystemic Therapy (Henggeler et al., 1998); and
- Prison-Based Rideau Integrated Service Delivery Model, which targets criminal thinking, anger, and substance abuse (Bourgon & Armstrong, in press)

Outlining the Principles. The format we have used in outlining the principles follows that of the Correctional Program Assessment Inventory–2000 (CPAI-2000) (Gendreau & Andrews, 2001). The CPAI-2000 consists of 131 items that were derived from the correctional treatment literature and were categorized into eight domains. It should be noted that, recently, two studies, one based on a meta-analysis of treatment programs (Nesovic, 2003), and the other on an assessment of a number of treatment programs in Ohio (Lowenkamp, 2004), found that scores on the CPAI were strongly predictive of recidivism. For the sake of parsimony, we have abstracted a sample of what we consider to be the key elements within each domain. We also offer additional clarifications where the occasion warrants. The recidivism results cited were taken from a variety of meta-analyses that are summarized in Andrews and Bonta (2003).

See *PRINCIPLES*, page 27

PRINCIPLES, from page 6

Principle #1: Organizational Culture. The organization has a culture that is receptive to implementing new ideas and has a well-articulated code of ethics. A history of responding to new initiations and coping with problematic issues in a timely manner is evident, as is a proactive orientation to problem solving. Organizational harmony is reflected in low staff turnover, frequent in-service training, and within-house sharing of information.

Comment: For a fuller treatment of Principles #1 and #2, please consult Gendreau, Goggin, and Smith (1999, 2001).

Principle #2: Program Implementation/Maintenance. The implementation of the program is based upon individual level survey data on the need for the service and a thorough review of relevant treatment literatures. Implementation occurs during a period when the organization does not face contentious issues (e.g., fiscal, staffing levels, stakeholder concerns) that might jeopardize the project.

Comment: Although dated, the empirical work on this topic originating years ago by Gendreau and Andrews (1979) still offers some useful insights for those concerned with implementation.

Principle #3: Management/Staff Characteristics. The director of the program has a post-B.A.-level degree in the helping professions and has several years experience working in offender treatment programs. He/she trains and supervises staff and provides direct service to offenders. The majority of staff involved in direct service delivery have undergraduate degrees in the helping professions and clinical experience working with offenders. Staff are hired on relationship and skill factors that enhance the integrity of the therapeutic relationship; moreover, they have a belief in the value of rehabilitation and confidence in their ability (i.e., self-efficacy) to deliver quality service. Staff are reassessed and retrained regularly with respect to their clinical skills.

Comment: Although patently obvious, this aspect of therapeutic integrity has been, heretofore, woefully neglected in the literature. Tentative evidence from meta-analysis (Andrews, 2001) indicates that some of the factors noted above are associated with meaningful (r = .20 to .35) reductions in recidivism.

Principle #4: Client Risk/Need Practices. Offenders are assessed on a risk instrument that not only has adequate predictive validities but also contains a wide range of criminogenic need factors. The assessment also takes into account the responsivity of offenders to different styles and modes of service. Risk level is routinely assessed over time (e.g., every three to six months) in order to monitor changes in risk/need levels that will, in turn, have a significant impact on case management strategies.

Comment: Very few risk measures have a meaningful number of criminogenic need items, and few are based upon extensive research demonstrating how well they predict recidivism. For comparisons of various measures in this matter, see Gendreau, Little, and Goggin (1996); Gendreau, Goggin, and Paparozzi (1996); and Gendreau, Goggin, and Smith (2002). The Level of Service Inventory-Revised (LSI-R; Andrews & Bonta, 1995) appears to be the most useful risk measure for a variety of settings and case management needs in this regard.

Principle #5: Program Characteristics. The single most important characteristic of effective programs is that they are behaviorally oriented (general responsivity) and target the criminogenic needs of higher risk

See *PRINCIPLES*, next page

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Table 1: Some Appropriate Targets for Intervention

1. Change attitudes and feelings supportive of law violations and anti-criminal role models.
2. Reduce antisocial peer associations.
3. Reduce problems associated with alcohol/drug abuse.
4. Replace the skills of lying, stealing, and aggression with prosocial alternatives.

