

CHANGES IN CRIMINAL JUSTICE POLICIES REGARDING REENTRY OF INMATES IMMINENT

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The following is a slightly edited version of an article Dr. John Gannon wrote in early 2004. The issues seem to be more alive than ever and well worth consideration by our members.

I vigorously encourage AACP members to consider making a special effort to educate themselves regarding the many issues surrounding the reentry of inmates into the civil community. The perfection of our expertise in this key area may well allow for the most significant elevation of our field in decades.

For very practical reasons, some of which are related to prison over-crowding, racial disparities in incarceration, community safety, and the various ramifications for politicians involving high prison budgets and the dramatic crimes sometimes committed by parolees, “reentry,” appears to be more than just the buzz word de jour.

Unlike so many other correctional topics that seem to rise and fall without explanation, “reentry” is continuing to gain traction nationally among prison cognoscenti and is becoming a topic of considerable interest at the upper levels of more enlightened (or, perhaps, stressed out) prison administrations, as well as at the highest levels of government. Eventually, changes, perhaps very big changes, in criminal justice policies are likely to come out of attempts to deal with “reentry” and its unique convergence of budgetary, political and community safety problems.

Who better than correctional and forensic psychologists to lead the discussion on many of the most important topics related to reentry. On everything from criminal thinking, criminogenic needs, inmate risk assessment, program design, and outcome success measurements, our field and our members already possess much of the special expertise that will make enormous contributions to both the debate about and the applications of evolving criminal justice policies.

As many of us are well aware, correctional psychologists too often get bogged down

in the internecine battles related to supervision by psychiatrists, inadequate union representation, medical staff privileges, admitting privileges to ad seg, administrative directives, and a hundred other annoyances. Many years of monitoring this merry-go-round of issues shows that little, if any, progress has been made toward resolution while considerable time, money, and energy has been sucked out of forensic and correctional psychology in the effort.

In fact, at this point in our professional

“The iron has long been hot, and the time for forensic and correctional psychologists to strike at improving conditions for inmates, citizens, and themselves will soon be past.”

history, our effect on criminal justice policies is virtually nil. Furthermore, it has not been shown that correctional psychologists of any persuasion can have anything other than sporadic influence even on the way mental health programs are developed, implemented, or monitored in correctional and forensic settings in the United States.

While good programs certainly exist, they are all too typically the result of idiosyncratic conditions combined with dynamic and opportunistic leadership. Sadly, when those conditions or leadership change, the dynamic influence and good programs are the first to disappear.

Regrettably, a genuinely effective model for influencing criminal justice policies, becoming more effective within institutions and guiding the provision of services to inmates consistent with what has been demonstrated as effective in the research literature has yet to emerge within our

(Continued on page 3)

INTERNATIONAL ASSOCIATION FOR CORRECTIONAL & FORENSIC PSYCHOLOGY

The Correctional Psychologist (TCP) is published every January, April, July, and October, and is mailed to all International Association for Correctional & Forensic Psychology (IACFP) members. Comments and information from individual members concerning professional activities and related matters of general interest to correctional psychologists are solicited. The IACFP endorses equal opportunity practices and accepts for inclusion in *TCP* only advertisements, announcements, or notices that are not discriminatory on the basis of race, color, sex, age, religion, national origin, or sexual orientation. All materials accepted for inclusion in *TCP* are subject to routine editing prior to publication. Please send material for publication or comments to Dr. Robert R. Smith: smithr@marshall.edu. Deadlines for submission of all material are:

January issue—

October 15

April issue—

January 15

July issue—

April 15

October issue—

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MEMBER ARTICLE

CHANGES IN CRIMINAL JUSTICE POLICIES (Continued from page 1)

field.

Is there something inherent in psychology or in psychologists that makes this state of affairs inevitable? Is it the result of psychologists' own "learned helplessness" after decades of being treated as unwanted step-children? Is it because the diversity of psychology training allows too many of us to understand the individual trees of our own problems in our own institutions while we miss the forest of social problems we face as citizens and psychologists? Should we blame an unaccountable "system" for being inured to inefficiency and unamenable to treatment?

Or might our failure to develop such a model for correctional psychology's influence and guidance be the result, at least in part, of the failure of a unifying issue to emerge around which psychologists can rally; an issue that crosses boundaries of training and specialties, an issue that provides a focus of effort through which correctional and forensic psychologists can contribute to the well-being of their patients and clients, the efficiency of their institutions and facilities, the safety and health of their communities, and the recognition of their professional skills and expertise? Could "reentry" be this issue?

Of course a thousand hypotheses could be offered for the causes of correctional psychology's limited influence up to this point, but debate about them would simply occasion one more quagmire in which correctional psychology can get bogged down. My hope is that I can convince you that "reentry"

is indeed the ideal issue around which forensic and correctional psychologists can circle in order to unify our approach to forensic and correctional work, influence the development and application of institutional and agency policies, and participate in the social debate that will be radiating from this issue. In short, the issues surrounding "reentry" offers us the potential to take a seat at the table of correctional and social dialog in a way that has heretofore been unavailable to us.

However, if we are to be successful in this regard, forensic and correctional psychologists must be knowledgeable about both aspects of their field. And it is here that I am making special plea for our members to educate themselves about the topics and sub-topics that are certain to direct much of the coming reentry dialog.

That is, we cannot proceed as if we were individual outsiders railing against "the system," based on some random and various set of idiosyncratic beliefs. We need to be knowledgeable about the history, research and problems in the field of correctional policy, particularly, with those specifically related to "reentry," as well as those related to the general field of psychology, if we are to be considered as legitimate participants in the upcoming debates.

I believe there is little doubt that of all the topics broached over the last decade involving prisons and crime policy in the United States, "reentry," indirect as it is, is the one most likely to have the energy and staying power needed for policy makers to gravitate toward better mental health for our patients and clients, more assistance to inmates who want to change

their lives, more satisfaction for taxpayers as they view correctional budgets, and, to the degree that we participate actively, better working conditions for forensic and correctional psychologists. We need to be a strong part of this process.

