

# Beyond Correctional Quackery— Professionalism and the Possibility of Effective Treatment

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## • In Memoriam •

*In Jan. 2022, Edward J. Latessa (1954-2022), long-time head of the School of Criminal Justice at the University of Cincinnati, died. Under his direction over several decades, the University of Cincinnati became a leader in research and advocacy for evidence-based practices in the field of criminal justice and particularly community supervision, and an exporter of large numbers of like-minded graduates. We have been fortunate to publish a number of his articles in Federal Probation and to have the benefit of his contributions to our Advisory Committee. One of those articles (co-written with Francis T. Cullen and Paul Gendreau)—a favorite both for title and content originally appearing in the Sept. 2002 issue of Federal Probation (Volume 66, no. 2)—we reprint below. He does not need our good opinion to clinch his legacy as a major figure in the field of criminal justice, but he has it anyway.*

**LONG-TIME VIEWERS OF *Saturday Night Live*** will vividly recall Steve Martin's hilarious portrayal of a medieval medical practitioner—the English barber, Theodoric of York. When ill patients are brought before him, he prescribes ludicrous “cures,” such as repeated bloodletting, the application of leeches and boar's vomit, gory amputations, and burying people up to their necks in a marsh. At a point in the skit when a patient dies and Theodoric is accused of “not knowing what he is doing,” Martin stops, apparently struck by the transforming insight that medicine might abandon harmful interventions rooted in ignorant

customs and follow a more enlightened path. “Perhaps,” he says, “I've been wrong to blindly follow the medical traditions and superstitions of past centuries.” He then proceeds to wonder whether he should “test these assumptions analytically through experimentation and the scientific method.” And perhaps, he says, the scientific method might be applied to other fields of learning. He might even be able to “lead the way to a new age—an age of rebirth, a renaissance.” He then pauses and gives the much-awaited and amusing punchline, “Nawwwwwww!”

The humor, of course, lies in the juxtaposition and final embrace of blatant quackery with the possibility and rejection of a more modern, scientific, and ultimately effective approach to medicine. For those of us who make a living commenting on or doing corrections, however, we must consider whether, in a sense, the joke is on us. We can readily see the humor in Steve Martin's skit and wonder how those in medieval societies “could have been so stupid.” But even a cursory survey of *current* correctional practices yields the disquieting conclusion that we are a field in which quackery is tolerated, if not implicitly celebrated. It is not clear whether most of us have ever had that reflective moment in which we question whether, “just maybe,” there might be a more enlightened path to pursue. If we have paused to envision a different way of doing things, it is apparent that our reaction, after a moment's contemplation, too often has been, “Nawwwwwww!”

This appraisal might seem overly harsh, but we are persuaded that it is truthful. When intervening in the lives of offenders—that is,

intervening with the expressed intention of reducing recidivism—corrections has resisted becoming a true “profession.” Too often, being a “professional” has been debased to mean dressing in a presentable way, having experience in the field, and showing up every day for work. But a profession is defined not by its surface appearance but by its intellectual core. An occupation may lay claim to being a “profession” only to the extent that its practices are based on research knowledge, training, and expertise—a triumvirate that promotes the possibility that what it does can be effective (Cullen, 1978; Starr, 1982). Thus, medicine's professionalization cannot be separated from its embrace of scientific knowledge as the ideal arbiter of how patients should be treated (Starr, 1982). The very concept of “malpractice” connotes that standards of service delivery have been established, are universally transmitted, and are capable of distinguishing acceptable from unacceptable interventions. The concept of liability for “correctional malpractice” would bring snickers from the crowd—a case where humor unintentionally offers a damning indictment of the field's standards of care.

In contrast to professionalism, *quackery* is dismissive of scientific knowledge, training, and expertise. Its posture is strikingly overconfident, if not arrogant. It embraces the notion that interventions are best rooted in “common sense,” in personal experiences (or clinical knowledge), in tradition, and in superstition (Gendreau, Goggin, Cullen, & Paparozzi, forthcoming). “What works” is thus held to be “obvious,” derived only from years of an individual's experience, and legitimized

by an appeal to custom (“the way we have always done things around here has worked just fine”). It celebrates being anti-intellectual. There is never a need to visit a library or consult a study.

