Objectives

At the end of the course, participants will be able to:

- Identify the reasons agencies are finding EBP difficult to implement
- Describe ways other disciplines have overcome barriers to change initiatives
- Understand how a checklist structure can help them achieve their supervision goals in a risk reduction agency

Background: Mark Carey

- Juvenile residential treatment counselor
- Probation/parole officer
- Director of four county Corrections agencies
- Deputy Commissioner, MN DOC
- Warden, women’s prison
- Consultant/trainer
What is the Issue?

1. Something is amiss
Probation as an intervention has almost a nil effect (.02) on recidivism (see meta-analysis; 25 studies, James Bonta, 2008)

What is the Issue?

2. We aren’t doing what we need to do.
What did 100 observations of PO’s in past year reveal?

Taking a Lesson From Others

• Is Community Corrections significant different from other professions?
• How are we the same, and what can we learn?
Two Types of Failure (Atul Gawande)

- Ignorance: we err because we only have partial knowledge

- Ineptitude: we err because while the knowledge exists we fail to apply it correctly

1. Ignorance (Partial Knowledge)

Medical Example

- Studies have shown that heart attack patients undergoing cardiac balloon therapy should have it done within 90 minutes of hospital arrival. After that, survival falls off sharply.

- In 2006, less than 50% patients had the therapy done within 90 minutes.

Community Corrections Knowledge

- Dr. Don Andrews starting making the speaking circuit in 1989
- Hardly a conference anywhere fails to prioritize EBP
- Yet, TCG quiz yields poor mastery of knowledge in almost every agency
Your Agency

- What is the EBP acumen in your agency?
- Is the knowledge being transferred to actual job performance?
- What does it mean to be professional?

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Danger Signals

- When agencies don’t act professionally and expect that all put public wellbeing first
- Example: if we are successful with EBP and have fewer victims we will lose our jobs. Why should I get behind EBP?

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2. Ineptitude (Apply Knowledge Incorrectly)

Whenever there is a discrepancy between the existing culture and a proposed change, the culture always wins.

Darryl O’Connor: Managing at the Speed of Change

Up to 85% of organizational change initiatives fail


“Culture eats strategy for lunch”

Source unknown

“At every crossway on the road that leads to the future each progressive spirit is opposed by a thousand men appointed to guard the past.”

Maurice Maeterlinck, Belgian Nobel Laureate

“Evidence based practices is not rocket science. It is more difficult than rocket science.”

Joan Petersilia: paraphrased

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Medical Example: Knowledge Exists but it is not Applied

- "As many as 98,000 people die every year in US hospitals due to medical injuries (IHI)
- Two million patients suffer hospital-acquired infections every year (Centers for Disease Control and Prevention)
- The US spends the most money on health care of all industrialized nations but performs more poorly on most measures

Source: Institute for Healthcare Improvement

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Criminal Justice Examples of Poor Application of Knowledge

- Recidivism rates unchanged for thirty years

Source: Checklist Manifesto, page 19

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Criminal Justice Example

- Two of every three death penalty cases are overturned because of errors

Source: Checklist Manifesto, page 19
So, What is the Problem? Medical

"I have been trying to some time to understand the source of our greatest difficulties and stresses in medicine. It is not money or government or the threat of malpractice lawsuits or insurance company hassles—although they all play their role. It is the complexity that science has dropped upon us..."  — Atul Gawande

Medical Complexity

- "The volume and complexity of what we know has exceeded our individual ability to deliver its benefits correctly, safely, or reliably. Knowledge has both saved us and burdened us"
  — Atul Gawande

The average patient required 178 individual actions per day, each one posing some risk. Only one percent of these actions resulted in an error but that meant a patient was the recipient of two errors per day.

So, What is the Problem? Justice

"Evidence Based Practices is not rocket science. It is more difficult than rocket science."
  — Joan Petersilia

"We work in a world of increasing complexity. More is expected of us and more is at stake. The best we can do is meet the minimum demands and to stay ahead of potential critics."

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A Scary Reality

- In the medical field, “This is the reality of intensive care: at any point, we are as apt to harm as we are to heal. Line infections are so common that they are considered a routine complication.”
  - Atul Gawande

- In the corrections field, professionals who are deemed to be incompetent when delivering effective FFT/ART had 7-24% higher recidivism rates than the control group.