To this end, I encourage all of our Association members to consider their level of knowledge about crime and correctional issues, policies, and research. Most of us have read Samenow's *Inside the Criminal Mind*, and many of us are aware of Andrews' and Bonta's *The Psychology of Criminal Conduct* and Gottfredson's and Hirschi's *A General Theory of Crime*. But are you familiar with Wilson's and Hernsteins' *Crime and Human Nature*? Do you have a copy of the *Oxford History of the Prison* available for review? Have you read *Prisons* by Tonry and Petersilia? How about *Crime and Politics* by Ted Gest? Marc Mauer's *Invisible Punishment: The Collateral Consequences of Mass Incarceration*? Are you reading your *Criminal Justice and Behavior* journals regularly?

More importantly for the upcoming dialog on "reentry" and our ability to participate effectively, do you know how many persons per 100,000 are incarcerated annually in your state? The total number of people incarcerated in your state prisons? How many are in jail and or on probation or parole? How many inmates are released each year? How many go to half-way houses? What percent are drug or alcohol abusers? How many of those are in treatment

(Continued on page 4)

MEMBER ARTICLE

CHANGES IN CRIMINAL JUSTICE POLICIES (Continued from page 3)

while incarcerated? What kind of treatment is available? What is the amount of return on each dollar invested in treatment of alcohol and drug addicted inmates? What percent of sex offenders in your state are being treated? Do you know the racial composition of inmates in your state? Are crime rates in the United States going up or down? What are the effects of "sentencing guidelines?"

Many of these questions are addressed in Joan Petersilia's book, *When Prisoners Come Home: Parole and Prisoner Reentry*, and I

encourage you to put this book as high as possible on your reading list. We have previously provided reviews in *The Correctional Psychologist* of Dr. Petersilia's book, and you may also consider going to amazon.com and reading the reviews of Dr. Petersilia's book there, or even go to seweb.uci.edu/users/joan/ to find out more about the extraordinary career of this award winning researcher.

The iron has long been hot, and the time for forensic and correctional psychologists to strike at improving conditions for inmates, citizens, and themselves will soon be past.

Educating ourselves now about these important issues is a crucial step that will propel our profession to the higher level of engagement, status, and efficacy for which we were trained. I hope that you will join your colleagues now in preparing for engagement in this critical effort.

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MEMBER ARTICLE

THE WAR ON DEPRESSION: JAIL OFFICERS ON THE FRONT LINE

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When working in a local jail, an inescapable fact of life is that offenders will get depressed. I can hear the jail officers now, "Oh no, not that crybaby again." Offenders may be depressed when they enter the jail for the first time, when they are booked in for the proverbial "umpteenth time" or after they have been in population for many months. Offenders have been known to be depressed even when they have a pending release date and they must face the world again. The world is not going their way...depression can result.

Offender or inmate depression can have a lasting effect on the local jail. Depressed inmates can take up staff time when they recount their feelings and problems. Depressed inmates who mental

health staff consider a risk for suicide attempts or self injurious behavior can tax staff time and resources because of high observation housing, the time spent talking to and monitoring them, and the necessary detailed documentation.

Another fact of life in jails is that the health and well being of these inmates is the responsibility of the jail staff, especially the correctional officers who are on the front lines in the war on inmate depression. The problem is that some, and certainly not all jail officers, become somewhat jaded, callous and unfeeling. This can be caused by the stress of job dangers; the shift work, the fatigue and seeing the same inmates come in over and over. Some officers begin to see their work, not as

a jail correctional officer but as a "babysitter."

I witnessed these negative emotions and beliefs in my 27 years working in a local jail, rising from custody officer to classification supervisor. There were times that I too felt that way. One way I found to alleviate these negative emotions and refocus was to remind myself of the importance of the correctional officer's role to the larger community. The public has entrusted us to keep them safe by keeping the inmates, no matter what their crimes and behavior, safely confined. All debates aside, safely confined means several things, including a legal duty to prevent inmates from harming themselves. This means that staff,

(Continued on page 5)

MEMBER ARTICLE

THE WAR ON DEPRESSION (Continued from page 4)

civilian (mental health) and sworn, must work together to achieve this goal.

In the February/March 2009 issue of *Corrections Managers' Report*, noted corrections consultant Martin Drapkin discusses the role of correctional staff when encountering depressed inmates. The correctional officer is on the front line. I have always believed that jail officers are fighting a kind of war; a war of no escapes, no inmate injuries, no staff injuries (or worse), no contraband, and inmates not harming themselves.

Related to this battle that we fight is the liability incurred if inmates are successful in killing themselves or suffering serious injury in the attempt. If inmates successfully kill themselves, we all know that there will be lawyers, families, media, and Internal Affairs getting involved to see if staff (most frequently the line officer) saw any sign that the inmate was suicidal, removed any means of self harm, referred the inmate to mental health, and did all that was possible to head off the suicide.

Am I saying that all suicides can be prevented? No, not really. Jails have had inmates killing themselves ever since the first place of confinement was built. What I am saying is that many can be prevented if the jail officers keep in mind some aspects of inmate management that are discussed in this article.

A Look at Depression in the Inmate Population

• There are different types of mood problems, but two types experienced by inmates, and which jail officers will encounter are, situ-

ational depression (Drapkin terms it normal depression) and the more serious biochemical depression.

• **Situational depression** is what the term implies, depression that results from being in a situation which is difficult for the person. In this case, an inmate is locked up, experiencing the shame of arrest. It can be any charge where the inmate is shamed, embarrassed, or believes that he or she cannot face friends or family. The inmate also has feelings of inadequacy, failure and loss, fear of other inmates, and fear of problems in relationships, employment, finances, and legal matters. The inmate worries about what may happen. Situational depression is something that we all feel occasionally, but while in the community, inmates may exacerbate the depression with alcohol and drugs, where despondency may set in during withdrawals. The feelings and thoughts of situational depression may be observable through conversation and behavior. In other words, a jail officer can learn a lot by simply asking what is wrong. The inmate may want to talk. Talking may be a "lifeline." Situational depression can escalate into intense emotional crisis situations where the inmate may think that suicide is a viable answer to problems. Also, if the inmate is susceptible to serious clinical depression (mental illness), normal feelings and thoughts of sadness or the "blues" sometimes alters a person's brain chemistry and can trigger a serious depression.

