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THE IMPORTANCE OF PSYCHOLOGICAL ASSESSMENT IN CORRECTIONAL SETTINGS

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In the landmark case *Ruiz vs. Estelle* (1980) the court ruled that access to needed



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mental health services by inmates is protected under the Eighth Amendment. In *Coleman vs. Wilson* (1995) the court found that there are six basic, essentially common sense components of a minimally adequate prison mental health care delivery system that include: screening and evaluation, treatment, adequate staff, records, medication, and a suicide prevention program. Therefore, it can be argued that access to appropriate psychological assessment (i.e., evaluation)

in a correctional setting has been established in case law. However, there is very little research regarding the use of psychological assessment in correctional settings. The research that can be found appears to focus on special populations, specific tools, or specific illnesses. There are several studies that also focus on substance abuse assessment. Given the high rate of substance use disorders detected in incarcerated inmates Peters, Greenbaum, Edens, Carter, and Oritz (1998) concluded that there is a need for prisons to adopt diagnostic screening and assessment procedures that address alcohol and drug use disorders in order to determine appropriate and effective treatment services. Taxman, Cropsey, (Continued on page 3)

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Young, and Wexler (2007) summarize current uses of risk assessment models by correctional facilities to assess substance abuse treatment needs and recidivism. They found that in making treatment placement decisions, a majority (58.2%) of institutions used a standardized substance abuse screening tool, and a minority (34.2%) used an actuarial risk tool for gauging risk. However, appropriate psychological assessment is important for addressing issues of co-morbid disorders, in addition to many other areas of mental health functioning.

Many articles can be found that address how the jail and prison systems are increasingly becoming the largest mental health providers. Adams and Ferrandino (2008) discuss the trend that mental illnesses are increasing in the prison system and indicates that as a result of the deinstitutionalization movement, state hospital populations went from 550,000 psychiatric patients in 1956 to 61,700 in 1996, for a decline of nearly 90%. The same authors go on to illustrate how prisons in Florida and Oklahoma have substantially increased their mentally ill population, almost doubling it. According to James and Glaze (2006), the U.S. Bureau of Justice Statistics (BJS), in a study conducted in 2005, more than half of all prison and jail inmates were found to have mental health problems. However, despite

the high prevalence of mentally ill inmates, the U.S. Bureau of Justice reported in 2000 that only 51% of state prisons provided 24-hour mental care (Beck & Maruschak, 2001). Access to mental health services in United States jails and prisons will become more difficult as available resources fail to keep pace with the rise in incarceration rates (Manderscheid, Gravesande, & Goldstrom, 2004). Furthermore, nearly a quarter of state prisoners and jail inmates in the 2005 BJS study had recidivated compared to a much lower percentage of inmates without mental health problems. With these statistics, it is evident that there is a need for mental health services throughout correctional settings. However, to ensure that inmates are receiving proper diagnosis and treatment, they need to be accurately assessed. This will not only assist clinicians with treatment planning, but also reduce overall costs associated with treating incorrect diagnoses and inmates who are malingering. Therefore, it is important that every correctional setting including state and federal prisons, county jails, and all juvenile correctional facilities have qualified psychologists on site to administer psychological testing. This article will highlight areas of concern where psychological testing is crucial including cognitive assessment, neuropsychological testing, mental health testing, as well as issues with malingering and forensic evaluations.

A Case For: Mental Health Evaluations

The need for mental health evaluations in correctional settings has already been established indirectly. According to the BJS, in a survey conducted in 2005, more than half of all prison and jail inmates had a mental health problem, including 705,600 inmates in state prisons, 78,800 in U.S. Federal prisons, and 479,900 in local jails (James & Glaze, 2006). These estimates represent more than half of all incarcerated adults. That report also indicates that approximately 24% of jail inmates, 15% of state prisoners, and 10% of federal prisoners reported at least one symptom of a psychotic disorder including reported hallucinations and/or delusions. The BJS report also indicates that incarcerated individuals with reported mental health problems had a higher rate of unemployment, homelessness, substance abuse, violent offenses, and increased rule violations than incarcerated individuals without reported mental health problems.

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Due to this disparity, it is important that individuals with mental health problems including mood disorders, thought disorders, and severe personality problems be accurately identified and diagnosed in order to assist with effective medication, treatment planning, and housing while incarcerated. This may include a referral to the department of mental health in extreme circumstances. Additionally, by accurately diagnosing these individuals through psychological assessment, they can be better identified to receive appropriate reentry planning which may include community resources and/or special housing once released. Magaletta, Diamond, Faust, Daggett, and Camp (2009) discuss how release can exacerbate preexisting mental health issues due to stresses of living in the community and the demands of finding employment, reuniting with family, maintaining stable housing, and desisting from criminal activities. Efficient parole planning for individuals with mental health issues should include an element of psychological assessment in order to best connect inmates with appropriate community resources and continued treatment while on probation or parole.

A number of articles and research studies have focused on specific psychological assessment with correctional inmates. Cloyes, Lovell, Allen, and Rhodes (2006) studied prison inmates in Super Maximum Security Unit (SMU) and found that inmates housed in a SMU were far more likely to have mental illnesses. The study implemented the Brief Psychotic Rating Scale (BPRS) and the authors found that: (a) the BPRS is a reliable and effective measure of psychosocial functioning in SMU residents, (b) comparison between factor-based BPRS scores in this sample and scores and factor solutions achieved in other populations points to considerations specific to this population that require further study, and (c) assessment of SMU residents using the BPRS and convergent operational measures of psychosocial function indicates that a significant number of participants meet criteria for serious psychosocial impairment. These authors also cite that there are more than 40,000 people confined in SMUs in the United States. Of these, up to 30%, or twice the rate of the general prison population, meet clinical criteria for serious mental illness and a larger number demonstrate documented psychosocial. However, the BPRS is only one instrument and it does not address issues of cognitive or neuropsychological impairment that inmates in the SMUs may also have.

Hare (1996) indicates that there has been extensive literature on the study of psychopathy in correctional settings and that accurate assessment is highly predictive of treatability, recidivism, and violence. Hare (1996) argues that studies have shown that treatment programs for psychopaths have been ineffective, and that psychopaths stayed in treatment programs for shorter periods of time. In spite of the psychopaths' small numbers – perhaps 1% in the general population – they make up 15% to 25% of our prison population and are responsible for a markedly disproportionate amount of crime, violence, and social distress in every society. While many studies have indicated a neurological component for psychopathy (Hare, 1996; Shannon, Sauder, Beauchaine, & Gatzke-Kopp 2009), appropriate psychological assessment can be utilized in order to identify those individuals who meet the criteria for psychopathy in order to inform treatment decisions and violence risk assessments. A further study conducted by Walters (2003) explored the validity of the PCL/PCL-R factor scores in predicting institutional adjustment and recidivism in forensic clients and prison inmates. Forty-two studies in which institutional adjustment, release outcome (recidivism), or both were addressed prospectively with the PCL/PCL-R and it was found that the PCL/PCL-R is a good tool for prognosticating recidivism, if not institutional adjustment, in forensic clients and prison inmates. This is certainly one tool that would be useful in a full psychological assessment.