*Correctional quackery*, therefore, is the use of treatment interventions that are based on neither 1) existing knowledge of the causes of crime nor 2) existing knowledge of what programs have been shown to change offender behavior (Cullen & Gendreau, 2000; Gendreau, 2000). The hallmark of correctional quackery is thus ignorance. Such ignorance about crime and its cures at times is “understandable”—that is, linked not to the willful rejection of research but to being in a field in which professionalism is not expected or supported. At other times, however, quackery is proudly displayed, as its advocates boldly proclaim that they have nothing to learn from research conducted by academics “who have never worked with a criminal” (a claim that is partially true but ultimately beside the point and a rationalization for continued ignorance).

Need we now point out the numerous programs that have been implemented with much fanfare and with amazing promises of success, only later to turn out to have “no effect” on reoffending? “Boot camps,” of course, are just one recent and salient example. Based on a vague, if not unstated, theory of crime and an absurd theory of behavioral change (“offenders need to be broken down”—through a good deal of humiliation and threats—and then “built back up”), boot camps could not possibly have “worked.” In fact, we know of no major psychological theory that would logically suggest that such humiliation or threats are components of effective therapeutic interventions (Gendreau et al., forthcoming). Even so, boot camps were put into place across the nation without a shred of empirical evidence as to their effectiveness, and only now has their appeal been tarnished after years of negative evaluation studies (Cullen, Pratt, Miceli, & Moon, 2002; Cullen, Wright, & Applegate, 1996; Gendreau, Goggin, Cullen, & Andrews, 2000; MacKenzie, Wilson, & Kider, 2001). How many millions of dollars have been squandered? How many opportunities to rehabilitate offenders have been forfeited? How many citizens have been needlessly victimized by boot camp graduates? What has been the cost to society of this quackery?

We are not alone in suggesting that advances in our field will be contingent on the conscious rejection of quackery in favor of an *evidence-based corrections* (Cullen &

Gendreau, 2000; MacKenzie, 2000; Welsh & Farrington, 2001). Moving beyond correctional quackery when intervening with offenders, however, will be a daunting challenge. It will involve overcoming four central failures now commonplace in correctional treatment. We review these four sources of correctional quackery not simply to show what is lacking in the field but also in hopes of illuminating what a truly professional approach to corrections must strive to entail.

## Four Sources of Correctional Quackery

### *Failure to Use Research in Designing Programs*

Every correctional agency must decide “what to do” with the offenders under its supervision, including selecting which “programs” or “interventions” their charges will be subjected to. But how is this choice made (a choice that is consequential to the offender, the agency, and the community)? Often, no real choice is made, because agencies simply continue with the practices that have been inherited from previous administrations. Other times, programs are added incrementally, such as when concern rises about drug use or drunk driving. And still other times—such as when punishment-oriented intermediate sanctions were the fad from the mid-1980s to the mid-1990s—jurisdictions copy the much-publicized interventions being implemented elsewhere in the state and in the nation.

### TABLE 1

#### *Questionable Theories of Crime We Have Encountered in Agency Programs*

- ✓ “Been there, done that” theory.
- ✓ “Offenders lack creativity” theory.
- ✓ “Offenders need to get back to nature” theory.
- ✓ “It worked for me” theory.
- ✓ “Offenders lack discipline” theory.
- ✓ “Offenders lack organizational skills” theory.
- ✓ “Offenders have low self-esteem” theory.
- ✓ “We just want them to be happy” theory.
- ✓ The “treat offenders as babies and dress them in diapers” theory.
- ✓ “Offenders need to have a pet in prison” theory.
- ✓ “Offenders need acupuncture” theory.
- ✓ “Offenders need to have healing lodges” theory.
- ✓ “Offenders need drama therapy” theory.
- ✓ “Offenders need a better diet and haircut” theory.

- ✓ “Offenders (females) need to learn how to put on makeup and dress better” theory.
- ✓ “Offenders (males) need to get in touch with their feminine side” theory.

Notice, however, what is missing in this account: The failure to consider the existing research on program effectiveness. The risk of quackery rises to the level of virtual certainty when nobody in the agency asks, “Is there any evidence supporting what we are intending to do?” The irrationality of not consulting the existing research is seen when we consider again, medicine. Imagine if local physicians and hospitals made no effort to consult “what works” and simply prescribed pharmaceuticals and conducted surgeries based on custom or the latest fad. Such malpractice would be greeted with public condemnation, lawsuits, and a loss of legitimacy by the field of medicine.

