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MEMBER ARTICLE

TREATMENT OF GENDER IDENTITY DISORDER IN THE PRISON

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The challenges of mental health care in general in the prison system are many and range from a lack of resources to a lack of general institutional support. Often, mental health workers engage with the least desirable and most dangerous of inmates. Among the most complicated of inmates likely to need mental health services are those identified as having Gender-Identity Disorder (GID). This disorder, possibly more than any other, involves not only complicated treatment issues, but legal and ethical ones as well. The mental health care practitioner treating GID is entering a highly controversial area of mental health within the correctional setting and must be aware of the significant events related to GID in the prison system. These include the significant court cases and the complex medical, political, and psychological issues surrounding this disorder and treatment options.

As indicated in *The Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR*, American Psychiatric Association, 2000). GID is recognized as a rare mental condition in which there is "a profound disturbance of the individual's sense of identity with regard to maleness or femaleness" and "persistent discomfort with his or her sex and a sense of inappropriateness in the gender role of that sex" *(DSM-IV-TR).* The prevalence of GID is widely debated. The *DSM-IV-TR* indicates that an occurrence rate of GID is approximately 1 in 30,000 adult males and 1 in 100,000 adult females, based upon those who seek gender-reassignment surgery. Olyslager and Conway (2007) add that many with GID will not, or cannot, seek corrective surgery and are therefore not known to clinicians. These researchers instead, estimate that the incidence of transsexualism in males and females is closer to 1 in 500. Rosenblum (2000) estimates that transsexuals who are incarcerated number in the low thousands.

The GID-affected individual typically reports strong feelings beginning in childhood of being the opposite sex, or desiring to be, of the opposite sex. They may have a history of dressing as the opposite sex and playing with toys typically associated with the opposite sex. As adolescents, they may continue to dress as the opposite sex and have adverse feelings towards their developing secondary sex characteristics. As adults, cross-dressing continues, either publicly or privately, and there is often preoccupation with getting rid of secondary sex characteristics and living as the opposite gender. Predisposing "intersex" conditions, such as partial androgen sensitivity, must typically be ruled out prior to diagnosis, although the disorder "Not Otherwise Specified" may be made under those conditions (*DSM-IV-TR*). Finally, the condition must cause a "clinically significant distress or impairment" in several aspects of the individual's life, including social and occupational *(DSM-IV-TR)*.

"This disorder, possibly more than any other, involves not only complicated treatment issues, but legal and ethical ones as well."

GID advocates assert that transgendered individuals suffer social and occupational impairments that render them economically marginalized (Tarzwell, 2006). As such, many move toward illegal activities such as the sex industry for support. They also show higher rates of homelessness and are at higher risk for depression, perhaps due to societal norms and non acceptance of their identities (King County Health Department, 2008).

Female-to-male GID affected individuals may be referred to as "trans males," while male to female GID diagnosed may be

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referred to as "trans females." Both may be in "pre-operative" or "post-operative" status in the gender reassignment process. "Preoperative" indicates that, although they are aware of their gender identity conflict, they have had no treatment, but may be dressing and living as the opposite gender. They may have started hormone treatment and/or electrolysis. "Post-operative" refers to the individual having undergone at least genital altering surgery (Meyer et al., 2001). Sometimes, additional cosmetic surgery is pursued to reduce the undesired secondary sex characteristics (Meyer et al., 2001).

Although they are a relatively small portion of inmates in prisons, transgender individuals present significant dilemmas for correctional staff (Wilkinson, 2003). These involve finding appropriate and safe housing for them, monitoring for self-harm, and whether or not to provide or continue hormone and/or surgical interventions (Wilkinson, 2003).

Few prisons have written policies regarding treatment or housing of transgender inmates. Edney (2004) reports that an international survey of correctional services yielded formal policies for transgender prisoners in only 20% of those services surveyed. The significance of this finding is unclear in light of a recently published survey of prison wardens. Moster and Aviva (2009) found that those wardens surveyed believed published policies were less effective against prison rape than staff training and inmate supervision.