A few studies could be located indicating the importance of psychological testing for the purpose of screening and assessment and illustrate the use of specific instruments and techniques. Ax, Fagan, Magaletta, Morgan, Nussbaum, and White (2007) discuss the benefits of a dimensional versus categorical approach to assessment, and illustrates the problem of comorbidity and dual diagnosis which affect treatment planning. These same authors also highlight the importance of suicide risk assessment and the assessment and treatment of neurological correlations of maladaptive behavior. Ford, Trestman, Wiesbrock, and Zhang (2007) demonstrated the need for a psychological screening assessment in jail detainees using a very brief screening tool derived from four screening questionnaires which resulted in the creation of the Correctional Mental Health Screen – Female (CMHS-F) an 8-item screen, and the Correctional Mental Health Screen – Male

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(CMHS-M) a 12-item screen. The study indicated that the new instrument(s) had an 83 to 100% predictive validity for identifying Axis I mental health disorders including thought and mood disorders. These authors also argue that when compared to prison inmates, jail detainees are 50% less likely to receive mental health services and almost 200% less likely to receive counseling or therapy. The study looked to identify undetected psychiatric impairments in newly incarcerated males and females using a gender specific brief screening instrument. Ford explained that a lack of screening creates problems in safety and effectiveness of custody procedures as well as for the detainees and concluded that vulnerable persons who are not readily identified because they do not present with florid psychiatric symptoms or distress may be a critical subgroup of newly incarcerated adults to target for mental health screening. They suggest further research is needed to determine if evaluation and treatment following early identification through assessment and screening can lead to improved correctional and post-incarceration psychosocial and socioeconomic outcomes on both a systemic and an individual basis. While both of these studies illustrate the need for psychological assessment and identify good screening measures and techniques for identifying mental health problems, a broader test battery is often required for exploring other mental health issues including cognitive and neuropsychological deficits, malingering and deception, and personality disorders.

Neuropsychological Assessment

Neuropsychological assessment is a specialized area of psychological assessment that requires additional training in the study of brain and behavior. Neuropsychological assessment can include testing for a variety of impairments including: dementia, impaired functioning due to traumatic brain injuries, and other neurological problems. Screening

for traumatic brain injury in prisons has been recommended as a means of informing more effective substance abuse treatment and inmate management within corrections facilities. (Wald, Helgeson, & Langlois, 2008)

Neuropsychological testing is incredibly important in order to accurately diagnose inmates with neuropsychological functioning deficits. If inmates with neurological impairment are identified early, they can receive adequate care such as specialized housing or transfer to a medical facility. In order for an inmate to receive this care, there is a need for collaboration between medical and mental health departments in order to coordinate treatment. Correctional officers and other staff can receive proper education on how to best prompt inmates with special needs related to neurological impairment. Finally, release planning can be coordinated in order to assist these individuals with appropriate care and supervision while on probation or parole. Officials from the Center for Disease Control and Prevention (CDC) suggest that, community reentry staff should be trained to identify a history of TBI and have access to appropriate consultation with other professionals with expertise in TBI in order to assist in transition services for released persons returning to communities (Center for Disease Control and Prevention, 2011).

Traumatic brain injury is an area that is also of especial concern for incarcerated individuals. Studies suggest that between 65% and 87% of incarcerated participants reported that they had sustained a traumatic brain injury in their lifetimes (Williams, Mewse, Tonks, Mills, Burgess, & Cordan, 2010; Slaughter, Fann, & Ehde, 2003). A brain injury can result in lowered frustration tolerance, higher instances of aggression or assaultive behavior, poor concentration, attention, planning, and disorganization. Additionally, the CDC (2011) illustrates how incarcerated

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individuals with traumatic brain injuries may also be slower to respond, thereby leading to increased negative contact with correctional officers.

Traumatic brain injuries can have lasting and dramatic changes to an individual's social and occupational functioning, and many individuals who have experienced a head injury may not be aware that their behavioral changes are due to the head injury. Many traumatic brain injuries affect executive functioning, which is identified as a specific constellation of cognitive abilities which is governed by the frontal lobes. Executive functioning is a higher order cognitive construct involved in the planning, initiation, and regulation (i.e., maintaining or altering) of goal-directed behavior (Lezak, Howieson, & Loring, 2004). Tong and Farrington (2008) discuss a meta-analysis of 19 studies carried out between 1988 and 2006 that evaluated both adult and adolescent offenders with traumatic brain injuries who demonstrated an overall 14% reduction in recidivism, compared to controls, at 1-year follow-up when they participated in remediation and rehabilitation treatment for executive functioning deficits. With appropriate early detection via neuropsychological assessment, individuals with neurocognitive deficits can be properly treated, thereby reducing the rate for potential recidivism.

In addition to traumatic brain injury for all incarcerated individuals, as the ages of our incarcerated population increase, the reality of dementia is becoming increasingly salient. The actual number of individuals in correctional settings who have dementia is unknown, however it is a progressive disorder characterized by impairment in memory, executive functioning, language, and activities of daily living. With the age of many incarcerated individuals doubling in the last decade, some facilities have been forced to create new housing for incarcerated individuals who have the diagnosis of dementia. New York State, for instance, has opened a 1,700 bed facility in Fishkill, New York in order to meet the demands of so many aging and impaired elderly inmate-patients. Doctor Edward Sottile, Medical Director for the Hudson Valley Prison, reported that some of the inmates do not remember their crimes (Hill, 2007).

Cognitive Assessment

There are numerous reasons why formal psychological assessment including an element of cognitive assessment

is crucial in most correctional settings. According to the National Assessment of Adult Literacy, it is estimated that almost 60% of prison inmates are functionally illiterate compared to 47% of United States population (Greenberg, Dunleavy, & Kutner, 2007). Some studies indicate that almost a quarter of prison inmates meet criteria for Attention Deficit Hyperactivity Disorder (ADHD) (Cahill, 2008). Other studies indicate that the prevalence rates for learning disabilities in the juvenile justice system can be as great as 70% for incarcerated youth (Leone, Zaremba, & Chapin, 1995). Additionally, it has also been estimated that between 2% and 10% of the incarcerated population are people who meet the criteria for Mental Retardation/Intellectual Disability (Anno, 1991). These numbers represent estimations of juvenile and adult inmates who have cognitive deficits and reinforce the necessity and integrality of effective assessment in the correctional setting.