It is fair to ask whether research can, in fact, direct us to more effective correctional interventions. Two decades ago, our knowledge was much less developed. But the science of crime and treatment has made important strides in the intervening years. In particular, research has illuminated three bodies of knowledge that are integral to designing effective interventions. First, we have made increasing strides in determining the *empirically established* or *known predictors* of offender recidivism (Andrews & Bonta, 1998; Gendreau, Little, & Goggin, 1996; Henggeler, Mihalic, Rone, Thomas, & Timmons-Mitchell, 1998). These include, most importantly: 1) antisocial values, 2) antisocial peers, 3) poor self-control, self-management, and prosocial problem-solving skills, 4) family dysfunction, and 5) past criminality. This information is critical, because interventions that ignore these factors are doomed to fail. Phrased alternatively, successful programs start by recognizing what causes crime and then *specifically design the intervention to target these factors for change* (Alexander, Pugh, & Parsons, 1998; Andrews & Bonta, 1998; Cullen & Gendreau, 2000; Henggeler et al., 1998).

Consider, however, the kinds of “theories” about the causes of crime that underlie many correctional interventions. In many cases, simple ignorance prevails; those working in correctional agencies cannot explain what crime-producing factors the program is allegedly targeting for change. Still worse, many programs have literally invented seemingly ludicrous theories of crime that are put forward with a straight face. From our

collective experiences, we have listed in Table 1 crime theories that either 1) were implicit in programs we observed or 2) were voiced by agency personnel when asked what crime-causing factors their programs were targeting. These “theories” would be amusing except that they are commonplace and, again, potentially lead to correctional quackery. For example, the theory of “offenders (males) need to get in touch with their feminine side” prompted one agency to have offenders dress in female clothes. We cannot resist the temptation to note that you will now know whom to blame if you are mugged by a cross-dresser! But, in the end, this is no laughing matter. This intervention has no chance to be effective, and thus an important chance was forfeited to improve offenders’ lives and to protect public safety.

Second, there is now a growing literature that outlines what does *not* work in offender treatment (see, e.g., Cullen, 2002; Cullen & Gendreau, 2000; Cullen et al., 2002; Cullen et al., 1996; Gendreau, 1996; Gendreau et al., 2000; Lipsey & Wilson, 1998; MacKenzie, 2000). These include boot camps, punishment-oriented programs (e.g., “scared straight” programs), control-oriented programs (e.g., intensive supervision programs), wilderness programs, psychological interventions that are non-directive or insight-oriented (e.g., psychoanalytic), and non-intervention (as suggested by labeling theory). Ineffective programs also target for treatment low-risk offenders and target for change weak predictors of criminal behavior (e.g., self-esteem). Given this knowledge, it would be a form of quackery to continue to use or to freshly implement these types of interventions.

Third, conversely, there is now a growing literature that outlines what *does* work in offender treatment (Cullen, 2002; Cullen & Gendreau, 2000). Most importantly, efforts are being made to develop principles of effective intervention (Andrews, 1995; Andrews & Bonta, 1998; Gendreau, 1996). These principles are listed in Table 2. Programs that adhere to these principles have been found to achieve meaningful reductions in recidivism (Andrews, Dowden, & Gendreau, 1999; Andrews, Zinger, Hoge, Bonta, Gendreau, & Cullen, 1990; Cullen, 2002). However, programs that are designed without consulting these principles are almost certain to have little or no impact on offender recidivism and may even risk increasing reoffending. That is, if these principles are ignored,

**TABLE 2***Eight Principles of Effective Correctional Intervention***1. Organizational Culture**

Effective organizations have well-defined goals, ethical principles, and a history of efficiently responding to issues that have an impact on the treatment facilities. Staff cohesion, support for service training, self-evaluation, and use of outside resources also characterize the organization.

**2. Program Implementation/Maintenance**

Programs are based on empirically-defined needs and are consistent with the organization’s values. The program is fiscally responsible and congruent with stakeholders’ values. Effective programs also are based on thorough reviews of the literature (i.e., meta-analyses), undergo pilot trials, and maintain the staff’s professional credentials.

