THE CORRECTIONAL PSYCHOLOGIST

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SEXUAL OFFENDER UPDATE: TREATMENT EFFECTIVENESS

Lorraine R. Reitzel & Lisa M. Matlock

Does sexual offender treatment work? Considering that the audience of this article is comprised primarily of correctional treatment providers, it is probably safe to assume that we believe it does, at least for some offenders. How do we know if sexual offender treatment works? There are a number of different outcome variables that have been used to determine if treatment works, but sexual recidivism post-treatment stands among them as the ultimate measure of treatment effectiveness. Does evidence in the research literature support sexual offender treatment effectiveness?

Hanson, Broom, and Stephenson (2004) recently published an article describing the results of a treatment effectiveness study that took place in British Columbia. This study allowed the comparison of a group of sexual offenders that had been mandated to attend weekly treatment (n = 403) with a group of offenders that had not (by virtue of their release date/location; n = 321). The sexual offenders in this study were men who had been convicted of a sexual offense or an offense with sexual motivation who had been given a sentence of at least 2 years. The Hanson et al. (2004) study was an extension of an earlier evaluation of the Community Sex Offender Program (CSOP), a mandatory treatment program for all sex offenders who were released into community supervision in the Pacific Region (British Columbia) during a specific period of time. The CSOP treatment was provided by a number of clinicians of varying theoretical orientations, across a number of treatment centers, with at least some programs implementing cognitive-behavioral treatments. The first evaluation of the CSOP program did not find a significant difference between the treatment and comparison groups (as cited in Hanson et al., 2004). The current study, however, extended the follow-up period from 4 years to an average of 12.5 years (range = 7-14 years), which resulted in an increase in power to detect a difference between groups.

The type of research design used in both CSOP studies was unique in that it took advantage of naturally occurring circumstances (mandatory treatment program implemented in the 1980s) to allow for the control of selection bias in the respective groups. Authors of the current study reported that significant differences between the treatment and comparison groups included that the treatment group had a higher average number of prior sexual offenses, and that the comparison group offenders were released an average of 1.5 years earlier than the treatment group offenders (Hanson et al., 2004). Authors were unable to control for any sexual offender treatment that might have been received by either the treatment or comparison group before or during their prison sentences. However, they were able to control for a number of other variables, including time at risk to recidivate, year of release, age, and quality of the treatment received. In this study, recidivism included new charges and/or convictions.

Results indicated no statistically significant differences in sexual recidivism between the treatment and comparison groups, even when controlling for potential moderator variables, such as year of release and follow-up period (Hanson et al., 2004). Rates of sexual recidivism (unadjusted) for the treatment and comparison groups were 21.1% and 21.8%, respectively. Although previous literature has suggested a small, but significant effect of treatment in reducing recidivism with sexual offenders (e.g., r = .12 with N =

(Continued on page 3)

AMERICAN ASSOCIATION FOR CORRECTIONAL & FORENSIC PSYCHOLOGY

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TREATMENT EFFECTIVENESS *(Continued from page 1)*

1,313 in Hall, 1995), the results of the Hanson et al. (2004) study appear to contradict this finding. Moreover, the recidivism rate of sexual offenders in the Hanson et al. (2004) study is quite high – previous meta-analyses have indicated sexual recidivism rates of 13.4% (N = 23,393 in Hanson & Bussiere, 1998) in one case, and 12.3% and 16.8% for treatment and comparison groups, respectively, in another case (N = 9,454 in Hanson et al., 2002). Reasons for the high sexual recidivism rates in the Hanson et al. (2004) sample are unclear. However, one should keep in mind that all sexual offenders coming out of prison were treated in the Hanson et al. (2004) sample, whereas many other treatment effectiveness studies have samples comprised of offenders who volunteered for treatment or who admitted to their crimes before treatment. Therefore, pre-existing sample differences may have contributed to the comparatively higher recidivism rates in the Hanson et al. (2004) study.