Learning Disabilities and ADHD are being studied and explored in greater depth, and neuropsychologists are finding neurological bases for the disorders (Pennington, 2009). Pennington explains that a specific environmental link has not been established for these disorders, but rather that many of them are multifaceted and may include genetic, as well as environmental causes. Additionally, ADHD and learning disabilities can often be accompanied by greater early childhood disturbances including difficulty in school and behavioral disturbances. Fisher, Aharon-Peretz, and Pratt (2011) outline that ADHD is a disorder of inhibition, suggesting that individuals with ADHD have difficulty inhibiting initial impulses and may be more likely to act out when easily frustrated. Cowardin (1995) discusses the characteristics of a learning disabled inmate. Inmates with ADHD and learning disabilities may manifest poor decision-making skills and be more easily manipulated by peers which lead to involvement in criminal behavior. Additionally, they may have behavioral problems resulting in harsher treatment within the justice system and difficulty learning from past mistakes in order to prevent recidivism. Cowardin goes on to describe how correctional institutions may be challenged by these inmates. Specifically, institutions may fail to provide educational, vocational, legal, and daily living accommodations because inmates are not adequately identified.

Inmates with learning disabilities and ADHD are

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similar in that they are often co-occurring disorders with similar behavioral components which may pose a problem with regard to programming. With proper diagnosis, correctional staff can make proper accommodations and guidance for these inmates. These accommodations may include more focused and/or repeated instructions by staff, and more time to complete tasks. Many times correctional staff may consider inmates difficult when it is actually a disability that is causing the impairment and perceived acting out.

The actual percentage of undiagnosed inmates is undetermined, thorough assessment is crucial. By accurately identifying inmates with intellectual disabilities, learning disabilities, ADHD, and other cognitive deficits, appropriate services can be provided. This may include special housing, staff assistants, appropriate direction by correctional officers, and appropriate programming and training for more effective rehabilitation. Additionally, psychological assessment will identify those inmates who may have vulnerability concerns and who may be more susceptible to influence from more predatory inmates. Finally, psychological assessments will afford appropriate treatment planning for inmates while incarcerated in addition to appropriate probation/parole planning in order to assist those individuals with adequate and necessary community resources.

Forensic Assessments

Having qualified psychologists on staff to administer psychological testing is also important for very specific specialized forensic assessments including Violence Risk Assessments, Mentally Disordered Offender evaluations, and Sexually Violent Predator evaluations (depending on court jurisdiction). These specialized evaluations are conducted in order to protect society, provide treatment, and to assist in sentencing determination. While many jurisdictions require outside evaluators to be contracted to conduct these specialized assessments, most institutions still need to complete violence risk assessments as a means of program placement in order to reduce potential harm to other inmates. There are several specialized measures for evaluating violence risk, but very few are normed for incarcerated individuals. The Risk Assessment Scale for Prison (RASP) represents how logistical regression analysis based on factors available at conviction and routinely collected at admission to prison can be used

to better inform risk assessment and classification determinations (Cunningham & Sorenson, 2006). The study indicated that the RASP is a valid tool for predicting violence in incarcerated individuals which suggests that it could be used to help identify inmates who are at greater risk for violence, thereby informing housing and appropriate psychological treatment of these offenders.

Malingering/Secondary Gain

As important as accurate identification of incarcerated individuals with real cognitive, neuropsychological, and mental health issues is, it is just as important to be able to identify those individuals who exaggerate or feign impairment for secondary gain reasons. Some incarcerated individuals prefer to appear impaired for many reasons including: appeals or to obtain benefits (Social Security Income), to delay the court process, to obtain preferred housing (single-cell status), medication (for sedation or intoxication effects), and various privileges (ability to attend mental health groups) (Chesterman, Terbeck, & Vaughan, 2008). The reasons why it is imperative to identify these inmates are many fold. It is important to identify those who malingering in order to prevent possible toxicity from overmedication, to prevent substance abuse or medication trafficking, and to prevent misallocation of resources. Additionally, many individuals misidentified as having an impairment prey on those individuals who actually do have legitimate mental health concerns. This means that they may intimidate truly impaired individuals into performing criminal acts while incarcerated and/or forcibly acquire their mental health medication from them for alternative use or to sell. The integrity of evaluations can be severely compromised when attempts to feign serious impairment go undetected and can have profound consequences in terms of the clinical management or case disposition. Determining that an examinee is or is not malingering is a complex judgment task that requires clinicians to synthesize and integrate various sources of information (Edens, Poythress, & Watkins-Clay, 2007). Therefore, a measure for malingering should always be included in psychological assessments conducted with incarcerated individuals.

There have been many studies that evaluate the efficacy of instruments such as the Structured Interview of Reported Symptoms (SIRS), Miller Forensic Assessment

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of Symptoms Test (MFAST), and Test of Memory Malingering (TOMM). Pollock, Quigley, Worley, and Bashford (1997) conducted a study evaluating 60 subjects who were housed in a medium security unit using the SIRS and selected Minnesota Multiphasic Personality Inventory -2 (MMPI-2) validity indices and found that 32% of the subjects were considered to be feigning. Additionally, it was found that individuals who were determined to be feigning mental health symptoms were more likely given a provisional label of undefined disorder.

Summary & Conclusion

To sum, it is evident that individuals with mental health concerns are overrepresented in correctional settings. Within these environments there are many individuals with cognitive deficits, including learning and intellectual disabilities, deteriorating problems such as dementia, or impairment due to head injury, and those with mental health problems, including mood, thought, and personality disorders. In fact, research indicates that almost half (if not more) of the incarcerated individuals have mental health concerns. It is evident that with this exponential growth in the number of inmates in need of mental health treatment, psychological assessment is increasingly crucial in order to accurately diagnose impairment and functional abilities. Thorough psychological assessment will assist with not only treatment planning while the individual is incarcerated, but also in release planning which, in turn, will reduce recidivism. Additionally, psychological assessment will assist in reducing the overall costs inflicted upon the institution that are associated with inaccurate diagnoses and malingering. These resources can then be effectively and appropriately reallocated to treating and providing assistance to those individuals with legitimate mental health concerns.

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A GLIMPSE OF SOUTH AUSTRALIA CORRECTIONS

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Over the past 5 years the number of sentenced prisoners in South Australia has increased by nearly 29% and the number of people on remand by around 79%. At present, there are around 2,000 people in custody across nine



ANNE MARIE MARTIN

prisons in South Australia and approximately 7,000 people serving community-based orders. In March 2011, nearly one quarter (24%) of people held in custody across South Australia were identified as Aboriginal or Torres Strait Islander. The most common convictions amongst people serving a

term of imprisonment were: assaults (15%), offenses against justice procedures (13%), sexual assaults (13%) and breaking and entering (10%). The most common convictions leading to community-based orders were: license/registration offenses (28%), physical assaults (8%), and theft (8%).