**3. Management/Staff Characteristics**

The program director and treatment staff are professionally trained and have previous experience working in offender treatment programs. Staff selection is based on their holding beliefs supportive of rehabilitation and relationship styles and therapeutic skill factors typical of effective therapies.

**4. Client Risk/Need Practices**

Offender risk is assessed by psychometric instruments of proven predictive validity. The risk instrument consists of a wide range of dynamic risk factors or criminogenic needs (e.g., anti-social attitudes and values). The assessment also takes into account the responsiveness of offenders to different styles and modes of service. Changes in risk level over time (e.g., 3 to 6 months) are routinely assessed in order to measure intermediate changes in risk/need levels that may occur as a result of planned interventions.

**5. Program Characteristics**

The program targets for change a wide variety of criminogenic needs (factors that predict recidivism), using empirically valid behavioral/social learning/cognitive behavioral therapies that are directed to higher risk offenders. The ratio of rewards to punishers is at least 4:1. Relapse prevention strategies are available once offenders complete the formal treatment phase.

**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.

**7. Inter-Agency Communication**

The agency aggressively makes referrals and advocates for its offenders in order that they receive high quality services in the community.

**8. Evaluation**

The agency routinely conducts program audits, consumer satisfaction surveys, process evaluations of changes in criminogenic need, and follow-ups of recidivism rates. The effectiveness of the program is evaluated by comparing the respective recidivism rates of risk-control comparison groups of other treatments or those of a minimal treatment group.

Note: Items adapted from the *Correctional Program Assessment Inventory—2000*, a 131-item Questionnaire that is widely used in assessing the quality of correctional treatment programs (Gendreau & Andrews, 2001).

quackery is likely to result. We will return to this issue below.

#### *Failure to Follow Appropriate Assessment and Classification Practices*

The steady flow of offenders into correctional agencies not only strains resources but also creates a continuing need to allocate treatment resources efficaciously. This problem is not dissimilar to a hospital that must process a steady flow of patients. In a hospital (or doctor's office), however, it is immediately recognized that the crucial first step to delivering effective treatment is diagnosing or *assessing* the patient's condition and its severity. In the absence of such a diagnosis—which might involve the careful study of symptoms or a battery of tests—the treatment prescribed would have no clear foundation. Medicine would be a lottery in which the ill would hope the doctor assigned the right treatment. In a similar way, effective treatment intervention requires the appropriate assessment of both the risks posed by, and the needs underlying the criminality of, offenders. When such diagnosis is absent and no classification of offenders is possible, offenders in effect enter a treatment lottery in which their access to effective intervention is a chancy proposition.

Strides have been made to develop more effective classification instruments—such as the Level of Supervision Inventory (LSI) (Bonta, 1996), which, among its competitors, has achieved the highest predictive validity with recidivism (Gendreau et al., 1996). The LSI and similar instruments classify offenders by using a combination of “static” factors (such as criminal history) and “dynamic factors” (such as antisocial values, peer associations) shown by previous research to predict recidivism. In this way, it is possible to classify offenders by their level of risk and to discern the types and amount of “criminogenic needs” they possess that should be targeted for change in their correctional treatment.

At present, however, there are three problems with offender assessment and classification by correctional agencies (Gendreau & Goggin, 1997). First, many agencies simply do not assess offenders, with many claiming they do not have the time. Second, when agencies do assess, they assess poorly. Thus, they often use outdated, poorly designed, and/or empirically unvalidated classification instruments. In particular, they tend to rely on instruments that measure exclusively static predictors of recidivism (which cannot, by definition, be changed) and that provide no information on the criminogenic needs that offenders

have. If these “needs” are not identified and addressed—such as possessing antisocial values—the prospects for recidivism will be high. For example, a study of 240 (161 adult and 79 juvenile) programs assessed across 30 states found that 64 percent of the programs did not utilize a standardized and objective assessment tool that could distinguish risk/needs levels for offenders (Matthews, Hubbard, & Latessa, 2001; Latessa, 2002).

Third, even when offenders are assessed using appropriate classification instruments, agencies frequently ignore the information. It is not uncommon, for example, for offenders to be assessed and then for everyone to be given the same treatment. In this instance, assessment becomes an organizational routine in which paperwork is compiled but the information is ignored.