Corrections Examples

<table>
<thead>
<tr>
<th>Number*</th>
<th>Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>Risk assessment tools for adult and juvenile justice, behavioral health, mental health, substance abuse, and school behavior</td>
<td>Assessment.com</td>
</tr>
<tr>
<td>Cognitive Behavioral Programs</td>
<td>NIC (note that many more exist than listed)</td>
</tr>
<tr>
<td>Model Programs</td>
<td>OJJDP</td>
</tr>
<tr>
<td>Traits of an Effective Professional</td>
<td>Dowden and Andrews</td>
</tr>
<tr>
<td>Organizational Development Items to Address</td>
<td>10 subscales; 139 questions; CJI, EBP Skills Assessment</td>
</tr>
<tr>
<td>Carey Guides</td>
<td>33 <a href="http://www.thecareygroup.com">www.thecareygroup.com</a></td>
</tr>
</tbody>
</table>

Comments we Hear

- I wish administration would just make up their mind what they want, too many priorities.
- This is just the flavor of the day.
- I can’t master one thing before you throw something else at me.
- Too much paperwork; I am drowning.
Learning From Other Fields

- Many professionals have made major strides by reversing poor outcomes
  - Airline
  - Medical
  - Architecture
  - Plumbing

In Each Industry They Simplified Complex Issues

- "When I look over the books I have written, I know exactly which parts I understood and which parts I did not understand when I wrote them. The poorly understood parts sound scientific. When I barely understood something, I kept it in scientific jargon. When I really comprehended it, I was able to explain it to people in language they understood.

Understanding Involves Three Stages

1. Simplistic
2. Complex
3. Profoundly simple

Order lies beneath complexity
### Example: First Session After Court

**Subject: Sharing Assessment Results**

| Simplistic | We repeat what the court told them to do. “We need to set up your drug treatment class and anger management class. Here are three places you can go. Come back with a verification that you enrolled.” No concern with motivation/readiness or responsivity factors. |
| Complex | Conduct multiple assessments (risk/need, specialized assessment, Jeenes, criminal sentiment scale, IQ, education, substance abuse, etc. Describe the criminogenic need terms to offender in complex/researcher terms, review a fifteen point behavioral contract (do’s and don’ts on probation) and make referrals to four programs and three sentencing conditions on a six page case plan. |
| Profoundly simple | Describe that you role is to hold them accountable and help them succeed. Describe the assessment results in clear terms like a doctor might explain a blood test. Ask offender for his/her input. Come up with one or two key areas to work on during supervision. |
These Solutions Assume That we are in Control

- “I am the master of my fate, I am the captain of my soul”

William Ernest Henley, “Invictus”

Structural Aid to Success

- In order for us to transform complexity into simplicity we need a structural aid
- This aid can reduce errors, provide direction, and help the professional focus on the actions that matter instead of those that distract.

Solid Structure or No Structure

- We get exactly what the system is built for
We are up against two common difficulties:
1. Fallibility of human memory
2. Attention when it comes to mundane, routine matters that are easily overlooked under the strain of more pressing events

### 1. Fallible Memory

- Just plain don’t remember
- Or, remember, but lull themselves into skipping steps especially when routine things usually happen….or so we think

### Memory Example

- Critical care specialist Peter Pronovost tried doctor checklist of “no brainer” items
- Wash hands
- Clean patient’s skin with chlorhexidine antiseptic
- Put sterile drapes over entire patient
- Wear a mask, hat, sterile gown, and gloves
- Put a sterile dressing over the insertion site once the line is in
- Found that in more than a third of patients, they skipped at least one step
John Hopkins Hospital authorized nurses to stop doctors if they saw them skipping a step on the checklist. Results?

In addition, average length of patient stay in intensive care dropped by half.

Did This Catch On?

NO

- Despite speaking to an average of seven cities a month few adopted it
- Offended by suggestion that they needed checklists
- Doubts about the evidence
- Too overwhelmed with filling out another piece of paper

Keystone Initiative

- Each hospital assigned a project manager to roll out the checklist and participate in 2x/month conference calls with Pronovost
- Discovered lack of supplies (“tools”) in that chlorhexidine soap was available in less than a third of the ICU’s
- Full size drapes were often unavailable
Sound Familiar in Corrections?