• **Serious biochemical depression**, often called "major depression" or "clinical depression" is a mental illness. Its symptoms are generally the result of changes in the brain's chemistry and medications are used as a basic treatment.

• As in situational depression, a biologically-rooted depression can exhibit symptoms that all jail staff that have frequent contact with inmates should be aware of. They include:

- Profound feelings of sadness that do not abate or the "blues."
- Irritability.
- Lack of energy to perform even the mundane, normal activities, including getting out of bed or keeping good personal hygiene.
- Isolation and loss of interest in people (friends, family, significant others) and normal activities such as programs and recreation.
- Deep feelings of pessimism and hopelessness.
- Thoughts of self-blame, guilt, and low feelings of self-worth.
- Changes in eating habits (too much or too little).
- Changes in sleeping habits (a lot, a little, or difficulty sleeping).
- Fatigue or feeling tired constantly.
- Constipation.
- Loss of sex drive. In a jail setting, this could translate into a lack of interest in a significant other. The inmate may also recount relationship problems on the street concerning sex.
- Complaints of physical ailments: headaches, stomach aches, dizziness, etc.

Fighting the War

There are some common sense strategies to fight this war on depression. I understand the reader of this article most likely is in the mental health field, thinking, "I know this material already, so what's the point?" In the 27 years that I worked in local corrections, (Continued on page 6)

MEMBER ARTICLE

THE WAR ON DEPRESSION (Continued from page 5)

these strategies served me best, so I ask for a little patience.

• **Get all staff involved.** In my in-service seminar on jail climate, I ask staff how many people walk through your jail every day. The answers are sworn staff, classification, mental health, commissary, medical, etc. Does anyone in training or management at least, or, at a minimum, discuss inmate depression with staff members who do not have critical daily functions but interact with inmates nonetheless? The other staff, such as commissary and food service, also get to know the inmates. I am not expecting them to take over the line officer's roles of inmate supervision, however, what I do advocate is letting the officers know if they encounter an inmate who exhibits signs of depression and their "gut instinct" causes them to believe that there may be a problem. The "gut" is probably the best gauge of possible trouble in a jail.

Allow me to illustrate. In our ETC Maintaining Boundaries class Tim Manley and I discuss the importance of staff letting officers know if inmates "come on" sexually to them. I use a true example from my work experience where a bright, pretty young female commissary worker was approached in a heavily flirtatious way by an inmate. She promptly reported it. A report was filed and, as a result, all staff were aware of this inmate's schemes.

Now let's think, if that worker could report flirtations from an inmate, why couldn't a civilian report that an inmate was talking about how worthless he was, or the inmate would not get up or appeared dirty when normally he was clean? What is to prevent a civilian from

walking up to an officer and saying "I think that inmate is not himself."

• **Selling the staff.** I have encountered officers who take a dim, condescending view of inmates and make no secret of it. I must admit there were days that I too thought, "they are scum, why should we care about them?, etc." We are human. But, I always thought that the corrections field is a profession where personal opinions cannot impede the job. I developed a mindset, "they are in my custody, I am responsible for them, and I have a duty to keep them safe-even from themselves. The courts will judge them." The staff must be encouraged to develop the same mind set. If they are pejorative and think that inmates do not deserve to be properly supervised, then those officers and staff should find another profession. Agency managers, from the sheriff, department head, etc., on down to the corporals, must sell this mindset.

• **Staff must be aware of indicators and symptoms of depression all throughout the inmate's stay, from booking to release.** Symptoms must be documented, from legible, clear, and accurate pass-on logs to well-written referrals and reports to qualified mental health staff. I would hate to produce a dog-eared, coffee, and mustard stained pass-on log about a seriously depressed inmate in open court. The lawyers would love that, especially if it did not contain critical information.

• **Pay attention to inmate physical injuries or illnesses. Consider them possible symptoms of serious depression.** Sure, some inmates love the attention from medical staff, and can be manipulative. They may possibly be sick or have a bona-fide medical problem. But, some

may be depressed. They must be checked out by medical staff and, if appropriate, by the mental health staff.

• **Avoid territoriality and callous attitudes.** Jail staff must function as a concerned team. Inmates who have depression problems should be discussed at roll call or staff meetings. If jail officers have the following points of view about inmates or mental health staff, supervisors must step in and "nip it in the bud." Or, review with them some good lawsuits filed by inmates, families, or those lovable attorneys. Be sure to include lawsuits where the jail had to pay out money (great in this economy) or the jail officers had to pay punitive damages, or were fired, all for taking a "flip" attitude about inmates and making major mistakes like:

- "All inmates are (you know what) and the world will be better off without them."
- "She should have thought about her kids (or whatever) before she got locked up. I don't give a damn about her or any other inmate."
- "We run the jail, not mental health."
- (To an inmate) "I don't care."
- "You got problems, I got problems, so what?"

• **Encourage positive communications.** The best way to combat depression is for jail officers to show compassion and concern to the inmate. It is the appropriate thing to do. It is also best not to argue with the inmate if he or she is feeling worthless. Just talk to them in a positive tone and refer them to mental health staff. Talking

(Continued on page 7)

MEMBER ARTICLE

THE WAR ON DEPRESSION (Continued from page 6)

to them away from other inmates is best. Privacy can be a great ally. Positive communications with inmates could include the following questions:

- "How are you doing today?"
- "You look a little down. Is there anything that you would like to talk about?"
- "Are you okay?"
- "I noticed that you didn't go to your program...is something wrong?"
- "You did not go to visiting today, what's up?"