In 2003, the United States passed the Prison Rape Elimination Act (PREA), a federal law that promotes a "zero tolerance" of rape and sexual abuse in prisons (Smith, 2008). Well before PREA was enacted, however, concerns had been voiced over the rate of sexual assault in prisons both within various government entities and in the literature. In 1992, the U.S. Federal Bureau of Prisons (BOP) reported that 9% to 20% of inmates had been sexually assaulted.

The U.S. Supreme Court case of Farmer v. Brennan (1994) was among the many events leading to this law. Farmer v. Brennen (1994) involved a preoperative trans female (Farmer) who showed significant female characteristics. Housed in a cell in the general population, Ms. Farmer was repeatedly raped and beaten by her cellmate (Edney, 2004). After several requests to be moved were disregarded, she was finally placed in protective custody. The Supreme Court decided in favor of Farmer, thus placing the responsibility of protecting inmates from harm by other inmates or staff with correctional staff. To fail to do so, according to the Supreme Court, amounted to "deliberate indifference" to the inmate's Eighth Amendment rights (Edney, 2004).

Since the enactment of PREA, the American Correctional Association (ACA) has adopted standards for adherence that included strategic or protective housing for at-risk inmates. In addition, ACA and others identified factors that placed certain inmates at higher risk for rape. These included a first time incarceration, being young, small stature, underweight, gay, white, disabled, feminine-appearing, having long hair, a high voice, being unassertive, middle class or in prison for a white collar or sex crime (Blackmore & Zwieg, 2008; Human Rights Watch, 2001).

In nearly all institutions, inmates are housed based on their birth gender, external genitalia, and custody concerns, rather than their internal gender identification. Transgender males, in particular, may show several of the previously discussed characteristics. Introducing these feminine-appearing inmates into the "hypermasculinized" prison environment continues to carry an increased risk of sexual assault or abuse (Edney, 2004; Tarzwell, 2006). One study found that while 9% of male inmates reported sexual assault, 41% of male prisoners perceived as gay and presumably demonstrating high-risk features had been raped (Wooden & Parker, 1982). Another study conducted 15 years later, found nearly identical rates in trans female inmates as compared to the general male prison population (Jenness, Maxson, Matsuda, & Sumner, 2007).

Housing options for high-risk inmates may include a special offender unit, found in California, Hawaii, and Washington state, or administrative segregation, which is often in the intensive management unit (IMU) or the "hole" (Israel, 2002; Rosenblum, 2000). Typically reserved for the most unmanageable of inmates, IMU's consist of single-person cells in which the inmate spends 23 hours a day in relative isolation. While it provides protective placement for transgender inmates, it is not an ideal option: in most IMUs, job opportunities are limited with the exception of tier porter and showers are not available every day. Also, in most IMUs, televisions and radios are either not available or must be earned through good behavior, regardless of the reason for placement. If a television or radio is granted early, it cues

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other inmates to that inmate's protective custody status and may earmark them for later abuse or retaliation.

Many researchers and human rights groups, as well as the inmates themselves, believe that protective custody results in undue additional punishment for those placed in IMUs for protection (Tarzwell, 2006). The negative psychological effects of isolation on individuals are well-documented and warrant frequent mental status exams and additional concern for those who may already have mental health conditions (Arrigo & Bullock, 2008; Edney, 2004; Walters, Callagan, & Newman, 1963).

The logistics of day-to-day living situations of transgender inmates involves not just the concern for personal safety, but other experiences they find disturbing. These include being strip searched in front of other inmates, sharing toilets and shower facilities with other non-GID inmates (Tarzwell, 2006). Their concern may be warranted, according to Rosenblum (2000), as such situations, in fact, have led to multiple sexual assaults in jails and prisons.

In most prisons, accoutrements of the other gender such as cross-dressing and makeup for males, are not allowed or severely limited. If the inmate has undergone a name change to one consistent with their preferred gender, it will not be allowed unless it was the inmate's legal name under which the crime was committed.