The following are also important targets when they are linked with any of the above:

5. Increase self-control, self-management, and problem-solving skills.
6. Enhance constructive use of leisure time.
7. Improve skills in interpersonal conflict resolution.
8. Promote more positive attitudes/increase performance regarding schoolwork.
9. Resolve emotional problems associated with intra-or extra-familial child abuse.
10. Promote family affection/communication/monitoring/problem solving.
11. Resolve deviant sexual arousal.
12. Provide low-pressure, sheltered environment for mentally disordered offenders.
13. Alleviate the personal and circumstantial barriers to service (client motivation, background stressors).

Source: Adapted from the CPAI-2000 (Gendreau & Andrews, 2001).

CLASSIFICATION, from page 26

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PRINCIPLES, from page 27

offenders (for a list of treatment targets, see Table 1). The program has a manual that describes the theory and data justifying the program and a curriculum that details the discrete steps to be followed in presenting the material; for an example of a comprehensive program manual, see Gibbs et al. (1995). Offenders spend at least 40% of their program time in acquiring prosocial skills. The ratio of reinforcers to punishers is 4 to1 or more, and completion criteria are explicit. Relapse prevention strategy methods are extended to offenders after completion of the initial treatment phase.

Comment: Programs that adhered to the behavioral/criminogenic need/high-risk guidelines produced reductions in recidivism of 28%. Furthermore, programs based on these principles that were also based in the community were twice as effective as those housed in custodial settings (35% and 17%, respectively).

Also of note is that programs that did not target criminogenic needs produced smaller reductions in recidivism (e.g., 4%); however, programs that did address criminogenic needs produced reductions in recidivism of 21%. It has also been found that programs that are "owned" by justice agencies/personnel are unlikely to flourish. This probably reflects the interests and skill sets of the people in justice agencies and the fact that the priorities of these agencies are orthogonal to rehabilitation.

Principle #6: Core Correctional Practice. Program therapists engage in the following therapeutic practices:

- Anti-criminal modeling;
- Effective reinforcement and disapproval;
- Problem-solving techniques;
- Structured learning procedures for skill building;
- Effective use of authority;
- Cognitive self-change;
- Relationship practices; and
- Motivational interviewing.

Comment: This principle represents an important development and refinement of the therapeutic process under the rubric of general responsivity (the CPAI-2000 section of core correctional practice is made up of 45 items). Although the data are sparse, indications are that staff who follow many of these practices are in programs where reductions in recidivism range from 25% to 35%.

Principle #7: Inter-Agency Communication. The agency aggressively makes referrals and advocates for its offenders (i.e., advocacy brokerage) so that they receive high-quality services in the community.

Comment: A frequent lament arising from those correctional professionals with regard to referring offenders to helpful services is the dearth of such services in the community. In any case, there is exploratory evidence that advocacy brokerage is associated with reductions in recidivism of several percentage points.

Principle #8: Evaluation. The agency routinely conducts program audits, consumer satisfaction surveys, evaluations of changes in criminogenic need, and follow-ups of recidivism rates. The effectiveness of the program is evaluated by comparing the recidivism rates of the treatment group with a risk-control no-treatment comparison group or a risk-control comparison group that has undergone an alternate or minimal treatment.

Comment: Only a handful of programs evaluated with the CPAI meet these criteria.

What Does Not Work

Several programmatic strategies have been found to have minimal effects on recidivism.

Phenomenological and Psychodynamic Therapies. First, no matter how well they are conducted, phenomenological and/or psychodynamic therapies or variants thereof have minimal effects on recidivism.

Sociological Perspectives. Second, sociological perspectives that primarily emphasize respect for an offender's culture, diversion from the system ("leave the kiddies alone"), or "doing good" for the disadvantaged by providing access to legitimate opportunities are associated with slight *increases* in recidivism. The reader may express dismay as to why the latter two approaches are ineffective. Although the sentiment is appealing, the fact is that offenders must first acquire the necessary prosocial skills to take advantage of, for example, work and educational opportunities.