- Agencies don’t have initiative project managers to troubleshoot
- Staff don’t have access to
- Effective programs
- Tools to use in one-on-one sessions

Keystone Results

- Within first three months of the project
  - The central line infection rate in Michigan’s ICU dropped by 66%.
  - Most institutions cut their quarterly infection rate to zero

All together the hospitals saved an estimated $175 million in costs and more than 1,500 lives!
Airline Industry

- Have scores of checklists
- Two types
  - Normal (routine tasks for everyday operations)
  - Non-normal (every conceivable emergency situation a pilot might run into)

Boeing Checklists

- Issues over 100 revised or new checklists per year
- Have a checklist factory
- Discovered that good checklists are
  - Precise, practical, and only contain the most critical/important steps
- They have earned the pilots’ faith
Miracle on the Hudson

- Captain Chesley Sullenberger ("Sully")
- US Air Airbus A320-214

When Checklists can Help

- Science of Complexity: Brenda Zimmerman (York University) and Sholom Glouberman (University of Toronto)

- The kinds of problems
  - Simple (bake a cake from a recipe)
  - Complicated (send rocket to moon)
  - Complex (raising a child, each unique, where expertise is valuable but not sufficient)
**Simple**

- Medical
  - Pre-operation

- Criminal Justice
  - Urinalysis chain of custody checklist (13 steps, US Probation and Pretrial Services, Western District of Oklahoma)


**Example Complex Problem: Construction Industry**

- Combining plumbing, HVAC, electrical and other systems into one building

**Complex Problem: Skyscraper**

- Listed every task day by day for a skyscraper
- Special color coding
- Which steps first
- Integrated list for each of the 16 trades involved
Complexity

- Checklist worked for simple problems, sequencing, and to keep on track

Communication

- People are fallible but maybe many people are less so
- Wisdom of the group
- Best part? It gives people power instead of what most do—centralize power and decision making

The Real Lesson

- “...under conditions of true complexity where knowledge exceeds that of any individual and unpredictability reigns, efforts to dictate every step from the center will fail.”
- Checklists then aid in judgment
Example: Tuned Mass Damper

- Problem: wind streams cause massive building swings, unsafe
- Solution: Four hundred ton concrete block from springs in the building’s crown on the 59th floor

Checklist Rules

- Research on checklists have determined that certain “rules” improve success including (example)
- Limit number of items
- Length of time to review/read must not exceed limit
- Color/text type
- Methods to evaluate

Checklist Structure

1. Use checklist for routine tasks to make sure critical but simple steps are not missed or skipped
2. Use specialized checklists for unique situations
3. Use another set of checklists to make sure that people talk through and resolve hard, unexpected problems
Corrections Example of Checklists

- The following are EXAMPLES of checklists that can be used for “routine tasks” throughout supervision.

These examples are for illustration only. Actual checklists would need to be developed using a group process and piloting.

Example - Phase One

<table>
<thead>
<tr>
<th>Phase</th>
<th>Checklist Items</th>
<th>Timelines</th>
</tr>
</thead>
</table>
| Set the Expectations and Conduct Initial Assessment | - Describe your role (to help him/her succeed and to hold accountable)  
- Describe what is needed for him/her to do for supervision success  
- Use affirmation to begin building rapport  
- Describe the assessment process and how it will be used  
- Complete the assessment and tell him/her next steps (assessment) | To be done in the first fifteen days of supervision |

Example - Phase Two

<table>
<thead>
<tr>
<th>Phase</th>
<th>Checklist Items</th>
<th>Timelines</th>
</tr>
</thead>
</table>
| Engage and Discuss Assessment Results | - Remind offender of the purpose of the assessment (to help the offender succeed on supervision and determine what will be spending time on)  
- Summarize the assessment results beginning with strengths  
- Use affirmation to build rapport  
- Determine offender views of results and motivation  
- Tell him/her of purpose of next session (to go over results and develop a plan) | To be done in the first thirty days of supervision |
### Example - Phase Three

**Phase** | **Checklist Items** | **Timelines**
--- | --- | ---
Case Plan Development | - Check-in: review results of assessment from last session  
- With offender, identify goal(s) around criminogenic needs (especially driver)  
- Identify responsivity factors and barriers  
- Write SMART goal on plan for 1-2 criminogenic needs (preferably the driver)  
- Have offender sign off on plan | To be done in days 31-60

### Example - Phase Four

**Phase** | **Checklist Items** | **Timelines**
--- | --- | ---
Introduce the Cognitive Approach | - Check in to build rapport, check for crisis, and check conditions  
- Teach the offender the thought-feeling-behavioral link using a worksheet that helps offender analyze one or more past antisocial acts  
- Teach the offender the eight thinking traps and which one he/she likely falls into  
- Explain that this process will be used throughout probation  
- Give a homework assignment based on the thought-feeling-behavior lesson | To be done the first session after the case plan is developed