The "medicalization" of GID has both supporters and detractors. There is not yet agreement whether every transgender individual has GID or if it, as in other mental health diagnosis, is based upon degree of discomfort or disability it causes.

Supporters assert that GID is a valid mental and physical condition. Many believe that endocrine disorder underlying GID will likely be discovered (Hare et al., 2009). Transgender, GID-affected individuals who support the medical labeling believe that it validates the seriousness of the condition, and increases the chances of treatment being paid for by insurers and institutions (Lee, 2008).

Detractors assert that it stigmatizes those so diagnosed as "mentally ill" and may lead to inappropriate treatment and confinement. They believe that the medical definition forces an oppressive binary definition of gender, leaving out many who fall somewhere in between fully male or fully female by society's standards (Lee, 2008). Further, they assert, only an individual with a certain level of economic advantage can accumulate the necessary medical documentation to meet the definition as presented in the *DSM-IV-TR* or as required by the Harry Benjamin Standards of Care (HBSOC), the accepted standards for treatment of gender disorders.

Medicalization renders GID as a recognized condition, albeit an extremely controversial one from the viewpoint of the public, political leaders, and prison officials. As such, however, medical treatment must be provided. The right to treatment has become as contentious an area within corrections as safe housing and has also received much public attention. The Eighth Amendment ruling, initially in response to safe housing for GID inmates, also applies to medical treatment and the question of deliberate indifference is raised if either one is ignored. Prisoners are wards of the state or federal government and essential medical care must be provided. Most people accept this, however the larger question revolves around what kind of treatment is considered essential and who will pay for that treatment. The state and federal government, individual institutions, and public opinion have varied widely in this area.

The state of Wisconsin might be the most dramatic of cases illustrating this conflict. In 2002, prison officials in that state decided that providing a GID affected inmate with hormone therapy fell within the requirements of the Eighth Amendment, but enacted a policy against paying for surgery (Lee, 2008). In 2006, lawmakers in Wisconsin heard about the prison paying for hormone therapy and protested the use of any federal or state funds to pay for any treatment of GID (Lee, 2008). Wisconsin enacted the Inmate Sex Change Prevention Act, the only act of its kind in the country, but one that is closely watched by other states.

Today, there are many pending lawsuits filed by GID inmates to force the correctional system to pay for hormones or gender reassignment surgery while incarcerated. The current BOP policy is to continue to provide hormones to inmates who were diagnosed prior to incarceration and provided at the level at which they were prior to incarceration. The medical director of any federal institution must approve all such maintenance treatment in writing (U.S. Department of Justice, 2005).

The "gold standard" for GID treatment on the streets is typically the HBSOC (Meyer et al., 2001). Benjamin, an endocrinologist,

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identified GID individuals early in the 1900s and, over the course of years, developed a treatment protocol. These protocols are not applied in correctional institutions since public funds are not generally used for gender reassignment treatment. Incarceration presents challenges for inmates who plan to pursue gender reassignment upon release. These individuals are not able to meet HBSOC prior to genital surgery, such as living as the opposite gender for a year prior to surgery.

Left untreated, GID inmates may develop severe depression, suicidal ideations, self-mutilation, and even psychosis. Dixen, Maddever, van Maasdam and Edwards (1984) found a pre-transition suicide attempt rate of 20% or more in GID male and female inmates. Male-to-female GID affected inmates were found to be more suicide prone than female-to-males. It is generally accepted by the medical community and others that both GID and the associated mental health disorders requiring psychotropic medication should be treated (Israel, 2002; Meyer et al., 2001; Israel, Tarver, & Shaffer, 1997).

The HBSOC includes an extensive list of requirements and descriptions of activities for mental health counselors who work with GID individuals on the streets. Outside of the institution, mental health staff would, for example, clarify gender identity issues, educate individuals regarding treatment options, and provide support throughout the process.

Currently, there is no official description of the role of mental health within the correctional system in the United States regarding GID affected individuals. Intervention chiefly consists of crisis intervention, supportive counseling, and possibly, documentation of the individual's desires for gender reassignment.