Results of the Hanson et al. (2004) study are discouraging, but how relevant are these results to correctional psychologists? Sexual offender therapists are invested in providing treatment that works for the protection of others – the protection of inmates and staff in a correctional setting and the protection of community after the offenders are released. Additionally, they are invested in maintaining their treatment programs (not to mention keeping their jobs!). Of course, a single study is not sufficient to conclude that sexual offender treatment is ineffective. However, studies with null findings, such as the recent Hanson et al. (2004) study, receive a lot of attention in both academic and lay circles. In fact, results of this study were first made known to the authors of this newsletter article from a National Public Radio report. Results like these can influence public perception of sexual offenders and the effectiveness of sexual offender treatment, and can have ramifications on decisions that impact the funding of correctional and community treatment programs. As correctional psychologists, it is up to us to justify the treatment we are providing. Therefore, it is important for correctional treatment providers to regularly conduct evaluations of their treatment programs and to do what they can to make these results public by publishing them or making them available to researchers who will pursue publication. The predominance of literature on sexual offender treatment appears to indicate that the completion of treatment programs can be effective in preventing offenders' sexual recidivism – it is up to us to continue contributing to this literature in order to determine what types of offenders are amenable to treatment and what makes some treatment programs more effective than others.

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AMERICAN ASSOCIATION FOR CORRECTIONAL AND FORENSIC PSYCHOLOGY STANDARDS FOR PSYCHOLOGY SERVICES IN JAILS, PRISONS, CORRECTIONAL FACILITIES, AND AGENCIES

ETHICAL PRINICIPLES

Introduction

Over the past 2 decades, the jail and prison inmate population of the United States has dramatically increased. This increase includes growing numbers of minority group members as well as mentally ill and drug-addicted individuals. Unfortunately, this unprecedented prison growth has strained the economies of many states, resulting in less financial support for ancillary rehabilitation services for those in need of special medical and mental health care. Despite constitutional mandates that provide for adequate mental health services to the seriously mentally ill, many correctional systems do not have sufficient staff or resources to meet these mandates. Consequently, mental health staff may confront ethical questions or practice dilemmas that general ethical standards alone do not clearly address.

When the American Association for Correctional and Forensic Psychology (AACFP) Practice Standards Committee revised the 1980 Standards for psychology services in jails, prisons, correctional facilities and agencies, our intent was to augment the American Psychological Association's (APA) Ethical principles of psychologists and code of conduct (1992) for psychologists providing services in correctional and forensic arenas. Since we believed that APA's ethical principles would suffice for our purposes, we did not believe it necessary to accompany the Standards with a separate set of ethical principles specific to AACFP.

The APA has recently published its revision of the 1992 Ethics Code, and over 2 years have passed since the completion of the revised 1980 AACFP Standards. The AACFP's Practice Standards Committee now believes that providing psychological services in correctional settings is sufficiently unique that a separate section of ethical principles that guide these practices is warranted. These ethical principles are not intended to supplant those of the APA (Beneficence and Nonmaleficence, Fidelity and Responsibility, Integrity, Justice, and Respect for People's Rights and Dignity). Rather, they are intended to augment their application in correctional settings to assist correctional psychologists in arriving at ethical courses of action and application of the practice standards.

GENERAL ETHICAL PRINCIPLES

Preamble

Ethics, as the philosophy of morality and right and wrong conduct, provides the foundation for many professional standards. Despite constitutional mandates for mental health services in forensic settings, there are few arenas in which cultural morality and psychology's ethics clash more strikingly than in that of criminal justice. Often, psychologists attempting to meet professional standards of practice in this arena find themselves struggling with conflicts among the morality of the criminal justice system, the punitive nature of the criminal justice model, their own professional ethics, and their personal values. In these struggles, it can be easy to lose sight of overriding principles that may provide essential ethical guidance.

In addition to the General Principles of the revised APA Ethics referenced above, the following are the general principles the American Association for Correctional and Forensic Psychology believes psychologists should also consider when providing services to offenders.

A. OFFENDER'S RIGHT TO DIGNITY AND RESPECT

We live in a society in which offenders are often considered and treated as "second class" citizens, and not worthy of the same rights and dignity as non-offenders. Psychologists strive to avoid such distinctions, and extend the same rights of dignity

(Continued on page 5)

STANDARDS FOR PSYCHOLOGY SERVICES *(Continued from page 4)*

and respect to their offender clients as they would to non-offender clients.

B. AVOID OR MINIMIZE HARM

Correctional psychologists must strive to avoid or minimize psychological harm to their clients. It has been said that offenders are incarcerated as punishment and not for punishment. Social, political and correctional administrative forces may indirectly pressure correctional psychologists to provide services in keeping with the current social and politically popular punitive model of deterrence. Such pressure may result in unnecessary delays in seeing clients, responding to their requests, insufficient safeguards of due process, sub-optimal assessments, inappropriate or incomplete treatments, and incomplete documentation.