Intensive Offense Focused Programs

The Rehabilitation Programs Branch (RPB) within the South Australia Department of Correctional Services was established during 2004 and given the responsibility of providing intensive programs to sexual offenders and violent offenders assessed as high risk of re-offending. The RPB has also been responsible for the delivery of programs to Aboriginal prisoners and offenders.

Sexual Offenders

One hundred sixty four sexual offenders entered the Sexual Behavior Clinic (SBC) of which 18% were identified as Aboriginal or Torres Strait Islander. The majority of group participants exclusively offended against child victims (58%), while 35% have only had adult victims. Seven percent of group participants had both child and adult victims.

Program hours have averaged 189 hours and average attendance has been high (93%). The average completion rate has also been high, at 88%. For those participants who have completed the program 83% have shown a reduction in risk, 46% have not been associated with a change in risk, and 2% have increased in risk; an increase in risk has been

associated with more information becoming available. Statistically significant changes have been identified in the following areas: self-esteem, aggression, loneliness, empathy for victims, and acceptance of facts around sexual offending. Decreases in emotional rumination and beliefs supporting sexual offending have also been observed. New sexual charges have been recorded for 7% and non-sexual charges recorded for 19%.

Violent Offenders

Between February 2006 and October 2011, a total of 168 offenders began the Violence Prevention Program (VPP). Of these, 79% completed the program in a prison setting while 21% undertook the VPP in the community. Of the 168 offenders, 30% were identified as Aboriginal or Torres Strait Islander.

Attrition from the prison-based programs has been relatively low, with an overall completion rate of 81%. However, just over half (56%) of the participants who undertook the VPP in a community setting went on to complete the program. Following treatment, 62% recorded a decrease in risk status and 38% showed no change in risk status. Changes have been in the expected directions on various measures suggestive of a greater tendency to: view events as under personal control and increased skills for managing anger and provocation, having less negative attitudes regarding the criminal justice system, having less attitudes that support antisocial behavior (including interpersonal violence), being less impulsive and aggressive towards others. Analysis of the relationship of program participation and recidivism is currently occurring.

General Offending

In 2010, the South Australia Department for Correctional Services developed and rolled out an intensive general offending program: *Making Changes*. Between the commencement in May 2010 and December 2011, 379 prisoners and offenders had completed *Making Changes*. This included 148 in prison and 231 in the community. Analysis of pre- and post-treatment changes is anticipated to occur in 2012.

Future Initiatives

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SOUTH AUSTRALIA CORRECTIONS *(Continued from page 10)*

By February 7, 2011, the number of prisoners and offenders that had received new assessment procedures amounted to 3,350 and an analysis of the data occurred during March 2011. The results of this review showed similarities and differences in criminogenic factors according to levels of risk of re-offending. It also identified differences according to gender and cultural background. For example, female prisoners were observed to have greater needs related to relationships and recreational activities than men. Aboriginal prisoners were found to have a greater history of using substances, including using substances around the time of offending. Problems within the family unit (including domestic violence) were more often identified amongst people serving community-based orders in comparison with those assessed within a custodial setting. The monitoring of this information will become increasingly valuable in the identification and development of programs to be delivered in the future, including a new modularized reintegration program.

In line with developing services that address both high-risk, and high-need prisoners and offenders, two progressive steps are to occur during 2012; a program for female prisoners with a personality disorder and engage in acts of self-harm, as well as a modularized reintegration program. The program for female prisoners is to be based on dialectical-behavior therapy, and will consist of the provision of group-based intervention, as well as individual sessions. Formal training for this program began in February 2012. The modularized reintegration is to provide men and women (both in custody and those serving community-based orders) with consistent information and links to address common needs across South Australia. This includes: personal identification, accommodation, budgeting skills/financial assistance, drug and alcohol services, relationships, health, employment. The delivery of this program will occur in partnership with other state and non-government agencies.

ICCA'S THREE ANNUAL EVENTS: HIGHLIGHT ON RENO

The International Community Corrections Association (ICCA) conducts three events annually, a research conference, a forum, and a summit. The Association is probably best known for its research conference featuring "What Works" in community corrections, where state-of-the-art research is presented by experts highlighting evidence-based best practices in the field. This year's research conference will be in Orlando, Florida, September 7-13, 2012, at the Caribe Royale Resort and Conference Center. We may join ICCA in Orlando as an Association to jointly conduct our annual members' meeting. More to come about that possibility in our July 2012, newsletter. The title for Orlando's research conference is: *ICCA's 20th Annual Research Conference on "What Works."*

The ICCA also hosts an *Annual Community Corrections Public Policy Forum* in Washington, D.C., featuring criminal justice leaders from the legislative and executive branches of federal government and highlighting important legislation in community corrections. Forum participants are assisted in visiting their elected officials in Congress during *ICCA's Annual Hill Day*. This year's forum was in March 2012.

What we are highlighting in this issue of the newsletter

is the ICCA summit titled: *Evidence-Based Sentencing and Negotiating the Risk Principle*. This intensive 2-day program will be held in Reno, Nevada, and will be most valuable to judges and court personnel, probation and parole staff, prosecutors and district attorneys, community corrections professionals, defense attorneys, and legislators and public policy leaders.

Experts from across the country will share the latest research and tools in sentencing reform and data-driven decision making, highlight policy reform efforts and evidence-based sentencing practices that have succeeded in federal, state, and local jurisdictions, focus on recidivism reductions and improving public safety, and provide cost-effective practices across the criminal and juvenile justice systems.

This year's summit is being supported by the National Judicial College, the International Association for Correctional and Forensic Psychology (IACFP), Great Lakes ATTC, and the Center for Health and Justice of TASC, Inc. The Reno summit will be held at John Ascuaga's Nugget, 1100 Nugget Avenue. For reservations call: 1-800-648-1177 and ask for the ICCA group. Register for the summit

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HIGHLIGHT ON RENO (Continued from page 11)

online at: iccaweb.org. Register by April 4, 2012, and pay \$225.00, after April 4, 2012, pay \$250.00.

A View of Scheduled Events and Presentations in Reno

• Sunday, May 6, 2012

Registration and ICCA Board Meeting

• Monday, May 7, 2012

Welcome to Reno

Framing the Dilemma for Navigating Risk

What is Evidence-Based Sentencing and Why is it the Right Thing to Do

How to Establish the Creditability Tools and Assessment Risk....