Awareness of the disorder is a necessary first step for prison system mental health staff. The first exposure to GID may be by inmate self-report or when the symptoms of other disorders are present, such as borderline personality disorder or psychosis (Meyer et al., 2001). The first step for clinicians is to become familiar with GID diagnostic criteria from the *DSM-IV-TR* and the HBSOC. Referrals to other practitioners who are familiar with the disorder may be recommended at this point. The second step is to advocate for protective housing placement. The third step is to provide therapy to address associated mental health issues like feelings of guilt, isolation, shame, and persecution (Kameya & Navita, 2000).

In a prison setting, the likelihood of other *DSM-IV-TR* Axis I or II disorders increases, although estimated rates range widely from about 37% to 94% (Watzke, Ullrich & Maneros, 2006). The most common disorders include antisocial personality disorder and substance abuse disorders. Does GID co-occur with personality disorders at significantly different rates in the prison setting? Interestingly, personality disorders have actually been found to rarely co-occur with GID and an inverse relationship was actually found in one study. Haraldsen and Dahl (2000) found that transgendered patients showed lower self-reported psychopathology on the Symptom Checklist 90 (SCL) than either healthy controls or those with personality disorders alone. Banks (2001) found similar results with GID individuals on results from MMPI and MMPI-2. No clinical elevations were found on the 417 protocols examined, and a slight but negative correlation was found between the severity of the GID and the presence of a personality disorder (Banks, 2001).

One of the first questions that invariably arises when a mental health or other medical condition occurs in any correctional setting is "What possible reasons could this inmate have for claiming this disorder or needing this treatment?" While there are countless possibilities, housing options and underlying personality disorders are among the most common causes driving extraordinary requests. Some have asserted that sex offenders "will play the GID card" to get closer to female inmates if housed with them. This is worth considering, but if the inmate is undergoing hormone therapy, it should be noted that his testes will shrink, he will be unable to achieve an erection, and he will lose interest in females. Israel (2002) asserts that malingering in transgenders is rare.

In either the case of male or female GID malingering, "better" housing may be at the basis of the request, although being placed in protective custody gives an inmate a more or less permanent "jacket" of being either a sex offender, a "snitch" or weak. It is often more limited than general population housing in both opportunities for work or education (Rosenblum, 2000).

A variety of sources provide guidance for treatment of GID that may be applied to the correctional setting. Among the first concerns is to establish the GID condition and pursue differential diagnosis of any co occurring conditions. Differential diagnosis and identification of co-occurring

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disorders may be determined by familiarity and referral to the *DSM-IV-TR* categories for the suspected conditions. Each condition will require separate interventions. This is consistent with the HBSOC Principles. Principle Nine reveals that the "intersexed" patient, one with a documented hormonal or genetic abnormality, should have that condition treated first by procedures commonly accepted as appropriate for those medical conditions. Principle Ten reveals that a patient having a psychiatric diagnosis such as schizophrenia, in addition to a diagnosis of GID should receive the commonly-accepted medical treatment as appropriate for those with a non-transsexual psychiatric diagnosis (Meyer et al., 2001). This would certainly be appropriate in a correctional setting and would assist in ruling out other causes for the dysphoria that may not be related to a GID.

While preoperative counseling may not be offered per se, the correctional mental health staff or at least one designated practitioner should be familiar with GID and the HBSOC. With or without medical intervention, GID affected inmates are often provided, at the minimum, supportive counseling if they so desire to assist them with the stress of living in a prison environment and to monitor them for depression, suicidal thoughts, or abuse by other inmates or staff. Since their families may or may not have accepted their GID and desire to become a person of the opposite gender, many inmates may lack outside support and may have grief and anger issues.

Most GID diagnosed inmates report that they find counseling support affirming, in and of itself. They can talk openly about the thoughts and feelings that they may hide, by necessity, while in the general population. They report that it is also affirming to be addressed by their desired name and preferred pronouns while in counseling sessions. While the question of hormones and surgery remain up in the air at this time, counseling support is usually supported by the institution as it addresses the concern of "deliberate indifference."