Correctional psychologists must strive to identify and resist such pressures, focusing instead on providing objectively optimal, research-based psychological and mental health services and interventions to their clients. Although the work of correctional psychologists may result in some temporary discomfort to the offender (e.g., placement in restraints or under constant observation), the overriding concern should always be the safety, welfare, and optimal mental health of vulnerable individuals (e.g., the offender, other offenders, and correctional staff).

C. MAINTAIN AND ADVOCATE FOR COMPETENT MENTAL HEALTH SERVICES AND RIGHTS.

One may easily lose sight of this general principle in correctional settings in which clinical oversight may be minimal and administrative, social, and financial support for competent psychological services is lacking. Nevertheless, correctional psychologists must adhere to the highest standards of professionalism when providing mental health care in the context of available resources. At the very least, providing mental services that are incomplete, ineffective, or otherwise inadequate is both an ethical and functional disservice to the offender client, the institutional community, and ultimately the society from which they come and to which they will ultimately return.

D. SOCIAL RESPONSIBILITY

Psychologists in correctional settings always have multiple layers of client responsibilities. Professional obligations are owed the offender, the correctional agency, and ultimately, society at large. A subset of society also includes colleagues, other offenders, and correctional staff. Clearly, correctional psychologists who fail their primary client ultimately must fail the public. Correctional psychologists must continuously remain mindful of these multiple layers of responsibility, including:

•advocating for and providing optimal psychological services of sufficient quality and quantity to meet the professionally determined mental health needs of seriously mentally ill offenders;

•contributing to the staff training needs of the forensic setting or agency, including identifying and caring for the mentally ill offender and suicide risk management;

•educating policy makers and the public about the mental health, rehabilitative, and community reintegration needs for offenders in general and mentally ill offenders in particular.

It is our belief that adhering to these ethical concepts and principles, correctional psychologists will optimally contribute to the understanding and care of mentally ill offenders by mental health professions, correctional staff, policymakers, and the public, and provide mental health services in keeping with the highest professional standards and expectations.

Practice Standards Committee
American Association for Correctional and Forensic Psychology
Richard Althouse, Ph.D., Chairperson

(Continued on page 6)

AMERICAN ASSOCIATION FOR CORRECTIONAL AND FORENSIC PSYCHOLOGY: SUICIDE PREVENTION/INTERVENTION STANDARD

32A. SUICIDE PREVENTION/ INTERVENTION

Correctional facilities and agencies shall have written and implemented suicide prevention/ intervention policies, procedures and protocols that provide for screening, assessment, management, and follow up with suicidal inmates, both at reception and during the period of their incarceration. These policies and procedures will be consistent with professionally recognized suicide prevention and management standards (e.g., National Commission of Correctional Health Care, American Correctional Association, American Association for Correctional and Forensic Psychology, National Institute of Corrections), and relevant statutory guidelines. Protocols shall provide for varying levels of intervention appropriate to the assessed suicide risk including non-punitive observation and restraints, with constant to randomly scheduled (at not more than 15 minute intervals) observations by designated staff when full-view constant monitoring is not available. Secured transfer of clinical information and the suicidal inmate to a mental health or medical treatment facility will occur when the continued safety of the individual cannot be ensured following release from observation or restraints status.

An agency's policy must provide for 24-hour on-call availability of crisis, mental health, and/or medical staff for rapid assessment of the potentially suicidal inmate regardless of population (e.g., general population or segregation) or agency. The facility must have and implement a policy regarding a level of humane management (e.g., availability of personal property, meal preparation and eating utensils, bedding, levels of confinement or restraint) that minimizes any potential self-harm risk until the initial mental health or medical assessment is undertaken. A suicidal inmate placed in observation status by other than mental health staff (e.g., security staff) must be assessed for suicide risk, management, and intervention needs—including a psychiatric referral or transfer— by qualified mental health staff within 24 hours of initial placement. After the initial assessments, mental health status assessments will be done at least every 48 hours, or more often as assessed risk warrants, until the inmate is released or transferred to an appropriate mental health facility. Rationale for lowered levels of observation or monitoring shall be thoroughly documented. Post-release assessments and management by mental health professionals should occur at least weekly (more often if assessed risk warrants) until determined otherwise by qualified mental health staff.