If the staff show inmates compassion, without sacrificing security, and are concerned over the effects of depression, the inmates might come to realize that they can talk about their problems, and, by doing so, who knows how many suicides can be averted?

All staff, sworn, civilian, and mental health, should consider

these views. If we do nothing about inmate depression, we may as well pack it up and go home.

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pression in the jail setting. *Corrections Managers' Report*, 5, 65-66, 70-74.

Special thanks to Tim Manley, MSW, LCSW, for his input into this article.

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MEMBER ARTICLE

SO HE'S MALINGERING, NOW WHAT?

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Malingering is a diagnosis that rarely informs treatment. We will discuss malingering in the case of Mr. H who had a history of self-injurious cutting, head banging, and pseudo-seizures. Although mental health, medical, and correctional staff suggested that Mr. H's complaints were not due to underlying medical condition(s), he frequently lodged formal complaints of neglect against correctional officers and administrative staff. The case is notable in that the diagnosis of malingering directly informed our treatment plan.

Unfortunately, discriminating

feigned from veridical impairment is difficult. Various methods have been used to study dissimulation (c.f., Boone 2007, 2009, & Vickery et al., 2001). One method entails examining performance of research participants instructed to feign neuropsychological impairments relative to the performance of a group instructed to perform normally. The clinician may also compare an individual's score to the score that would be expected given random responding to test items. Performance that is significantly poorer than chance is suggestive of feigned symptoms. Additionally, clinicians may examine

performance on standardized tests for unusual and/or inconsistent response patterns.

Case Illustration

Mr. H, a middle-aged Hispanic male serving a long sentence in a maximum-security prison, presented with a paralyzed left hand and an inability to move his lower extremities. He used a wheelchair for mobility. His physical complaints could not be explained by medical and neurologic examination. He was referred for neuropsychological evaluation to determine whether

(Continued on page 8)

MEMBER ARTICLE

SO HE'S MALINGERING, NOW WHAT? (Continued from page 7)

cognitive deficits and/or faking accounted for his presentation. As described below, we concluded that Mr. H's presentation was more consistent with a diagnosis of malingering than with either a somatoform disorder wherein the patient inaccurately perceives physical impairment or with a factitious disorder wherein the patient intentionally feigns impairment in order to maintain identification as a sick person.

The validity of Mr. H's self-report was suspect. In addition to the observation that his self report regarding the duration of his symptoms contradicted medical documentation, Mr. H's symptoms were manifest only when he was aware of being observed. Functioning improved dramatically under surreptitious observation. This is inconsistent with a diagnosis of somatoform disorder. The diagnosis of malingering was supported by the observation that Mr. H explicitly sought resources and accommodations that he believed himself entitled as a result of his disabilities. Mr. H feared for his physical safety given that he had witnessed another inmate's crimes and he believed that he would be safer if he were removed from general population. He also requested a transfer to a facility closer to home under the rationale of accommodating his medical needs.

Empirical evidence of volitional feigned impairment was evident on multiple tests. The Portland Digit Recognition Test, is a forced-choice test of recognition memory wherein random responding results in an accuracy rate of 50% (Binder & Willis, 1991). Mr. H correctly recognized digit sequences on only six of the first 18 trials, a performance well below that expected from even

seriously impaired brain injury patients. His performance then altered dramatically so as to be consistent with a random response pattern. This shift presumably reflected his realization that below chance responding implies volitional feigning. Additional evidence was observed in his performance on Trails A compared to Trails B. On Trails A, the individual is presented with an array of letters scattered on a page. The task is to draw a line connecting the letters in alphabetic sequence. On Trails B, both letters and numbers are scattered on the page. The task there is to draw a single line that alternately connects letters and numbers in sequence (e.g., A-1-B-2 etc.). Norms are based on time required to complete the tasks. Although Trails A is a far less cognitively complex task than Trails B, there was essentially no difference in the time it took Mr. H to complete the two versions. These findings support a diagnosis of malingering. In summary, the conclusion that Mr. H was feigning impairment was supported by discrepancies in self-report, questionable symptoms of his alleged epileptic bouts, and a pattern of remarkably improbable and inconsistent neuropsychological test scores.

Because we concluded that Mr. H's symptoms were purposeful and linked to his presumed goals, we reasoned that returning him to general population would increase his self-injurious behavior and the frequency of his formal complaints. We recommended an intervention that would enable Mr. H to preserve his story and thereby save face while reducing his costly malingered symptoms. With the approval of the correctional facility, we suggested to Mr. H that with his help he could regain the ability to walk and use his left arm. To do so,

he must help design an exercise program to increase his strength, flexibility, and mobility. We asked Mr. H to record his progress and to provide us with detailed feedback. We met with Mr. H biweekly for an hour in order to review his records and develop the next step in his program. This social contact served as the initial reinforcement for his participation.

As agreed, Mr. H began by attempting to flex his toes. His movements were slight but real. Over the next weeks he slowly advanced so that he could flex his ankles and then straighten and flex his legs. Simultaneously, we had Mr. H begin to strengthen his arms and hands. He slowly progressed to standing, and to doing push-ups. Over approximately 6 months Mr. H began to walk and climb stairs, and to regain some functional use of his left arm and hand. His self-injurious behavior became infrequent and there was a major reduction in the frequency of his formal complaints. Mr. H's improvements led to his reassignment to an intermediate-care unit of the prison and eventually to general population.

Our intervention yielded impressive results but was labor-intensive and expensive. There were concerns about his special treatment, in light of the mandate of the prison system that all prisoners be treated in roughly equivalent manner (c.f., Vanderhoff, Jeglic, & Donovan, submitted). Although some of Mr. H's disabling behaviors returned as we withdrew our contact, he was still walking when he left the prison 6 months after we met with him last.

This case serves as an illustration of how a diagnosis of malingering
(Continued on page 9)

MEMBER ARTICLE

SO HE'S MALINGERING, NOW WHAT? (Continued from page 8)

can have value as a useful starting point in the development of individually-tailored treatment programs that can improve the functioning of the individual and reduce their demands for resources.