A final point must be made about counseling intervention concentrating on the GID issue only. Equal attention must be paid to interventions focused on the reason the inmate is incarcerated in the first place. The need for drug and alcohol treatment, stress and anger management, coping with a long sentence, and antisocial traits are as important as the GID. In fact, discussing how much the role of GID did not play in the crime is as important as how much it played in the crime. Resolution of the GID will not erase a felony record. The astute therapist will help the inmate keep perspective about expectations upon release should gender reassignment be accomplished.

The diagnosis of GID is a contentious area in the field of correctional mental health. Public opinion varies widely as to the existence and validity of the condition and medicalization of the condition has both supporters and detractors in both the medical and GID community. The correctional system faces huge challenges with housing and treatment. At this time, policies vary state by state and institution by institution. Added to these issues are the challenges for mental health staff who work with GID individuals and who must address the GID disorder itself, as well as the frequently-associated risk factors. Additionally, the personality disorders often found in prison inmates may be present in this population, along with questions of malingering and underlying motives, addiction, drug and alcohol abuse, post-traumatic stress disorder (PTSD), and general anxiety and stress. Other Axis I diagnoses may present as well and may require additional intervention.

In sum, mental health staff in prisons must develop an awareness of the historical issues associated with GID and their own feelings regarding GID and its treatment. The implications for this disorder are, indeed, farther reaching in the correctional setting than they are on the streets.

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THE ALPHA-STIM SCS AS A TREATMENT FOR CLINICAL AND STRESS SYMPTOMS IN A COURT-ORDERED OUT-PATIENT ALCOHOL AND DRUG DEPENDENT POPULATION: A PROVOCATIVE REPORT

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There have been over 125 human subjects' studies using cranial electrotherapy stimulation (CES) to treat a wide range of emotional and drug related problems (Kirsch, 2002). The great majority of studies have reported positive results.

The Alpha-Stim SCS treatment changes brain functioning at a physical level and its effects can be cumulative. These positive changes are secondary to the Alpha-Stim's SCS electrical current that encourages the production of serotonin (5HT) which, in turn, increases the cortex's alpha bandwidth activity (relaxation). Conversely, it reduces cholinergic (Ach) effects such as agitation and arousal activities (Giordano, 2006).

For example, two studies, using EEGs, found important changes in cortical function after CES treatments. The EEG Gamma (35+Hz), Beta (15-35Hz), Alpha (8-14Hz), Theta (3-8 Hz), and Delta (0-3Hz) bandwidths have been used in identifying cortical dysfunctions and measuring treatment success. In addition, low P-300 amplitudes (the height of a brainwave), also measured by EEG, were found to distinguish alcoholics from non-alcoholic populations and, in general, alcoholics had lower P-300 amplitudes than non-alcoholics.

Braverman, Smith, Smayda, and Blum (1990), using a sample group of alcoholics in a treatment program, found improvements in four bandwidths (Beta through Delta) and P-300 amplitudes as a function of CES. Control group members received the same treatment protocols but did not receive CES and showed no improvement in the four bandwidths nor did they experience an increase in P-300 amplitudes.

In the second study, Kennerly (2002) used the Alpha-Stim SCS 100 with 30 non-clinical volunteers. He examined changes in cortical functioning as measured by qEEG. The measurements occurred during and following 20-minute treatment sessions. Each subject received one session. During CES treatment, increases in Delta and Gamma bandwidth activity were observed. These bandwidths are at the extreme low and high ends of the brain's cortical activity.

After treatment, there was a decrease in Delta and Theta bandwidths which coincided with an increase in Alpha, creating a relaxed but focused response. Post-treatment subjects reported feeling more awake and experiencing less anxiety. In addition, subjects who were feeling pain prior to CES treatment reported significant reductions in their physical pain.