A suicidal or self-injurious inmate whose behavior appears out of his/her control and who is placed in restraints following imminent or repeated injury to self or others for purposes of minimizing self-harm or harm to others should be assessed by a qualified mental health professional as soon as practical. After the initial assessment, assessments of mental status shall occur at subsequent intervals sufficient to determine the risk potential of the inmate and to make recommendations for continued restraint placement, reduced levels of restraint, or release, to the appropriate authority. Following release from restraints, the inmate shall be seen as warranted to assess, manage, and intervene to minimize suicide risk. If it is determined that an inmate in restraints cannot be safely released and treated at the facility, arrangements for transfer to an appropriate mental health facility shall be made and implemented as soon as is practical.

Forms necessary for the documentation of screening, assessment, levels of intervention, monitoring, and follow-up procedures should be readily available to staff for completion. This documentation will be placed in the inmate's mental health and medical records file in sufficient time to afford professionals an opportunity for review within 5 working days or sooner if the assessed risk and

(Continued on page 7)

SUICIDE PREVENTION/INTERVENTION STANDARD *(Continued from page 6)*

level of intervention warrants.

The facility will have a written and operational plan for debriefing (such as a critical incident stress debriefing) for both staff and inmates following a serious suicide attempt or a completed inmate suicide. The critical incident debriefing shall be facilitated by appropriately trained staff cognizant of the advantages and disadvantages of this type of debriefing for those involved. The debriefing shall not be part of any investigative or review process, and participation will be voluntary. The results of the debriefing should be confidential and not shared with administrative or investigative staff. Professional and confidential referrals shall be made for staff and inmates needing additional assistance with psychological difficulties.

In addition to a critical incident debriefing, there will also be a review of procedures following an attempted or completed suicide to ensure that proper precautions were taken and procedures followed. The results should be shared with quality assurance personnel and other staff as warranted.

There is a written and implemented training program for staff training and review of the policies and procedures for suicide assessment, intervention, and transfer. Training and review should occur at least on an annual basis; more often if staff turnover warrants.

Discussion

Clearly, incarceration is a stressful experience, and incarceration in combination with serious medical and/or mental illness or other personal stress can be precursors to suicidal ideation, gestures, serious attempts, and completions. These are among the reasons why the incidence of suicide in prisons and jails far exceeds that of the general population. Because there is professional recognition that an individual who is sufficiently stressed and determined to end his or her life is likely to eventually succeed, any standard of suicide prevention and intervention policies and procedures must somewhat arbitrarily balance an agency's obligation to firmly minimize the risk of suicide attempts or completions against the use of unwarranted restraint to prevent any possible attempt or completion.

Nonetheless, the constitutional scope of the Fourth and Eighth Amendments mandates a suicide prevention program in correctional facilities and agencies that have custody of inmates. To effectively meet these mandates, jails, correctional institutions or agencies that are responsible for the care of offenders should have written and implemented suicide prevention policies and procedures with operational time-frames both on site and in central administrative offices of multi-site systems. It should be said that not meeting these mandates can result in time consuming, stressful, and potentially expensive litigation against the parties involved.

Beyond the constitutional mandates, however, experience has shown that many who contemplate and/or attempt suicide do so in the midst of a crisis that, given time and appropriate interventions, can be resolved. This leads the potentially suicidal person—and possibly others— to be thankful she or he had not attempted it or succeeded. Therefore, apart from any constitutional mandate, there are humanitarian reasons to facilitate suicide risk assessment and intervention strategies.

An inmate suicide is also a critical incident for other inmates and staff. Because of the potential for investigations, staff discipline, and agency litigation that may follow a completed offender suicide, staff and other offenders' emotional trauma may be intensified or prolonged with negative impacts on agency morale, productivity, and security. Therefore, a comprehensive suicide assessment and intervention policy—including quality assurance program reviews and critical incident debriefings—is a necessary adjunct to any correctional facility's inmate care and treatment obligations.