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CONFERENCES**ICPA 11TH AGM AND CONFERENCE**

The International Corrections and Prisons Association (ICPA) will hold its 2009 general meeting and conference, October 25-30, 2009, in the Hilton Hotel, Barbados, a short walk from Bridgetown Center. Last year, the ICPA celebrated a decade of lessons learned at the Association's 10th anniversary annual general meeting and conference.

Paper presentations, symposia, and panel presentations are planned around the following topics:

- Racial Disparity and Over-Representation in Criminal Justice;
- Radicalization, Extremism, and the Management of Terrorist Prisoners;
- Corrections in the New World of Financial Meltdown: Implications and Responses;
- Sentencing & Criminal Justice Reforms in Managing Growing Prisoner Populations;
- Community Engagement in Prisoner Reentry/Reintegration;
- Innovative Models of Intervention;

tion;

- Facility Planning and Design;
- Prisoner and Staff Safety;
- Staff Training;
- Prisoner Management;
- Correctional Leadership;
- Corrections Experience in Post-Conflict Situations;
- Community Corrections / Probation and Parole; and
- Care and Custody of Prisoners with Mental Health Needs.

Contact icpa.ca for more information.

ASSOCIATION UPDATES**RICHARD ALTHOUSE, PH.D., AT 2009 APA CONVENTION**

I was pleased to be able to represent IACFP as President and SAGE publishing at the 117th APA Convention in Toronto, Ontario, August 6-9. Attendance estimates were between 5 to 7 thousand less than previous years, undoubtedly owing to the struggling economy. The conference offered a large variety of publisher exhibits, workshops for CEUs, shorter presentations, and many interesting

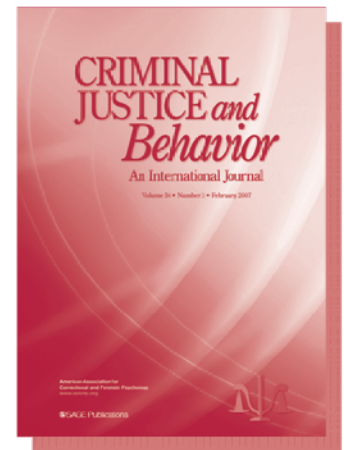
poster exhibits. In between meeting attendees at the SAGE booth and discussing our association, I was able to attend a number of presentations, including: Marty Seligman (positive psychology), Joel Dvoskin (the importance of psychology to crime prevention, prison treatment, and parole), and Allan Schore (the importance of the right hemisphere in understanding behavior), as well as review many

student poster presentations on topics ranging from the application of neuroscience to understanding criminal behavior to correctional issues in public policy. Finally, the conference offered an opportunity to talk with individuals from other associations about how IACFP may help with future conferences. We're already looking forward to next year's convention in San Diego.

Criminal Justice and Behavior

Most-Cited Articles

IACFP members have free online access to these full-text articles. Simply visit the Members Only Area of the IACFP website at ia4cfp.org and click on *Criminal Justice and Behavior* under "Online Resources."



Violent Recidivism of Mentally Disordered Offenders: The Development of a Statistical Prediction Instrument

Authors: Grant T. Harris, Marnie E. Rice, and Vernon L. Quinsey

December 1993...pp. 315-335

Multivariate techniques were used to derive and validate an actuarial instrument for the prediction of violent post-release offenses by mentally disordered offenders. The 618 suspects were a heterogeneous group of men who had been charged with serious offenses. Approximately half had been treated in a maximum security psychiatric institution, and the rest had been briefly assessed prior to imprisonment. The actuarial instrument consisted of 12 variables and significantly predicted violent outcome in each of five subgroups. The instrument's practical application and its use in clinical appraisals of dangerousness are discussed.

Classification for Effective Rehabilitation: Rediscovering Psychology

Authors: D. A. Andrews, James Bonita, and R.D. Hoge

March 1990...pp. 19-52

Four principles of classification for effective rehabilitation are reviewed: risk, need, responsivity, and professional override. Many examples of Case x Treatment interactions are presented to illustrate the principles.

Where Should We Intervene?

Authors: R. Karl Hanson and Andrew J. R. Harris

February 2000...pp. 6-35

Effective intervention with sexual offenders requires the targeting of appropriate risk factors. In this study, information on dynamic (changeable) risk factors was collected through interviews with community supervision officers and file reviews of 208 sexual offense recidivists and 201 non-recidivists. The recidivists were generally considered to have poor social supports, attitudes tolerant of sexual assault, antisocial lifestyles, poor self-management strategies, and difficulties cooperating with supervision. The overall mood of the recidivists and non-recidivists was similar, but the recidivists showed increased anger and subjective distress just before re-offending. The dynamic risk factors reported by the officers continued to be strongly associated with recidivism, even after controlling for preexisting differences in contemporaneous case notes, which suggests that the interview findings cannot be completely attributed to retrospective recall bias.

Evaluating the Predictive Accuracy of Six Risk Assessment Instruments for Adult Sex Offenders

Authors: Howard E. Barbaree, Michael C. Seto, Calvin M. Langton, and Edward J. Peacock

August 2001...pp. 490-521

Five actuarial instruments and one guided clinical instrument designed to assess risk for recidivism were compared on 215 sex offenders released from prison for an average of 4.5 years. The Violence Risk Appraisal Guide, Sex Offender Risk Appraisal Guide, Rapid Risk Assessment of Sexual Offense Recidivism, and Static-99 predicted general recidivism, serious (violent and sexual) recidivism, and sexual recidivism. The Minnesota Sex Offender Screening Tool-Revised and a guided clinical assessment (Multifactorial Assessment of Sex Offender Risk for Recidivism) predicted general recidivism but did not significantly predict serious or sexual recidivism. On its own, the Psychopathy Checklist-Revised predicted general and serious recidivism but not sexual recidivism. The results support the utility of an actuarial approach to risk assessment of sex offenders.