Both of these studies offer support for the proposition that CES changes brain functioning at the neuronal level and does so by producing a broad-based brain modulation effect. Changes in bandwidths and P-300 amplitudes addressed how the Alpha-Stim SCS may modulate brain functioning. However, questions remained regarding the extension of cortical effects to everyday life challenges such as improvements in intelligence quotients, treatment program retention rates, and addicts' ability to think more clearly and engage in more appropriate behaviors.

Schmitt, Campo, Frazier, and Boren's (1984) research addressed the issue of CES's influence on subjects' intelligence quotients. The subjects were alcohol and polysubstance abusers. The dependent variables were the Revised Beta (IQ), and three clinical indicators of organic brain damage (Digit Symbol, Digit Span, and Object Assembly) from the Wechsler Adult Intelligence Scale (WAIS). Prior to treatment, 88% of the patients showed dysfunctions in one or more of the WAIS subscales.

Results demonstrated that subjects treated with CES, compared to a control group and a sham control group, made significant gains on all three measures of brain function. They also made significant gains on the IQ measure which were not found in the two control groups.

Improvements in IQ secondary to CES treatment were also noted in Smith's (1999) study. Changes between pre- and post-treatment IQs (WISC-R and WAIS-R) for the sample of 23 subjects were noteworthy.

The positive results CES produced in cortical functioning and subjects' intellectual abilities helped us

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understand the relationship of CES driven changes to brain functioning. The study below examines the ability of CES to enhance retention (staying in the program) and reductions in clinical symptoms for subjects going through substance abuse treatment programs.

The issue of retention during treatment was addressed by Brovar, (1984). Twenty-five consecutive admissions to a hospital's detoxification unit which included a 5-day in-patient treatment program, were randomly assigned to either a treatment group (Alpha-Stim SCS) or a control group. Five of the 13 assigned to the treatment group agreed, while eight refused Alpha-Stim SCS treatment. The control group had 20 subjects, including those who had refused to participate in the treatment program.

All five treatment subjects completed both detoxification and the hospital treatment program while 65% of the control group completed both. At an 8-month follow-up, no Alpha-Stim SCS subjects had returned for treatment, while 61% of the control group had been readmitted.

Dropout rates were a part of a 7-year project conducted by Patterson, Firth, and Gardiner (1984). They studied the potential positive influence CES had on drug addicts and alcoholics experiencing detoxification. The treatment group received continuous treatment during the first 6 days of detoxification with progressively shorter treatment times until day 10, the final day in the treatment center. On day 10, each subject received 6 hours of CES treatment.

Results were impressive. The dropout rate over the 7-year period was 1.6% with CES treatment. Conversely, the dropout rates for the three comparable programs without CES were 90%, 75%, and 45%. In addition, over 98% of the 186 patients in her program were successfully detoxified and none of the treatment group experienced withdrawal symptoms. Cravings and anxiety symptoms were also reduced. Specifically, by the 10th day, 95% of the treatment group were free of craving and 75% were free of anxiety.

Bianco's (1994) research focused on the feasibility of CES to reduce depression and anxiety in an in-patient population of polysubstance abusers. He divided his sample into three groups. One was a standard control group which received the hospital's typical treatment program. A second group was a sham control group, who thought they were receiving CES treatment but were not. The third group received CES along with the standard hospital treatment protocol. Significant post-treatment differences ($p=<.05$) were found between the CES group, when compared to each of the control groups. That meant, when CES was combined with standard treatment, depression and anxiety were significantly lower than when subjects received the standard treatment alone, or the standard treatment group with the sham experience.

Results from a single-case study (Mellen & Mitchell, 2008) were also impressive. The 19-year-old inmate was remanded by the court to the detention center's drug abuse program. Completing the program was the only condition for returning home. If he washed-out he would be sent to prison. The Alpha-Stim SCS treatment was initiated after the inmate failed to complete the program on two earlier occasions, due to violent behavior in the pod where he lived, including a physical attack on a detention center security officer. If he failed the third attempt he would be immediately sent to prison.