Why Consider Substance Abuse and Mental Health

Why Treating High-Risk Substance-Involved Health-Impaired Offenders is Important

What Really Counts in Assessing Needs and Risk to Reduce Recidivism

• Tuesday, May 8, 2012

How to Develop a Statewide Reinvestment Strategy

The Concept of Redemption and Its Impact on Redemption Strategies

Potential of Federal Sentencing Reform and Justice Reinvestment and Pretrial Reform
Creating the Will to Make Justice Reinvestment and Second Chances Happen
Closing Session on Making Change Happen



May 6-8, 2012
Reno, Nevada

THE MISSOURI BOARD OF PROBATION AND PAROLE AND PSYCHOLOGICAL EVALUATIONS

Cher Congour, A 2nd-Year, Double-Major, B.A. Student in Psychology (Emphasis on Human Behavior) and Criminology, Avila University, Kansas City, Missouri
congour@att.net

“At least 60% of the individuals I arrest in 1 year are individuals I have arrested before. It’s disturbing to me that we try so hard on the street to put the bad guys away and it’s disconcerting to know that I will eventually be arresting them again because someone in Jeff City decided they were ‘ok’ and should ‘go home.’”

- Kansas City, Missouri Patrol Officer

is a name that invokes fear. In 2004, Blair was convicted of murdering six women along the Prospect Avenue corridor, on the city’s East side during the summer of 2002. He is believed to have committed two other murders as well. Although police suspected a serial killer, they

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CHER CONGOUR

To most people in Kansas City, Missouri, Terry Blair

PSYCHOLOGICAL EVALUATIONS *(Continued from page 12)*

didn't know that at the time of the Prospect corridor murders, Blair was actually on parole for a prior murder conviction. At the time of the murders, Blair had been on parole for only 2 months, after serving 21 years of a 25 year sentence.

By his own account, Terry Blair lived a normal childhood in a lower middle class neighborhood. His mother and grandmother taught him how to cook; he played baseball with his brothers. In a recent interview, he sounded cheerful when we talked about playing baseball in the YMCA Baseball League and preforming in the school band. But there was one thing that made Terry Blair different from his peers: almost everyone in his immediate family – his mother and two siblings – was all convicted of violent crimes.

When Blair was only 17 years old, his mother, Janice Blair, who had been diagnosed with a mental disorder, shot and killed his step-father. Ultimately, she entered an Alford Plea to avoid a prison sentence and was placed on probation.

In 1983, when Blair was just 21 years old, his brother, Walter Blair, was convicted of kidnapping and attempted murder. Walter Blair was sentenced to death and was executed in 1993. In 1982, Blair's half-brother, Clifford Miller, was convicted of kidnapping and forcible sodomy. He received two life sentences plus 240 years and has, in fact, been imprisoned with Terry at the same correctional facility at different times over the last 5 years. Around that same time Blair would find himself convicted of murdering Angela Monroe, his ex-girlfriend and the mother of his two sons. Terry was sentenced to 25 years in prison.

An examination of the treatment modalities that are currently utilized in the Missouri penal system points to this question: Do the policies and procedures adopted by the Missouri Board of Probation and Parole (hereafter referred to as the Parole Board) give adequate consideration to psychological evaluations needed in assessing the recidivism risk posed by an offender?

Members of the Parole Board are charged with the assessment of offenders and determining their suitability for parole. Public safety is a key consideration in their determinations. With 9,000 Parole Board hearings occurring each year in Missouri one would determine that the necessary procedures to ensure the safety of the Missouri public would involve a thorough review of an offender's medical and mental evaluations.

At a Parole Board hearing, the offender is asked questions relating to six items or issues: (a) the offender's

version of the offense and prior criminal history, (b) the offender's problems and needs, (c) progress made in treatment or plans for treatments, (d) reasons why the offender deserves parole, (e) plans for the future, (f) any matters appropriate for consideration, including challenges to any information about the offender perceived to be false. At a Parole Board hearing, if the offender answers the six questions in clear, short, and precise answers and does not exhibit any mental instability in front of the Parole Board members, they are inclined not to review medical history, including psychological evaluations.

Pursuant to state regulations, the Parole Board is permitted to review all available reports and case history material pertinent to the case only. These reports may include social history; medical, psychological, and psychiatric reports; circumstances of any prior criminal history including arrests, convictions, and incarcerations; past and present patterns of behavior; and confidential information. The language of the statute however, leaves a loophole in that the Parole Board is permitted to review only the reports available at the hearing. Add to that the provisions of the Federal Health Insurance Portability and Accountability Act (HIPAA) which prevents general access to medical reports. Those reports are the sole property of the health care entities that prepare and maintain them. Simply stated, the Parole Board does not have ready access to the offender's medical files including psychological evaluations. It seems to be an inherent conflict between patient-inmate-privacy and a more accurate determination of recidivism risks and/or threats to public safety.

In Missouri, prison health care is administered by Corizon Health, Inc., a private company contracted by the state. Corizon is rested with the promise of conveying necessary medical and mental care within the confines of Missouri correctional facilities. Since Corizon is a private company and under HIPAA restraints, they essentially have control over all offender medical records, including, but not limited to, mental health evaluations. Simply stated, the Missouri Board of Probation and Parole does not have readily available access to any medical records or mental evaluations while the inmate was incarcerated.

There are certain state laws however, that prohibit or restrict the disclosure of medical information and those

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PSYCHOLOGICAL EVALUATIONS *(Continued from page 13)*

laws will control even if such disclosure is permitted by HIPAA. Thus, if state law limits the manner or circumstances in which a disclosure permitted by HIPAA may be made, then these state law provisions must be followed. In Missouri, there is a law enforcement exception where a formal written demand or request must be provided by a judicial or other enforcement agency. Disclosure must be strictly limited to the scope of the request. This legal process involves documents to include a court order, subpoena, or summons by a judicial officer, or an administrative subpoena, summons, or investigative demand. The Parole Board must have a well-defined and justified reason as to why the need for those records is necessary. If an offender with a dubious medical and family history like Terry Blair appears before the Parole Board, provides innocuous answers to the Parole Board's questions, and doesn't otherwise give the Parole Board a reason to examine his medical history, then the Parole Board won't ask for authorization to review those records.

There are 30,796 offenders currently incarcerated in the State of Missouri. An additional 2,736 offenders are being held on Missouri charges in other states. The total number of offenders, 33,532, will eventually all meet with the Parole Board over the span of their sentence with the first of those meetings occurring within the first 90 days of incarceration. With approximately 9,000 parole hearings being held each year, an average of 40 parole hearings are heard each week throughout the state. In other words, the Parole Board should review the medical records of all 40 inmates each week. As stated early however, with the unwieldy process of receiving those records, there is simply not enough time, money, or expertise available to evaluate those records.

In Ohio, when considering the parole release of the offender, the statute is clear in that their parole board considers any reports of physical, mental, or psychiatric examinations, among others. Missouri's language in their statute is less specific, using terms like available and relevant reports. The Missouri statute goes on to say the parole officer shall secure such other information as may be required by the court and, whenever it is practicable and needed, the information will include a physical and mental examination of the defendant. The statute does not identify when an evaluation is practical and needed. A thorough review of case law suggests that the only

time the Parole Board deems it practicable and needed is where an inmate has been convicted of a sexual offense.