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(Continued on page 8)

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Practice Standards Committee
American Association for Correctional and Forensic Psychology
Richard Althouse, Ph.D., Chairperson

ETHICAL PRINCIPLES AND SUICIDE PREVENTION/INTERVENTION GUIDELINES PROPOSED BY PRACTICE STANDARDS COMMITTEE

Since the publication of our revised Standards in 2000, our Practice Standards Committee believed our Standards would be enhanced by two additions; one regarding ethical principles, the other, related to suicide prevention/intervention policies and procedures in jails and prisons. Over the past year and a half, the Practice Standards Committee reviewed, researched, and sought consultation in both areas. After numerous drafts, Dr. Althouse and I are very pleased to share the results of the committee's work in this issue of *The Correctional Psychologist.*

The two sections in this issue are proposed as supplements to our Standards. Comments from the membership are invited, and should be sent to: Richard Althouse, Ph.D. Oakhill Correctional Institution, Box 140, 5212 Highway 12, Oregon, WI 53575 or e-mailed to: Richard.Althouse@doc.state.wi.us. Absent any substantive changes, these proposed guidelines will be amended into our Standards later this year.

I would like to express my appreciation to the Practice Standards Committee—Richard Althouse, Mark Skrade, Robert Reitz, John Rushbrook, Pat Orud, and Leonard Morgenbesser— for their diligence in this effort, as well as John Stoner, Paul Woodward, Tyler Carpenter, and Gerald Koocher for their helpful suggestions.

John Gannon
President
American Association for Correctional and Forensic Psychology

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December 17, 2004

Dear fellow FMHAC members,

I am writing this letter to provide you with information about some of the exciting changes occurring at this year's conference.

We are very excited about our move to the Embassy Suites Hotel for the March conference. This move will allow our venders to set up their exhibits closer to the attendees and our attendees will enjoy nicer rooms, with TV, telephone and internet access. The hotel also has a fitness center, indoor pool and hot tub. Your stay includes free hot breakfast and happy hour.

You'll also have noticed that your previously mailed conference brochure arrived with another brochure for the American Association for Correctional and Forensic Psychology (AACFP). The AACFP approached us to discuss ways we could combine our strengths and work together. The AACFP is an organization of behavioral scientists and practitioners who are concerned with the delivery of high-quality mental health services to criminal offenders, and with promoting and disseminating research on the etiology, assessment and treatment of criminal behavior. Our missions are very similar but we differ in two important ways. The AACFP conducts their efforts via an excellent journal, *Criminal Justice and Behavior*, but they do not have a conference. We offer a fine conference but do not have a journal. The two Boards of Directors decided to try a joint venture.

Our 30th year conference will be held in association with AACFP and we are offering special conference discounts for joint memberships. For more information about AACFP, visit www.eaacp.org. The full conference program and a registration form is available at our website: www.fmhac.com. We have also applied for CME's and we are working in cooperation with UCSF for CME approval.

I look forward to seeing you at this year's conference. If you have any questions please call the association at (415) 407-1344. Molly Willenbring is providing excellent administrative support for FMHAC and is available to answer all your questions.

Sincerely,

Joel Fay, Psy.D.
President

FMHAC is excited to present the

30th ANNUAL CONFERENCE!

❖ The 2005 Conference

The Forensic Mental Health Association of California, in association with the American Association of Forensic and Correctional Psychology, present the following seminars as well as a full day of workshops, listed in their entirety on our website, **www.fmhac.com**. CEU, CME, and STC credits will be offered.

Wednesday Pre-Conference: ISSUES IN GERIATRIC MENTAL HEALTH CARE
(designed to meet recent CEU requirements) John Gillette, M.D., Private Practice

Keynote: Jeanne Woodford
Director, California Department of Corrections

Wrap Up: PUTTING THE PSYCHOLOGY BACK INTO EXPLANATIONS OF SPOUSAL ASSAULT
Donald Dutton, Ph.D., Professor, Department of Psychology, University of British Columbia

Workshop Topics:

- Mental health treatment in the CYA
- Inmate suicides
- Personality disorders
- Management and assessment of sexual offenders
- Collaborative approaches to mentally ill offender mgmt
- ADHD
- Coping with stress
- Medication issues
- HIV, hepatitis and amphetamines
- Electronic technology
- Competency restoration
- Empathy in violent offenders

❖ Of Interest

State Council on Mentally Ill Offenders Open Meeting
Wednesday, March 16, 10:00 am
The Embassy Suites, Seaside
Chair: Roderick Hickman, Agency Secretary, Youth and Adult Corrections Authority
Co-chair: Steven Mayberg, State Director of Mental Health
Members:

Andrew Hall	Dave Meyer
Wendy Lindley	Jo Robinson
Duane McWaine	James Sweeney

Check our website, **www.fmhac.com**, for the full program and updates on a Thursday luncheon speaker.