The inmate underwent 15 sessions of Alpha-Stim SCS treatment and, for the first time, was successful in completing the program. Because of changes in the inmate's thinking and behavior patterns, the director of the detention center promoted the inmate to pod leader. These results were also indicators of improved global cortical functioning by the inmate.

The objective of the this study was to determine the ability of the Alpha-Stim SCS to reduce clinical and stress symptoms in a sample of alcohol and drug abusers in a court-ordered out-patient group counseling program. The subjects' average age was 33 years and the mean reported time for using alcohol/drugs was 8.8 years. The range of alcohol/drug use was from 1 year to 25 years. The final sample included 16 male and 6 female subjects. Ten (71%) of 14 experimental group subjects completed the treatment and pre- and post-treatment assessments. Twelve (41%) of 29 control subjects completed both pre- and post-assessments. The subjects' educational levels were low and many had to have help reading the Brief Symptom Inventory (BSI; Derogatis, 1993) and an alcohol/drug questionnaire. The subject pool combined alcohol dependent and polysubstance dependent subjects. The study did not control for medication. Males and females were randomly divided between the experimental (7 males, 3 females) and control (9 males, 3 females) conditions. There were a total of 20 sessions

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per subject, each lasting 30 minutes. Subjects completed two sessions per week for 10 weeks.

The Alpha-Stim SCS was the experimental condition, a CES type device. The sub-scales of the BSI were chosen as dependent variables. The BSI provides a multi-symptom assessment for measuring nine clinical areas. The BSI also has three global scales for measuring stress (Derogatis, 1993).

The Nine Clinical Scales Include:

1. Somatization: measures bodily complaints.
2. Obsessive/Compulsive: repetitive thoughts and actions.
3. Interpersonal Sensitivity: difficulties with interpersonal relationships.
4. Depression: sad mood, loss of energy, difficulty sleeping or sleeping too much.
5. Anxiety: excessive worry
6. Hostility: feelings of anger toward others and the world
7. Phobia: excessive fearful reactions toward objects, insects and such.
8. Paranoia: excessive fears that are not supported by evidence.
9. Psychoticism: these individuals can appear unusual and emotionally distant

The Global Scales Include:

1. Global Index: the most sensitive measure of stress.
2. Positive Symptom Distress: degree of stress being reported.
3. Positive Symptom Total: total number of symptoms endorsed by a subject.

Alcohol/Drug Questionnaire

A 19-item drug use questionnaire was developed by the authors. Twenty of the studies' participants completed the questionnaire to provide demographic information on their addictions. To avoid forced choice (yes-no) biases, a 7-point Likert scale was utilized.

The questions addressed five broad categories:

1. Psychological issues: self-confidence, tension/stress, drinking alone or drinking to avoid loneliness, and remorse for drinking/drug use.
2. Physical problems: diarrhea, nausea, withdrawal symptoms, blackouts, shakes, and/or hallucinations.
3. Financial issues: economic costs for alcohol/drug use, loss of job or missed work time.
4. Friends and family: changing friends to be with other drug/alcohol users or hiding drug use from family/friends, making excuses, or putting friends in danger with one's drug/alcohol use.
5. Leng~~th of time the a~~lcohol/drug use had been a problem.

Pre-treatment comparisons of means found no difference between the scores of the treatment group and control group on the BSI subscales. Also, no change was found between pre- and post-assessment means for the control group.

However, significant differences in pre- and post-treatment means for the treatment group were noteworthy.

Clinical Scales:

1. Somatization..... <.008
2. Obsessive/Compulsive <.020
3. Depression ..... <.015
4. Anxiety..... <.015
5. Psychoticism ..... <.050
6. Paranoia ..... <.066
7. Hostility..... <.077
8. Interpersonal Sensitivity <.077
9. Phobia ..... <1.77

Global Scales:

1. Global Stress Index ..... <.007
2. Positive Symptom Distress Index..... <.042
3. Positive Symptom Total .. <.004

Attendance for the treatment group was higher than for the control group: 71% for the treatment group compared to 41% for the control group.