Effects of Cognitive-Behavioral Treatment on Sex Offender Recidivism: Preliminary Results of a Longitudinal Study

Authors: Janice K. Marques, David M. Day, Craig Nelson, and Mary Ann West

March 1994...pp. 28-54

Preliminary results from a longitudinal study of the effectiveness of cognitive-behavioral treatment with sex offenders are presented. The study's research design includes three groups: a treatment group, a volunteer control group (those who volunteered for but did not receive treatment), and a nonvolunteer control group (subjects who refused the opportunity for treatment). Although the treatment group had the lowest re-offense rates for both sex and other violent crimes, main effects analyses did not yield conclusive results regarding the program's effectiveness. The results highlight the importance of including appropriate comparison groups, managing attrition from both treatment and methodological standpoints, examining sex and other violent offenses separately as outcome variables, employing tests with adequate statistical power, and analyzing data while taking into account time at risk for reoffense.

Psychopathy: A Clinical Construct Whose Time Has Come

Authors: Robert D. Hare

March 1996...pp. 25-54

Although the evolution of psychopathy as a formal clinical disorder began more than a century ago, it is only recently that scientifically sound psychometric procedures for its assessment have become available. The result has been a sharp increase in theoretically meaningful and replicable research findings, both in applied settings and in the laboratory. The construct of psychopathy is proving to be particularly useful in the criminal justice system, where it has important implications for sentencing, diversion, placement, and treatment options and for the assessment of risk for recidivism and violence. Although the etiology of the predatory, cold-blooded nature of psychopathy remains obscure, the theories and methods of cognitive neuroscience and behavioral genetics promise to greatly increase our understanding of this disorder.

The Accuracy of Five Risk Appraisal Instruments in Predicting Institutional Misconduct and New Convictions

Authors: Daryl G. Kroner and Jeremy F. Mills

August 2001...pp. 471-489

The predictive accuracy of the Psychopathy Checklist–Revised, Level of Service Inventory– Revised, HCR-20, Violence Risk Appraisal Guide, and the Lifestyle Criminality Screening Form were compared in a sample of male offenders. Both correlations and receiver operating characteristics measured the relationship between the instruments and the predictive outcome criteria of institutional misconduct and release failure. Although some instruments performed better across the outcome measures, there were no statistical differences in predictive accuracy among the instruments.

The Psychological Inventory of Criminal Thinking Styles: Part I: Reliability and Preliminary Validity

Authors: Glenn D. Walters

September 1995...pp. 307-325

This article describes the evolution, standardization, and preliminary validation of the Psychological Inventory of Criminal Thinking Styles (PICTS), an instrument designed to measure thinking styles believed to be associated with serious patterns of criminal conduct. Responses obtained from 450 federal prison inmates were used to establish norms for the PICTS, assess the reliability of the various PICTS scales, and investigate preliminary validity issues. The results indicate that maximum-security subjects attained significantly higher scores on the PICTS thinking scales than minimum- and medium-security subjects and that the PICTS possesses sufficient reliability and initial validity to warrant continued investigation.

IACFP members have free online access to these full-text articles. Simply visit the Members Only Area of the IACFP website at ia4cfp.org and click on *Criminal Justice and Behavior* under "Online Resources."

ASSOCIATION UPDATES

International Association for Correctional and Forensic Psychology

(formerly American Association for Correctional and Forensic Psychology)

Join today and receive
FREE ONLINE ACCESS
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Criminology and Psychology!*

The International Association for Correctional and Forensic Psychology (IACFP) 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 dissemination research on the etiology, assessment, and treatment of criminal behavior.



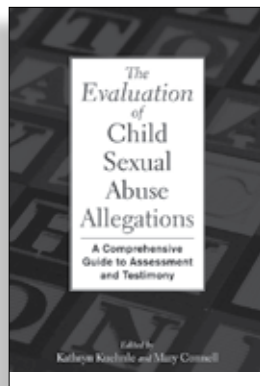
Benefits of membership to the IACFP include:

- A monthly subscription to the Association's journal, *Criminal Justice and Behavior*—for a free sample issue, visit the journal online at: cjb.sagepub.com.
- Free online research tools, including access to current *Criminal Justice and Behavior* content via SAGE Journals Online, as well as online access to more than 55 journals in *Criminology: A SAGE Full-Text Collection* and *Psychology: A SAGE Full-Text Collection*, both of which include archived issues of *Criminal Justice and Behavior* back to 1976.
- A quarterly print subscription to the Association's newsletter, *The Correctional Psychologist*. You may electronically access back issues of the newsletter by visiting ia4cfp.org.
- Discounts on books from SAGE and other publishers.
- Various discounts on other forensic and correctional educational materials.
- Discounts on IACFP sponsored conferences and events.
- Access to the Members Only Area of the Association's website at: ia4cfp.org.

Sign up online at:
ia4cfp.org
click on "Become a Member"

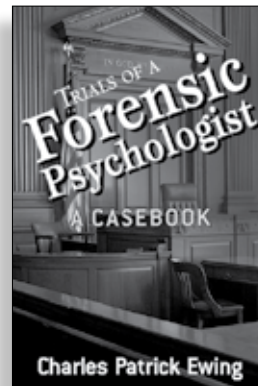
ITEMS OF INTEREST

Must-have resources for all forensic psychologists from Wiley Psychology.

**New!**
The Evaluation of Child Sexual Abuse Allegations: A Comprehensive Guide to Assessment and Testimony

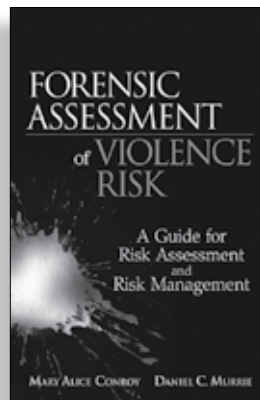
EDITED BY KATHRYN KUEHNLE
AND MARY CONNELL
978-0-470-28860-3 • Hardcover
592 pp. • \$90.00

This practical and straightforward guide uniquely addresses clinical, research, and legal issues involved in the evaluation of child sexual abuse allegations. Edited by experienced practitioners, this timely book contains contributions from an international array of professionals and provides a research-based approach to evaluating and reporting allegations of child sexual abuse for the legal system.