Again, these practices increase the likelihood that offenders will experience correctional quackery. In a way, treatment is delivered blindly, with agency personnel equipped with little knowledge about the risks and needs of the offenders under their supervision. In these circumstances, it is impossible to know which offenders should receive which interventions. Any hopes of individualizing interventions effectively also are forfeited, because the appropriate diagnosis either is unavailable or hidden in the agency's unused files.

#### *Failure to Use Effective Treatment Models*

Once offenders are assessed, the next step is to select an appropriate treatment model. As we have suggested, the challenge is to consult the empirical literature on “what works,” and to do so with an eye toward programs that conform to the principles of effective intervention. At this stage, it is inexcusable either to ignore this research or to implement programs that have been shown to be ineffective. Yet, as we have argued, the neglect of the existing research on effective treatment models is widespread. In the study of 240 programs noted above, it was reported that two-thirds of adult programs and over half of juvenile programs did not use a treatment model that research had shown to be effective (Matthews et al., 2001; Latessa, 2002). Another study—a meta-analysis of 230 program evaluations (which yielded 374 tests or effect sizes)—categorized the extent to which interventions conformed to the principles of effective intervention. In only 13 percent of the tests were the interventions judged to fall into the “most appropriate” category (Andrews et al., 1999). But this failure

to employ an appropriate treatment approach does not have to be the case. Why would an agency—in this information age—risk quackery when the possibility of using an evidence-based program exists? Why not select effective treatment models?

Moving in this direction is perhaps mostly a matter of a change of consciousness—that is, an awareness by agency personnel that quackery must be rejected and programs with a track record of demonstrated success embraced. Fortunately, depending on the offender population, there is a growing number of treatment models that might be learned and implemented (Cullen & Applegate, 1997). Some of the more prominent models in this regard are the “Functional Family Therapy” model that promotes family cohesion and affection (Alexander et al., 1998; Gordon, Graves, & Arbuthnot, 1995), the teaching youths to think and react responsibly peer-helping (“Equip”) program (Gibbs, Potter, & Goldstein, 1995), the “Prepare Curriculum” program (Goldstein, 1999), “Multisystemic Therapy” (Henggeler et al., 1998), and the prison-based “Rideau Integrated Service Delivery Model” that targets criminal thinking, anger, and substance abuse (see Gendreau, Smith, & Goggin, 2001).

#### *Failure to Evaluate What We Do*

Quackery has long prevailed in corrections because agencies have traditionally required no systematic evaluation of the effectiveness of their programs (Gendreau, Goggin, & Smith, 2001). Let us admit that many agencies may not have the human or financial capital to conduct ongoing evaluations. Nonetheless, it is not clear that the failure to evaluate has been due to a lack of capacity as much as to a lack of desire. The risk inherent in evaluation, of course, is that practices that are now unquestioned and convenient may be revealed as ineffective. Evaluation, that is, creates accountability and the commitment threat of having to change what is now being done. The cost of change is not to be discounted, but so too is the “high cost of ignoring success” (Van Voorhis, 1987). In the end, a professional must be committed to doing not simply what is in one's self-interest but what is ethical and effective. To scuttle attempts at program evaluation and to persist in using failed interventions is wrong and a key ingredient to continued correctional quackery (more broadly, see Van Voorhis, Cullen, & Applegate, 1995).

Evaluation, moreover, is not an

all-or-nothing procedure. Ideally, agencies would conduct experimental studies in which offenders were randomly assigned to a treatment or control group and outcomes, such as recidivism, were measured over a lengthy period of time. But let us assume that, in many settings, conducting this kind of sophisticated evaluation is not feasible. It is possible, however, for virtually all agencies to monitor, to a greater or lesser extent, the *quality* of the programs that they or outside vendors are supplying. Such evaluative monitoring would involve, for example, assessing whether treatment services are being delivered as designed, supervising and giving constructive feedback to treatment staff, and studying whether offenders in the program are making progress on targeted criminogenic factors (e.g., changing antisocial attitudes, manifesting more prosocial behavior). In too many cases, offenders are “dropped off” in intervention programs and then, eight or twelve weeks later, are deemed—without any basis for this conclusion—to have “received treatment.” Imagine if medical patients entered and exited hospitals with no one monitoring their treatment or physical recovery. Again, we know what we could call such practices.