Over the years, a set of central risk factors have been identified that would help target offenders who would be at the highest risk for recidivating. These risk factors have been labeled the central eight and by identifying these eight factors, state parole boards have had the ability to generally predict the offender's behavior after release. The central eight factors include: (a) family/marital supports and individuals who the offender might rely upon for support, (b) educational and employment history, (c) completion of high school or GED and successfully holding a job in the past, (d) prosocial and recreational activities participated in and with whom, (e) antisocial personality and cognitions, is the offender social, did they get along and regularly communicate with others inside the prison, (f) criminal history, what is their history of crime, not just the crime for which they are currently incarcerated, (g) disciplinary infractions, was the offender ever disciplined for violating certain rules and regulations while in prison, and (h) substance abuse, does the offender have a history of substance abuse. These risk factors are considered criminogenic needs because just the factor alone that the offender previously committed a crime is considered immutable. If an individual committed a crime, they may not do it again. However, if their criminogenic needs do not meet a certain standard, then it is more likely they will commit another crime once released. Interestingly enough however, mental illness is not one of the central eight risk factors because, in itself, it has been found to have little or no relationship to an offender's recidivating.

These eight factors are evaluated by a prison psychologist or psychiatrist and at the very least should be available at any time. Other states have identified this need and have recognized that their parole board shall have access to those records. Missouri statute, in using particular language like practical and needed and available and pertinent poses a problem, in that it creates questions like who deems it practical and needed and who decides if the records should be available or pertinent? A review of relevant case law in Missouri suggests that Missouri sets no guidelines as to who will have the responsibility of making such decisions. The decision of reviewing medical records is simply left in the hands of the Parole Board. Yet, there are no guidelines found

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PSYCHOLOGICAL EVALUATIONS *(Continued from page 14)*

that require the Parole Board to review medical records.

In the case of Terry Blair, if Missouri had followed the central eight risk factors used generally by other parole boards, it is presumed that one might have seen the warning signs for recidivism risk. Although Blair did admit to having family with whom he could live upon a parole release, that individual was his mother who did have a known mental illness and had committed murder herself. Blair also admittedly did well in school, yet never held a full-time job. Blair's leisure time was spent primarily alone and he admitted to having few to no friends. While he was in prison he was also described as being alone and not spending time with others or participating in coordinated activities. Had Blair's medical records been reviewed by the Parole Board, he might not have been released. Unfortunately he was in 2004, and within 2 months of his release, he murdered Patricia Wilson Butler, followed by a string of five other murders in rapid succession.

"The only thing that I can think of worse than a serial killer on the streets of Kansas City is not being able to capture one. We have to be more cunning than they are. And let's face it, they have been able to fool everyone, including their victims."

-Kansas City, Missouri Detective

In preparing for this article, the author had a number of telephonic or in-person interviews with individuals who were involved with the offender or had information about him. She also consulted various relevant state codes, regulations, and procedures, as well as, authors on sentencing and parole procedures. For more information about this article and references used, please contact the author at: congour@att.net.

REDUCING RE-OFFENDING THROUGH EVIDENCE-BASED STRATEGIES

Philip Wheatley, LLB, CB, Non-Executive Director of the Northern Ireland Prison Service, and Companion of the Order of the Bath (CB), an honor bestowed by the Queen of England
pmwheatley@hotmail.co.uk



PHILIP WHEATLEY

The evidence shows imprisonment is a powerful experience, which can be used to reduce re-offending rather than reinforce criminal identities. Prisons can only succeed by actively engaging partners internally and externally.

The best community corrections also reduce re-offending, in partnership with other agencies and community organizations.

International evidence as to what helps offenders desist from crime shows that traditional cognitive behavioral programs are part of the solution, but are not sufficient on their own.

Persistent offenders have problems, attitudes and skill deficits that make it very difficult for them to stop offending, but tackling these in isolation is not enough. The latest criminological thinking suggests that building and sustaining

the motivation to desist from crime is key.

Prisons regimes must be designed and operated in an integrated way to motivate and help prisoners to change, so that the total experience of imprisonment is powerful and constructive; it must be followed through by post-release supervision and support that draws on community resources to build and support the motivation to break clear from crime.

Decency and justice must be central tenets of both imprisonment and community supervision; the treatment of offenders must be driven by clear principles that are operated fairly and reasonably in order to ensure that they are engaged, not antagonized. Prison must be decent across all its functions; the residential and treatment aspects, security and dealings with security staff are all core to the experience of imprisonment and must therefore operate on consistent principles.

There must be clarity and predictability about the regime and entitlements for offenders, with consistent systems to deliver what is promised. Decisions must be taken promptly, based on clear, reasonable rules that guide how discretion

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REDUCING RE-OFFENDING *(Continued from page 15)*

can be used, enabling staff to better explain and defend their decisions to offenders. Appeal systems must also be designed to support transparent and reasonable decision taking.

The approach to security, order and control in prisons must be proportionate to the risks and take full account of quality of life issues for prisoners. Decisions about breach, recall and restrictions on liberty in the community must also be proportionate to the risk created by reoffending. All this must be underpinned by intolerance of criminal activity in order to ensure the safety of staff, offenders, and the public.

The key to motivating offenders is strong and meaningful relationships between staff and prisoners. The ability to influence, motivate and persuade offenders to give up crime is crucial. Successful engagement requires a real interest in and understanding of offenders. Staff must be selected for their ability to forge positive, meaningful relationships, to act fairly, to be willing to hear and understand an offender's point of view. They must demonstrate a belief in an offender's ability to change while using their authority appropriately to set limits. Good relationships are sustained by reliable delivery on promised action. And by personal warmth and a sense of humor.

Staff support, appraisal and training systems must enable staff to develop their skills in working with offenders. Staff and their managers need to review the handling of cases and difficult situations to learn lessons. Managers and supervisors must publicly recognize and praise good work by staff and ensure there is no tolerance of staff behavior that is unfair, collusive, or aggressive.

Offender motivation also requires recognition and praise for achievement, with systems to identify and highlight progress, for example, through award ceremonies for gaining qualifications or completing programs. The aim is to identify and build on strengths, giving positive messages about potential to change and give up crime, and not concentrating solely on risks and deficits.

To support this approach offenders must be given practical help: to get off drugs and alcohol, to increase employability through education and development of skills relevant to the current jobs market, to develop logical thinking that will help them understand the impact of their crime on victims

through cognitive behavior programs. They should also be encouraged to engage with external groups and supportive family networks that will support them in giving up crime.

Preparation for release from prison is particularly important. There must be proper handover of the work done and progress made to others who can provide support outside. This will be easier where prison and community corrections services work closely, and should include voluntary organizations that are prepared to help and well motivated family and friends.