### Example - Phase Five

**Phase** | **Checklist Items** | **Timelines**
--- | --- | ---
Ongoing Case Supervision Around Risk Reduction | - Check-in to build rapport, check for crisis, and check conditions  
- Review past session and homework  
- Teach skill on targeted criminogenic need (driver) or deepen skill (including practice)  
- Give homework | To be done between days 61-240 days or longer
Example – Special Conditions

<table>
<thead>
<tr>
<th>Circumstance</th>
<th>Checklist Items</th>
<th>Timelines</th>
</tr>
</thead>
<tbody>
<tr>
<td>When the offender is at high risk of supervision violation</td>
<td>To be determined</td>
<td>Individualized</td>
</tr>
<tr>
<td>When the offender is unmotivated</td>
<td>To be determined</td>
<td>Individualized</td>
</tr>
<tr>
<td>When you suspect the offender has a propensity for violence</td>
<td>To be determined</td>
<td>Individualized</td>
</tr>
<tr>
<td>When an offender relapses</td>
<td>To be determined</td>
<td>Individualized</td>
</tr>
<tr>
<td>Other...</td>
<td>To be determined</td>
<td>Individualized</td>
</tr>
</tbody>
</table>

Example – Phase Six

<table>
<thead>
<tr>
<th>Phase</th>
<th>Checklist Items</th>
<th>Timelines</th>
</tr>
</thead>
<tbody>
<tr>
<td>Transition to Life After Supervision</td>
<td>To be determined</td>
<td>Individualized but begin the process 90 days before transition</td>
</tr>
</tbody>
</table>

Lessons Learned - #1

All successful checklists were:
- Simple
- Measurable
- Transmissible

- Checklists must be BRIEF!
- Checklists must be CLEAR!
- Checklists must be EASY TO READ!
Example: Simplicity Lesson

- Low tech solutions needed for infectious outbreaks in Pakistan
- Gave soap to test neighborhoods (3.3 bars per week) and told them when to use them
- Result: diarrhea fell 52% and pneumonia fell 48%, impetigo (bacterial skin infection) fell 35%
- Conclusion: it was the checklist of six examples of when to use the soap that made the behavioral difference

Six Item Checklist

- Wash bodies once per day
- When defecated
- When wiped an infant
- About to eat
- Prepare food
- Feed food to others

Why was This Significant?

- They already had soap
- Since they were poor, they had to remove the economic disadvantage by giving them the soap
- They made the use of soap more systemic
- They had to teach them how to wash
Applying Lesson to Community Corrections

<table>
<thead>
<tr>
<th>Pakistan Lesson</th>
<th>Application to CC</th>
</tr>
</thead>
<tbody>
<tr>
<td>They already had soap</td>
<td>We already have tools that support behavioral change</td>
</tr>
<tr>
<td>Remove economic barrier</td>
<td>We have not done a good job of putting the tools in staff hands and removing barriers to their use</td>
</tr>
<tr>
<td>Had to teach them how to wash</td>
<td>We have not adequately supported staff on the use of the available tools</td>
</tr>
<tr>
<td>Made use of soap systematically</td>
<td>We have not used checklists</td>
</tr>
</tbody>
</table>

Lessons Learned - #2

Complications must be anticipated for in advance, most of which can be addressed with a checklist

- The complications in the medical field are infection, bleeding, unsafe anesthesia, and unexpected
- The first three need a checklist

Lessons Learned - #3

Unexpected complications cannot be resolved with a checklist; they require communication

- They had to stop and talk
How Much do we Talk?

- Traditionally surgery is regarded as an individual performance, but it is not
  - John Hopkins survey study of a thousand operating room staff in five countries asking if they had high levels of teamwork
    - 64% surgeons said yes
    - 39% anesthesiologists
    - 28% nurses
    - 10% anesthesia residents
- Silent disengagement is dangerous

How Safe is the Surgical Team?

- Studies: people who don’t know one another’s names don’t work together nearly as well as those who do
- John Hopkins: “activation phenomenon”
  - When you give people a chance to say something at the start it increases their sense of participation and responsibility to speak up

What is the Solution?

- Make up our minds what we want (BHAG)
- Eliminate or reduce distractions and low value-add activities
- Simplify a complex job
  - Example:
    - Face to face time
    - Teaching a skill around a criminogenic need
Have a Plan to Put it in Place

- The critical steps

![Diagram showing the critical steps]

Imagine What Would Happen if We DID?

For more information:
Mark Carey
mark@thecareygroup.com
www.thecareygroup.com
651-226-4755

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