Intermediate Sanctions. Third, intermediate sanctions have generated minuscule reductions in recidivism ($r = -.01$, $CI = -.03$ to $.01$). Using a huge data base of 167 comparisons and 66,500 offenders, Smith et al. (2002) found that there is little variation among various types of intermediate sanctions. In fact, within these sanction programs, the only program constituent that seems to produce modest reductions in recidivism ($r = .10$) is the inclusion of some counseling and educational components (Gendreau, Goggin & Fulton, 2000). Some of the reasons why intermediate sanctions do not work are discussed in Gendreau (1996b, pp. 128–129). From time to time, it is argued that prison can serve as a sanction. The results of a meta-analysis by Smith et al. (2002), however, found prisons to be associated with increases of several percentage points in recidivism.

Focusing on Non-Criminogenic Needs. Last, even programs that follow many of the principles of effectiveness will produce very marginal results if the focus is on the non-criminogenic needs of lower risk offenders.

Simply put, the majority of programs out there "in the real world" are sadly lacking in therapeutic integrity.

Obstacles to Effective Program Delivery

Lack of Therapeutic Integrity. Although it is one thing to document the fact that some programs "work," and work very well, there is another harsh reality that anyone concerned with the implementation and delivery of effective programs must face. Simply put, the majority of programs out there "in the real world" are sadly lacking in therapeutic integrity. Gendreau, Goggin, and Smith (2001) summarized the surveys of 291 correctional treatment programs using the CPAI (Gendreau & Andrews, 2001). The surveys covered Canadian federally funded substance abuse prison programs, juvenile offender community-based programs in Ontario, Canada, and programs in various settings in the United States. A charitable estimate is that about 70% of programs received a failing grade. More recent reports encompassing 240 programs report the same degree of negative results (Latessa et al., 2002). And, in a recent meta-analysis of the treatment literature with 374 tests of the effectiveness of correctional treatment, Andrews et al. (2002) found only 13% of the interventions conformed to the most basic of the principles of effectiveness (i.e., behavioral programs targeting the criminogenic needs of higher risk offenders). Regrettably, it is almost laughable to discover what is being done under the guise of therapy. Some of the more egregious examples we have encountered lately are cross-

See *PRINCIPLES*, next page

PRINCIPLES, from page 28

dressing humiliation, sandwich board justice, john TV, pets in prison, drama classes, getting back to nature, acupuncture, and better diet (Gendreau, Goggin, Cullin, & Paparozzi, 2002; Latessa et al., 2002).

Respecting Evidence in Forming Policy. We have attempted to address the reasons why there seems to be so little respect for evidence in forming policy (Cullen & Gendreau, 2001; Gendreau, 1996a; Gendreau, Goggin, Cullin, & Paparozzi, 2002; Latessa et al., 2002). The reasons range from academic turf wars and limited attempts at technology transfer to policy makers and field staff, to blatant ideological agendas masquerading under the cloak of common sense. Nevertheless, it is naive to expect that scientific evidence will invariably be translated into public policy. In fact, that would be an undesirable state of affairs. Sometimes, evidence changes as a result of shifting social contexts, and occasionally, further research markedly alters the conclusions reached from a body of literature that was originally thought to be unassailable. But, if only 20% to 40% of well-validated research evidence that stands the test of time sees its way into public policy, then substantial progress will occur (Gendreau, 2000).

To establish this, we must work toward what Gendreau, Goggin, Cullin, and Paparozzi (2002) call the "3 Cs" of effective policy, that is:

- Insisting upon correctional organizations establishing credentialing standards for the appointment of senior managers (e.g., graduate degrees in psychology and criminology);
- Credentialing the organizations themselves, so that they are obliged to manage their system based on the concepts of fairness, justice, and the betterment of the lives of those in their care by ethically defensible means; and
- Fueling correctional system policies through credentialed knowledge (i.e., meta-analysis), a practice that, fortunately, is growing.

In only these ways will the service delivery standards of the field be raised.

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See *PRINCIPLES*, next page

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