To help create a new non-criminal identity, offenders should have opportunities to have a degree of personal choice and opportunities to help others: peer-mentoring schemes are a good example like the UK scheme that provides suicide prevention support by trained prisoners. Other useful schemes are those that involve offenders in helping the less advantaged in the wider community or simply giving them opportunities to give something back to the prison community, for example, through representation in wing/unit committees or food committees.

As much positive contact as possible should be made with non-criminal society, linking offenders including serving prisoners with organizations and groups completely unrelated with offending and crime, particularly if it leads to long term relationships that can continue after sentence.

Achieving success requires: strong leadership to drive the creation of a positive culture across the whole organization not just good work done in silos; active engagement with staff at all levels and across disciplines to create a shared sense of purpose, supported by strong teamwork; regimes which maximize positive contact time between staff and offenders, avoiding complex administrative processes which divert staff away from this contact. It is essential to provide continuity of staff contact and ensure that where several staff are working with an offender there is exchange of information about progress. Finally, if this approach is to achieve maximum impact there must be effective systems to direct and coordinate work with and engage offenders, while providing continuous support to staff to enable them to operate effectively in what will always be demanding and complex work.

ICPA ANNOUNCEMENT

Doctor John Gannon, IACFP Executive Director, has recently been notified that he has been elected to the Board of Directors of the International Corrections and Prisons Association – North America (ICPA-NA). The ICPA has a well-deserved reputation as one of the most dynamic new organizations grappling with correctional issues around the globe. Similar to many of our own goals, ICPA promotes co-

operation and collaborative initiatives between jurisdictions in areas of common interest, staff exchanges and study visits, while trying to enhance public education and understanding, as well as involvement in correctional matters. The ICPA's next major international conference will be held in Mexico City from October 28 to November 2, 2012. Information on ICPA may be found at: icpa-ca.org

ANNUAL MEETING OF THE BOARD OF DIRECTORS FOR THE NATIONAL COMMISSION ON CORRECTIONAL HEALTH CARE

*Edwin I. Megargee, Ph.D., CCHP, Professor Emeritus of Psychology, Florida State University
megargee@aol.com*

The purpose of the National Commission on Correctional Health Care (NCCHC) is to improve the quality of health care in the nations' jails, prisons, and juvenile detention facilities. The Board of Directors is comprised of representatives from the National Commission's three dozen national supporting



EDWIN MEGARGEE

organizations, which include the American Bar Association, American Medical Association, American Nurses Association, American Psychiatric Association and American Psychological Association, among others. For the last 10 years, our Association, the International Association for Correctional and Forensic Psychology (IACFP), has been

one of these organizations.

In October 2011, I represented IACFP at the annual NCCHC Board meeting in Baltimore. I also participated in the semiannual meeting of the Board of Trustees of the NCCHC's Certified Correctional Health Professional (CCHP) Program and had the honor of being named Chair for the coming year. This is a brief report of those meetings.

Standards and Accreditation. Since the 1970s, the National Commission has formulated and published standards for health care delivery that are recognized as the gold standards in the field of correctional health care. The NCCHC prison standards and jail standards were last updated in 2008, and revised NCCHC juvenile standards were published in 2011. Approximately 500 facilities in 46 states with daily populations ranging in size from 10 to 9,000 inmates are currently participating in the National Commission's program of voluntary accreditation, and 159 peer surveys were carried out in 2011.

Certified Correctional Health Professional (CCHP) Program. In 2011, the 20th anniversary of the CCHP Program was celebrated. The basic CCHP Program certifies the ability of health care professionals from any discipline to practice in correctional settings by passing a proctored multiple-choice examination on the NCCHC standards. Approximately 2,500 health professionals are currently certified.

After 3 years, a CCHP can apply for advanced (CCHP-A) status, which is obtained by a review of credentials and a written essay-type examination. An increasing number of facilities are reported to be considering CCHP status in making hiring and promotion decisions, and I urge all IACFP members to consider seeking CCHP certification.

In response to demand from the field, the CCHP Program has begun offering CCHP's specialty certification in the clinical practice of their disciplines in correctional settings. We recently administered the first specialty examination for RNs (CCHP-RN), and a specialty examination for physicians (cosponsored by the Society of Correctional Physicians) is nearing completion. The IACFP members will be interested to learn that we are currently considering a specialty examination for CCHPs who are mental health professionals.

Policy Statements and Clinical Guidelines. The NCCHC Board also considers and adopts position and policy statements on issues relevant to correctional health care and formulates clinical guidelines for the diagnosis and treatment of various conditions in correctional settings. At the October meeting in Baltimore, we considered policy statements on managing chronic pain and using restraints with pregnant inmates. We also adopted clinical guidelines for the management of juvenile obesity and sickle-cell disease. Thus far, most clinical guidelines have focused on medical conditions, but IACFP members will be interested to learn that we may soon be formulating guidelines for managing and treating certain mental disorders in correctional settings.

Educational Programs and Conferences. The NCCHC sponsors several educational conferences each year. Upcoming conferences include the annual conference on Updates in Correctional Health Care in May 2012, a Correctional Mental Health Conference in July 2012, and the National Conference on Correctional Health Care in October 2012. There are also NCCHC "boot camps" for new medical directors and health administrators.

Publications. The NCCHC publishes the peer-reviewed *Journal of Correctional Health Care (JCHC)*. Like our own *Criminal Justice and Behavior*, the *JCHC* is published by Sage and thus readily available to IACFP members. The American Psychological Association has approved papers

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ANNUAL MEETING *(Continued from page 17)*

presented at NCCHC conferences and articles published in *JCHC* for CEU credit for psychologists.

The National Commission also publishes *CorrectCare*, a quarterly magazine with 15,000 readers featuring news, articles, and commentary on topics of interest to health care professionals. Online as well as print copies are available.

Correctional Health Outcome and Resource Data Set (CHORDS). National Commission President Ed Harrison announced at this Board meeting that NCCHC is taking the lead in establishing a nationwide data sharing system designed for correctional health care systems. The goal is to develop standardized performance measures assessing the effectiveness and availability of inmate care, use of

services, treatment outcomes, and the costs associated with health care delivery. The goal is to establish a national data repository that can be used to compare systems and detect trends over time. No such standard system currently exists as the various states and the Federal Bureau of Prisons all use different measures. The NCCHC hopes that this initiative will facilitate correctional health care research and evaluation and will also allow the comparison of correctional with free world epidemiological and public health data.

For more information on the National Commission and its programs, go to: ncchc.org or feel free to e-mail me at megargee@aol.com.