❖ We Have a New Venue

This year's conference will be held at the Embassy Suites, located in the Monterey Bay area. The hotel offers a wide range of luxuries and amenities for you to enjoy between seminars including large, cozy suites, a swimming pool, fitness center, child care area...and of course the lovely Monterey beach is only blocks away.

❖ The Details

Where and When: The Embassy Suites, 1441 Canyon Del Rey, Seaside, CA 93955
March 16-18, 2005

Registration: To attend this conference, please fill out the enclosed registration form and return it to the Association by March 1, 2005. See the program on our website, **www.fmhac.com**, for more complete information about the conference.

Lodging: Please make reservations at the Embassy Suites by calling 800-559-4308. **Mention the Forensic Mental Health Association for a conference rate of $119 per night.**

MENTAL HEALTH IN CORRECTIONS CONSORTIUM

2005 Symposium

Integrated Mental Health Skills and Services: The Total Correctional Population

April 11-13, 2005

Presented by
Forest Institute of Professional Psychology
Springfield, MO
Forest.edu

The Mental Health in Corrections Consortium (MHCC) Planning Committee is pleased to announce the agenda for Mental Health in Corrections Symposium. The Symposium is being held in Kansas City, Missouri, April 12 and 13, at the Kansas City Marriott Country Club Plaza. Attendees will include psychologists, social workers, psychiatrists, administrators, medical doctors, mental health practitioners, substance abuse treatment professionals, registered nurses, chaplains, counselors and numerous other professionals working in the mental health and corrections fields.

This year's theme is Integrated Mental Health Skills and Services: The Total Correctional Population. Trends in correctional mental health care have lead to a number of treatment and management strategies for what may be called specialty groups among the correctional population.

Traditionally though, and continuing in current practice, the majority of mental health professionals' time has been centered on the non-specialized correctional client. Personality and conduct disordered inmates, aggressive and repeat offenders, inmates disruptive to the system, are the vast majority of correctional clients. These general population inmates require extensive professional services; services designed to improve functioning with the correctional system as well as to reduce recidivism and relapse.

In addition to the symposium, three one-day, pre-conference workshops will be conducted on Monday, April 11.

Don't miss this opportunity to join with many other mental health providers in the criminal justice system for education, networking and fellowship.

Sincerely,

Steve Norton

Steve Norton, PhD
MHCC Executive Director

Mark Skrade

Mark Skrade, PsyD, CCHP
President, Forest Institute

(Continued on page 12)

2005 Symposium *(Continued from page 11)*

General Information

Who Should Attend: Psychologists, Psychiatrists, Social Workers, Nurses, Chaplains, Administrators, as well as other mental health or substance abuse treatment providers, especially those in the criminal justice setting.

Learning Objectives: At the end of this symposium, participants will:
1. Improve knowledge of treatment resources for the general population correctional client.
2. Identify programmatic and management resources for the correctional mental health professional.
3. Be aware of new directions for correctional clients and staff.

Symposium Sponsors: Forest Institute of Professional Psychology, Springfield, MO

Continuing Education Credits: Forest Institute of Professional Psychology will grant continuing education credits for hours attended. Forest Institute of Professional Psychology is approved by the American Psychological Association to offer continuing education for psychologists. Forest Institute maintains responsibility for the program. Up to 12 Continuing Education credits will be available for the symposium, April 12 and 13. Credit will be given only for workshops attended. Seven hours Continuing Education credits will be granted for participants in a pre-conference workshop, April 11.

Included in Your Registration: Symposium registration includes two days of educational programming, CE credits where applicable, appropriate educational materials, admittance to the exhibit area, continental breakfast and lunch on Thursday and Friday, and beverage breaks in the afternoons.

Conference Information: Up to date symposium information will be posted on the Forest Institute Web Site: www.forest.edu, click on Welcome, then Mental Health in Corrections Consortium.

Poster & Networking Session: A poster session with refreshments and a cash bar will be held on Tuesday evening, April 12, from 5:00 - 6:00 p.m. We are excited to report that a number of posters have been received. It is not too late to submit your idea - informal research, pilot studies, dissertations are ideal submissions. In addition to the poster presentations, we are planning to host opportunities for networking on issues challenging mental health providers in criminal justice settings. We also hope to have representatives from several companies that offer resources applicable to criminal justice settings available. This session will be ideal for assembling groups interested in exploring Kansas City's jazz & blues clubs, great restaurants, and other entertainment options. For more information, contact Becky Moyer at bmoyer@forest.edu or 417.823.3477.