**New!**
Trials of a Forensic Psychologist: A Casebook

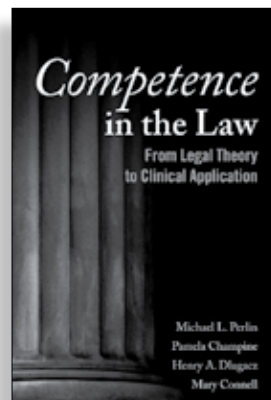
CHARLES PATRICK EWING
978-0-470-17072-4 • Paperback
304 pp. • \$39.95

Written by psychologist and lawyer Charles Patrick Ewing, *Trials of a Forensic Psychologist* is a scholarly, thought-provoking collection of cases from the author's three decades of professional experience. Bringing to life the psychological and legal details of each case as well as the personal stories involved, this volume insightfully covers those issues facing forensic psychologists, including ability to waive Miranda rights, coerced confessions, the insanity defense, malingering, battered woman syndrome, evaluating allegations of child sexual abuse, and the implications of extreme emotional disturbance.


Forensic Assessment of Violence Risk: A Guide for Risk Assessment and Risk Management

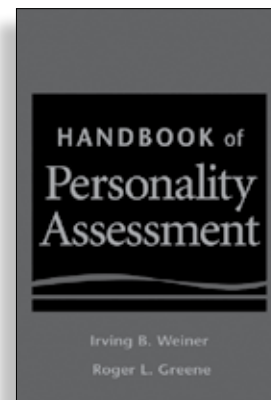
MARY ALICE CONROY AND
DANIEL C. MURRIE
978-0-470-04933-4 • Hardcover
384 pp. • \$75.00

This book presents a summary of all the research to date and an integrated model to use when conducting risk assessments. It includes coverage of conducting assessments with a variety of populations such as juveniles, sexual offenders, psychiatric patients, and adult violent offenders, while providing unique coverage of both assessment and management of risk.


Competence in the Law: From Legal Theory to Clinical Application

MICHAEL L. PERLIN, PAMELA R. CHAMPINE, HENRY A. DLUGACZ, AND MARY A. CONNELL
978-0-470-14420-6 • Hardcover
312 pp. • \$75.00

The best source for a comprehensive overview of mental competency in criminal, mental disability, and civil law, this book prepares you to assess questions of both civil and criminal competence and to counsel lawyers and judges in cases in which these issues are germane. It provides insight from experts in the fields of mental disability law and forensic training and offers the conceptual background to support your assessments for the courts.


Handbook of Personality Assessment

IRVING B. WEINER AND ROGER L. GREENE
978-0-471-22881-3 • Hardcover
677 pp. • \$125.00

A comprehensive, balanced guide to personality assessment, this essential reference includes a historic overview, detailed discussion of the assessment process and its psychometric foundations, valuable sections on conducting the assessment interview, and the nature, interpretation, and applications of the most popular self-report (objective) and performance-based (projective) measures. A concluding section of special topics such as computerized assessment, ethical and legal issues, and report writing are unique to the book.

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ITEMS OF INTEREST

FirePsych, Inc. & MatchBook

Robert Stadolnik, Ed.D.—*Contact: firepsych@comcast.net*

I am inviting you to join in what I believe is an exciting advance in our work with children and adolescents who engage in problem firesetting. We are pleased to launch our new journal, *MatchBook*, a journal under the direction of Dr. Timothy Callahan from the Brandon School in Natick, Massachusetts. *MatchBook* is a biannual online scholarly journal and, along with an accompanying website (matchbookjournal.org), they serve as vehicles for multiple professional disciplines to share and disseminate varied forms of information for a greater level of communication and common direction. The *MatchBook* website will allow for immediate response or comment to significant events in the field, allow for posting of video segments that are relevant, announce opportunities to collaborate, and for regular monthly-poll questions for news updates. As one of the initial members of the journal editorial board, I am writing to invite you to become an active participant in this initiative by submitting articles for publication, encourage the submission by others of articles or information to both the journal and the website, and to provide feedback as to the value and direction of the mental health information provided in *MatchBook*. I hope that you will join me and your colleagues by accepting this invitation and hope that you will feel free to contact me for any questions. If you would like to distribute an online version of *MatchBook* to any organization or association with a pre-written introductory letter signed by you, please feel free to get in touch with me and I will be happy to make the arrangements.

FirePsych Projects Include:

Title: *Rapid Firesetting Assessment: A Residential Model*

Partner: Brandon Residential Treat-

ment Center, Natick, Massachusetts

Description: A pilot project to develop an evidence based, structured, firesetting specific assessment protocol for boys, ages 7-17, who require residential level of care during assessment.

Title: *An Explorative Study of Gender Differences Among Juveniles with Problem Firesetting Behavior*

Partner: The Children's Hospital, Denver, Colorado

Description: A study to compare trauma related symptoms and beliefs, attachment quality, aggression, and firesetting behavior patterns between boys and girls referred for firesetting specific evaluation.

Title: *Adolescent Firesetting Behavior*

Partner: Northeastern University, Department of Counseling Psychology

Description: A retrospective analysis of data from 120 firesetting evaluations

(60 male, 60 female) of 12-17 year olds completed between 2002-2007. Data on personality functioning, aggression, behavioral functioning, and firesetting behaviors will be analyzed between groups and within groups.

Title: *Violent Media Exposure and Relationship to Firesetting Among Boys, Ages 7-17*

Partners: FireSmart Kids (Rhode Island); Brandon Residential Treatment Center, Natick, Massachusetts.

Description: A study to explore the impact of elevated exposure to violent forms of media, including fires and explosions, on the characteristics of firesetting behavior among boys.