FROM DR. JOHN GANNON, IACFP EXECUTIVE DIRECTOR

Association Leadership Changes and News

After considerable correspondence, dialogue, and mutual reflection, the previous officer holders and the Executive Board decided that a change in leadership was in the best interest of our Association. As a result, the positions of President and Secretary/Treasurer were vacated, and replacements have been confirmed by the Board as directed by the bylaws. The Board also voted to separate the position of Secretary/Treasurer into two positions, Secretary and Treasurer. Doctor Edward Dow, formerly President Elect is our new President, Mr. Thomas Bisette, our accountant, has agreed to serve as Treasurer, and Mr. Michael Clark will serve as Secretary.

For most of the 50+ year history of the Association, funding was very limited and finances were managed and controlled entirely by members. More recently, as a result of cost cutting, close attention to spending, and considerably increased revenues, our financial condition has undergone significant improvement.

In light of that improvement, it became clear several years ago that professionalizing our management was crucial, and to that end, the Board and I have worked closely with our attorney and our accountant to assure good stewardship of the Association's reputation and resources. First, Mr. Jim Charlton, and more recently, Mr. Bisette, have provided vital counsel and considerable skill on our behalf to get and keep us current on our tax reporting and generally to bring order and accountability out of the previous financial chaos.

Throughout this period, while we have focused primarily on revenue generation and building financial stability, the Board and I have received regular monthly accountant

summaries, a considerable improvement over just the annual summary required by the bylaws. A review of those summaries shows that the Association has more assets, better financial controls, and is in the best financial condition in its history. In addition, a previously scheduled outside audit of Association records is in progress and will be completed shortly.

Lastly, now that we are stable, I have submitted a long-term, multi-pronged plan of action to the Board focusing on themes of leadership and effectiveness in correctional psychology and I expect to have a report on this plan in the next issue of our newsletter. If you have any suggestions or ideas regarding positive roles the Association can play, please contact me. We're looking forward to a great year in 2012, and there will be many opportunities in the new year for your participation. Please contact me directly if you would like to be more active in IACFP. We've got room for you. Contact me at: jg@ia4cfp.org or by phone (805) 489-0665.

Romanian Cooperation Agreement

We are happy to announce that we have concluded a non-binding cooperation agreement between our Association and the Romanian Prison Service. The goal of the agreement is to exchange ideas and foster improvements in corrections in numerous areas of the world. Doctor Robert Powitzky, IACFP member and Past President and I will be working collaboratively with the Romanians to advance their efforts related to conditions of worldwide confinement, staff training, and mentally ill offenders in what we hope will be to the benefit of many developing nations.

Two Special Issues of *CRIMINAL JUSTICE AND BEHAVIOR*

**ISSUE ON DIVERSION FROM STANDARD PROSECUTION
KIRK HEILBRUN AND DAVID DEMATTEO, GUEST EDITORS
THIS ISSUE IS SLATED FOR APRIL 2012**

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THE BUDAPEST SEMESTER IN COGNITIVE SCIENCE (BSCS)

Cognitive Science is a Hungarian study abroad program. Undergraduate students in cognitive science and other disciplines may be interested. The program's focus is on philosophical questions related to psychology and neuroscience should be of special interest to students in criminal justice and pre-law. The BSCS is hosted by the Department of History and Philosophy of Science at Eotvos Lorand University, Hungary's premium science university established in 1635 and serving as a center of excellence for modern higher education. A world-class new campus has been added to the premises built on the scenic banks of the Danube and hosting the faculties of Natural and Social Sciences and Informatics, where BSCS courses are held.

The BSCS, established in 2003, focuses on cognitive science from an interdisciplinary perspective and offers credit-earning courses in neuroscience, psychology, philosophy, linguistics, biology, and computer science, as well as continuous and optional intensive Hungarian language courses. The program is complemented by an optional independent research module tailored to students' curricula and research interests. The courses will be taught in English and the deadline for applications is April 15, 2012.

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Visit: bscs-us.org, e-mail inquiries, bscs@bscs-us.org or, Tony Chemero, U.S. Director, tony.chemero@fandm.edu

International Association for Correctional and Forensic Psychology

(formerly American Association for Correctional and Forensic Psychology)

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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.



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Northeast Region	Gerard Bryant, Ph.D.	(718) 840-5021
South Central Region	Ben Wheat, Ph.D.	(214) 224-3560
Southeast Region	Chad Lohman, Ph.D.	(678) 686-1488
Western Region	Robie Rhodes, Ph.D.	(209) 956-9775
North Central Region	Don Denney, Ph.D.	(913) 551-8321

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Public Law 100-238 precludes initial appointment of candidates after they have reached their 37th birthday. However, waivers can be obtained for highly qualified applicants prior to their 40th birthday. To qualify for a position, the applicant must pass a background investigation and urinalysis. The Bureau of Prisons is an Equal Opportunity Employer.

Robert R. Smith, Ed.D.
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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.

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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 IACFP Newsletter, 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@ia4cfp.org or at (805) 489-0665.

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The International Community Corrections Association (ICCA) conducts three events annually, a research conference, a forum, and a summit. The Association is probably best known for its research conference featuring “What Works” in community corrections, where state-of-the-art research is presented by experts highlighting evidence-based best practices in the field. This year’s research conference will be in Orlando, Florida, September 7-13, 2012, at the Caribe Royale Resort and Conference Center. We may join ICCA in Orlando as an Association to jointly conduct our annual members’ meeting. More to come about that possibility in our July 2012, newsletter. The title for Orlando’s research conference is: *ICCA’s 20th Annual Research Conference on “What Works.”*

The ICCA also hosts an *Annual Community Corrections Public Policy Forum* in Washington, D.C. featuring criminal justice leaders from the legislative and executive branches of federal government and highlighting important legislation in community corrections. Forum participants are assisted in visiting their elected officials in Congress during *ICCA’s Annual Hill Day*. This year’s forum was in March 2012.

What we are highlighting in this issue of the newsletter is the ICCA summit titled: *Evidence-Based Sentencing and Negotiating the Risk Principle*. This intensive 2-day program will be held in Reno, Nevada, and will be most valuable to judges and court personnel, probation and parole staff, prosecutors and district attorneys, community corrections professionals, defense attorneys, and legislators and public policy leaders.

Experts from across the country will share the latest research and tools in sentencing reform and data-driven decision making, highlight policy reform efforts and evidence-based sentencing practices that have succeeded in federal, state, and local jurisdictions, focus on recidivism reductions and improving public safety, and provide cost-effective practices across the criminal and juvenile justice systems.

This year’s summit is being supported by the National Judicial College, the International Association for Correctional and Forensic Psychology (IACFP), Great Lakes ATTC, and the Center for Health and Justice of TASC, Inc. The Reno summit will be held at John Ascuaga’s Nugget, 1100 Nugget Avenue. For reservations call: 1-800-648-1177 and ask for the ICCA group. Register for the summit online at: iccaweb.org. Register by April 4,

2012, and pay \$225.00, after April 4, 2012, pay \$250.00.

A View of Scheduled Events and Presentations in Reno

• Sunday, May 6, 2012