### Conclusion—Becoming an Evidence-Based Profession

In assigning the label “quackery” to much of what is now being done in corrections, we run the risk of seeming, if not being, preachy and pretentious. This is not our intent. If anything, we mean to be provocative—not for the sake of causing a stir, but for the purpose of prompting correctional leaders and professionals to stop using treatments that cannot possibly be effective. If we make readers think seriously about how to avoid selecting, designing, and using failed correctional interventions, our efforts will have been worthwhile.

We would be remiss, however, if we did not confess that academic criminologists share the blame for the continued use of ineffective programs. For much of the past quarter century, most academic criminologists have abandoned correctional practitioners. Although some notable exceptions exist, we have spent much of our time claiming that “nothing works” in offender rehabilitation and have not created partnerships with those in corrections so as to build knowledge on “what works” to change offenders (Cullen & Gendreau, 2001). Frequently, what guidance criminologists have offered correctional agencies has constituted *bad* advice—ideologically inspired, not rooted

in the research, and likely to foster quackery. Fortunately, there is a growing movement among criminologists to do our part both in discerning the principles of effective intervention and in deciphering what interventions have empirical support (Cullen & Gendreau, 2001; MacKenzie, 2000; Welsh & Farrington, 2001). Accordingly, the field of corrections has more information available to find out what our “best bets” are when intervening with offenders (Rhine, 1998).

We must also admit that our use of medicine as a comparison to corrections has been overly simplistic. We stand firmly behind the central message conveyed—that what is done in corrections would be grounds for malpractice in medicine—but we have glossed over the challenges that the field of medicine faces in its attempt to provide scientifically-based interventions. First, scientific knowledge is not static but evolving. Medical treatments that appear to work now may, after years of study, prove ineffective or less effective than alternative interventions. Second, even when information is available, it is not clear that it is effectively transmitted or that doctors, who may believe in their personal “clinical experience,” will be open to revising their treatment strategies (Hunt, 1997). “The gap between research and knowledge,” notes Millenson (1997, p. 4), “has real consequences....when family practitioners in Washington State were queried about treating a simple urinary tract infection in women, eighty-two physicians came up with an extraordinary 137 different strategies.” In response to situations like these, there is a renewed evidence-based movement in medicine to improve the quality of medical treatments (Millenson, 1997; Timmermans & Angell, 2001).

Were corrections to reject quackery in favor of an evidence-based approach, it is likely that agencies would face the same difficulties that medicine encounters in trying to base treatments on the best scientific knowledge available. Designing and implementing an effective program is more complicated, we realize, than simply visiting a library in search of research on program effectiveness (although this is often an important first step). Information must be available in a form that can be used by agencies. As in medicine, there must be opportunities for training and the provision of manuals that can be consulted in how *specifically* to carry out an intervention. Much attention has to be paid to implementing programs as they are designed. And, in the long run, an effort must be made to support

widespread program evaluation and to use the resulting data both to improve individual programs and to expand our knowledge base on effective programs generally.

To move beyond quackery and accomplish these goals, the field of corrections will have to take seriously what it means to be a *profession*. In this context, individual agencies and individuals within agencies would do well to strive to achieve what Gendreau et al. (forthcoming) refer to as the “3 C’s” of effective correctional policies: First, employ *credentialed people*; second, ensure that the *agency is credentialed* in that it is founded on the principles of fairness and the improvement of lives through ethically defensive means; and third, base treatment decisions on *credentialed knowledge* (e.g., research from meta-analyses). By themselves, however, given individuals and agencies can do only so much to implement effective interventions—although each small step away from quackery and toward an evidence-based practice potentially makes a meaningful difference. The broader issue is whether the *field* of corrections will embrace the principles that all interventions should be based on the best research evidence, that all practitioners must be sufficiently trained so as to develop expertise in how to achieve offender change, and that an ethical corrections cannot tolerate treatments known to be foolish, if not harmful. In the end, correctional quackery is not an inevitable state of affairs—something we are saddled with for the foreseeable future. Rather, although a formidable foe, it is ultimately rooted in our collective decision to tolerate ignorance and failure. Choosing a different future for corrections—making the field a true profession—will be a daunting challenge, but it is a future that lies within our power to achieve.

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