Robert Stadolnik, Ed.D. is President of FirePsych, Inc., Medway, Massachusetts, and he is on the editorial board for *MatchBook*. Telephone (781) 762-8815.

ASSOCIATION UPDATES

JOHN L. GANNON, PH.D., REPRESENTS IACFP

As Executive Director/Affiliate Liaison, I was pleased to represent IACFP at the American Correctional Association (ACA) Congress in Nashville, Tennessee, August 7-12, 2009. At the Congress, I represented IACFP on the Council of Professional Affiliates, the Mental Health Committee (MHC), and the International Relations Committee (IRC). I have also applied for a seat on the Substance Abuse Committee. The MHC is working toward the development of standards of practice for mental health services, with occasional success, though the participation of multiple disciplines, and consequent different viewpoints, on the committee can make the process difficult. The IRC is working closely with the International Corrections and Prisons Association

(ICPA) to support the up-coming ICPA conference in Barbados and the once-every-5-year, United Nations Congress on Crime Prevention and Criminal Justice, to be held next April in Salvador, Brazil. Of the many Congress workshops that I attended this year, the IRC-sponsored workshop titled *Radicalization of Prisons* was the most interesting. I was also delighted to meet with Carl Nink of the Management Training Corporation (MTC) Institute during the Congress, and he gave me a copy of his latest monograph, *Programs that Help Offenders Stay Out of Prison*. I'm sure that he would make additional copies available to our members should they ask. Write Carl at institute@mtctrains.com.

ITEMS OF INTEREST

MMPI WORKSHOPS*APA-approved continuing education: 6 units/day*

- **SKOKIE, ILLINOIS, NOVEMBER 7, 2009:**
MMPI-2-RF WORKSHOP
- **NEW ORLEANS, LOUISIANA, NOVEMBER 11, 2009:**
MMPI-2-RF WORKSHOP
- **SAINT PETERSBURG BEACH, FLORIDA, MARCH 3-9, 2009:**
MMPI-2/MMPI-A WORKSHOPS AND 45TH ANNUAL SYMPOSIUM

To register by mail or fax: download the registration form at upress.umn.edu/tests/tx09reg.pdf. Telephone: (612) 627-4821. For more information, visit: upress.umn.edu/tests/workshops. You may also contact Wendy Tschampl, MMPI Workshop Coordinator, telephone (612) 627-4821 or fax (612) 627-1980.

CONFERENCES

NICABM CONFERENCE

The National Institute for the Clinical Application of Behavioral Medicine (NICABM) will hold the 21st International Psychology of Health, Immunity, and Disease Conference, December 7-13, 2009, at Hilton Head Island, South Carolina. Upon completion of the conference, participants will be able to:

- demonstrate proficiency in determining the role of psychosocial distress and/or well-being in shaping health outcomes for clients;
- apply behavioral medicine skills and techniques effectively and efficiently;
- incorporate improved communication skills into your practice;
- identify latest findings in mind/body and integrative medical research;
- demonstrate an understanding of the theories behind such

treatment modalities as meditation, hypnosis, relaxation training and Eastern-based exercise modalities;

- discuss the clinical application and implementation of mind/body and integrative medicine therapies.

CE/CME Credits

This entire program meets the qualifications for a maximum of 40 continuing education credits (16 continuing education credits for the main conference Wednesday evening at 7 p.m.-Saturday noon) are available for most professions. Nurses are approved for up to 18 hours for the main conference or up to 45 hours for the entire program.

Accredited Providers:

- Accredited Council for Continuing Medical Education (ACCME);
- American Psychological Association (APA);
- National Board for Certified

Counselors (NBCC);

- California Board of Registered Nurses;
- California Board of Behavioral Sciences;
- Florida Board of Clinical Social Work, Marriage, and Family Therapy and Mental Health Counseling;
- Ohio Counselor, Social Worker, and Marriage and Therapist Board;
- National Association of Social Workers (NASW).

Register online at nicabm.com with your P-Code any time before November 30 to save an additional \$10.00. Telephone 1-800-743-2226.

CORRECTION

The July, 2009, issue of *The Correctional Psychologist* incorrectly had No. 2 instead of No. 3 on page 1. It is Vol. 41, No. 3.



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INTERNATIONAL ASSOCIATION FOR CORRECTIONAL & FORENSIC PSYCHOLOGY "THE VOICE OF PSYCHOLOGY IN CORRECTIONS"

The IACFP is a non-profit, educational organization in service to mental health professionals throughout the world. Many of our members are doctoral level psychologists, but neither a Ph.D. nor a degree in psychology is required for membership. If you are interested in correctional and forensic issues, we welcome you to the Association.

APPLICATION FOR MEMBERSHIP

Name: _____ Title: _____ Application Date: _____

Please check mailing preference:

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City/State/Zip _____ Address _____

Educational Achievement:

Institution _____ Major _____ Degree _____ Year _____

Brief Description of Work Experience:

The membership fee for IACFP is \$75 for 1 year or \$125 for 2 years, paid at the time of enrollment or renewal. Membership includes four issues of our newsletter, The Correctional Psychologist, and 12 issues of IACFP's highly-ranked, official journal, Criminal Justice and Behavior. Membership also includes electronic access to current and archived issues of over 65 journals in the Sage Full-Text Psychology and Criminology Collections.

The easiest way to join IACFP, or to renew your membership, is through our website at ia4cfp.org. However, if you prefer, you may also join by mailing this form, with payment payable to IACFP, to our journal publisher, Sage Publications. The address is: Shelly Monroe, IACFP Association Liaison, Sage Publications, 2455 Teller Rd., Thousand Oaks, CA 91320

If you have questions about missing or duplicate publications, website access, or membership status, please contact Shelly Monroe at shelly.monroe@sagepub.com or at (805) 410-7318. You are also welcome to contact IACFP Executive Director John Gannon at jg@aa4cfp.org or at (805) 489-0665.