Forest Institute of Professional Psychology: Mental Health in Corrections Consortium is presented by Forest Institute, a not-for-profit independent school of clinical psychology. Dedicated to caring for the diverse mental health needs of the community, the school offers an APA-accredited Doctor of Psychology (Psy.D.) degree, as well as a Master of Arts (M.A.) degree and an accredited post-graduate certificate in Marriage and Family Therapy. Other certificate programs include Pain Management (approved by the American Association of Pain Management) and Integrated Health Care: Practice, Consultation, and Management.

Students who have a strong interest area, or specific career goals, have the option of choosing a concentration of coursework and practica training that focus on a single clinical area, such as Corrections/Forensics. Through the school-owned Robert J. Murney Clinic, licensed psychologists and psychologist trainees deliver over 1,000 therapy sessions each month. These sessions occur both onsite and through 14 external community agencies, and provide diverse training opportunities in a full range of therapies and testing.

Forest Institute of Professional Psychology is accredited by the Higher Learning Commission and is a member of the North Central Association of Colleges and Schools (NCA). Professional accreditation of the Doctor of Psychology (Psy.D.) degree is granted by the American Psychological Association (APA).

(Continued on page 13)

2005 Symposium *(Continued from page 12)*

REGISTRATION FORM – Registration Deadline April 1, 2005

Name & Title _____ Working Title _____

Employer _____

Mailing Address _____

Telephone _____ E-Mail _____

Fees must be in US Dollars	Prior to 2/14/05	After 2/14/05	Amount Paid
Pre-Conference Workshops:	**$125.00**	**$150.00**	

Choose one workshop for Monday April 11, 2004, 8:30 pm – 4:30 pm:

1. Existential Themes in the Treatment of Incarcerated Individuals- Philosophy and Clinical Interventions – Joseph A. Grillo, PsyD _____
2. What Do We Say When They're Not Mentally Ill - John W. Stoner, PhD _____
3. Suicide Risk Management: Identifying Suicidal and High Risk Inmates – Thomas W White, PhD _____

Symposium: Tuesday, April 12 and April 13, 2005

	Prior to 2/14/05	After 2/14/05	
Individual	$220.00	$265.00	_____
Group of 4 or more	$175.00	$220.00	_____
Student with proof of Current enrollment	$ 75.00	$ 75.00	_____
Student Poster Presenter	$ 50.00	$ 50.00	_____
One Day Registration	$150.00	$175.00	_____
		Total Paid in US Dollars	_____

Method of Payment:

Check _____ MasterCard _____ VISA _____

Credit Card # _____ Exp Date: _____

Authorized Signature _____

Purchase Order or Training Authorization # _____

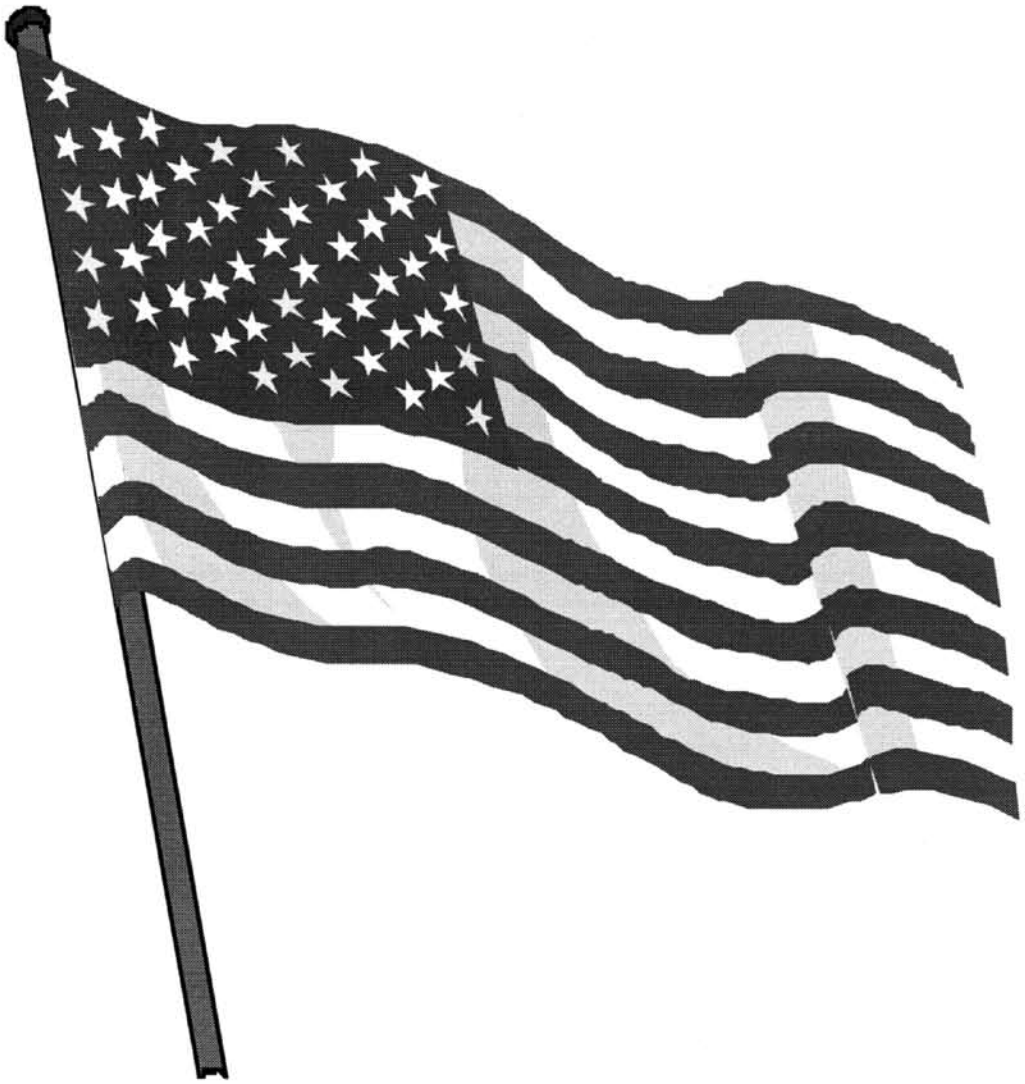
Mail Registration form and payment to:

MHCC, Forest Institute of Professional Psychology, 2885 W. Battlefield Rd, Springfield, MO 65807 **OR** Fax Registration to 417 823-3442. For further information contact Becky Moyer, bmoyer@forest.edu

Cancellation Policy: A cancellation fee of $25 will be charged for all cancellations made prior to March 30, 2005. All cancellations must be submitted in writing. Confirmed registrants who fail to attend and do not cancel prior to March 30, 2005, are liable for the entire symposium registration. You may send a substitute.

smithr@marshall.edu

UNITED WE STAND



Robert R. Smith, Ed.D.
The Correctional Psychologist Co-Editor
625 Richardson Road
Fortson, GA 31808

American Association for Correctional and Forensic Psychology
—Application for Membership—

Name_____ Title_____

Application Date_____

(Check preferred mailing address)

Home:_____ Institution:_____

_____ _____

_____ _____

_____ _____

Phone:_____ Phone:_____

Academic Attainment

College or University | Major Area | Degree | Year

_____

_____

_____

Work Experience

Where | From/To | Position

_____

_____

_____

List three major areas of interest: _____

_____

Are you an APA member?_____ If so, what Division(s)_____

Are you an ACA member?_____ Other organizations_____

_____

_____

Membership fees for AACFP are $65.00 per year in U.S. currency, and include four issues of The Correctional Psychologist and six issues of Criminal Justice and Behavior (CJ&B) each year. Renewal notices are sent to current members in December of each year. Since membership is on a calendar-year basis, applicants or renewing members with applications dated after the first of January receive any copies of CB&J issued before the date of the application, as well as all those issued after the application date through the year's end. Timely renewals are a great help to the Association for both financial and planning reasons, and we appreciate your assistance in helping us keep the new enrollment and renewal process working smoothly.

Please send your check or money order payable to AACFP in the amount of $65.00 (U.S. currency), along with your new or renewal application to: AACFP, P.O. Box 7642, Wilmington, NC 28406. All notices of change of address will also be processed most efficiently when sent to the same address.

Check type of application: ❑ New

❑ Renewal