Alcohol/Drug Questionnaire Results

The average length of time drugs/alcohol were considered to be a problem for both groups was 8.8 years. The Likert scale ranged from 1 (not a problem) to 7 (a serious problem). Means of the highest and lowest self-reported problems are listed follow:

Financial problems related to drug use..... 4.9
Time sent getting alcohol/drugs..... 4.7
Remorse related to alcohol/drug use..... 4.7
A danger to self and/or others 4.5
Hiding alcohol/drug use .. 4.5
Trouble with the legal system due to alcohol/drug use..... 4.4
Loneliness, anxiety & tension 4.4
Blackouts..... 4.0
Withdrawal symptoms..... 3.1
Hallucinations..... 2.8

The attrition rate for the experimental group was 29% and for the control group 59%. The most common reason for not completing the program was non-compliance (failure to attend), a failed drug test, or other program rule violation.

One of the four experimental group dropouts was due to injuries related to a car accident. A second experimental group member stated that the treatment was helping and she wanted to

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continue, but physical discomfort while using the Alpha-Stim SCS was not diminished by reductions in the uA.

The results revealed no statistical differences on the pre-treatment BSIs for the treatment and control groups. This was true for the clinical scales and the global scales suggesting that both groups were similar, as measured by the BSI. Also, there were no changes in pre- and post- BSI assessments of clinical and global stress measures for the control group.

However, significant changes were found in the treatment group's BSI results, suggesting a positive influence from using the Alpha-Stim SCS treatment. In addition, the treatment group findings support the argument that the Alpha-Stim SCS provides a global brain modulation.

In summary, the Alpha-Stim SCS seems to provide a global modulation effect in substance abusers. The effect could be calming the subjects and allowing them to access the cortical and sub-cortical areas of the brain that they need for making better decisions.

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ASSOCIATION UPDATES

FROM THE PRESIDENT

Richard Althouse, Ph.D.—*Contact: goldmine123.a@gmail.com*

As we go through another year, I'm happy to report that both the financial and professional status of our Association remains healthy and vibrant. From our rather humble beginnings in l953 as the Society of Correctional Psychologists and our first newsletter in l956, we have grown into a nationally, if not internationally known professional organization with a firmly established and highly respected flagship journal (*Criminal Justice and Behavior*) and newsletter (*The Correctional Psychologist*) that provides periodic updates, a forum for member interests, and conference announcements.

To further support our members' professional interests, we have developed a strong association with a world-class publisher (SAGE), and have working affiliations with a number of other professional

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ASSOCIATION UPDATES

FROM THE PRESIDENT (Continued from page 11)

organizations including the American Correctional Association, the National Commission for Correctional Health Care, and the Mental Health in Corrections Consortium. We have had two published sets of national standards for correctional mental health care, with a second revision currently underway. We have also developed a website for members and interested others.

As a result, we have enjoyed a stable or growing membership of psychologists, social workers, other mental health or corrections professionals, and students, and we are constantly engaging in a variety of outreach activities to attract professionals and students. Please remember that a member does not have to be a psychologist to join our organization.

Finally, under the energetic leadership of Dr. John Gannon, our Executive Director, there are a number of other projects in the works, including the revision of our national standards for correctional mental care and development of our Ethics Hotline. Readers will be updated as these projects come to fruition. This should continue to be an exciting period of growth for our Association.

All these benchmarks make the International Association for Correctional and Forensic Psychology an influential professional association for those in the fields of correctional and forensic psychology. If anyone has suggestions or questions about the Association or its activities, please do not hesitate to bring them to my attention.

Richard Althouse, Ph.D., is President of IACFP and recently retired from the Wisconsin Department of Corrections after 37 years of service as a psychologist.

MEMBER ARTICLE

REFLECTIONS AND PERSPECTIVES....

Richard Althouse, Ph.D.—*Contact: goldmine123.a@gmail.com*

After 37 years as a psychologist in state corrections and forensic settings, I quit. Well, actually, retired from state service. It was economically prudent to do so, but I was otherwise ready. Bob Smith, our dedicated and vigilant newsletter Executive Editor wondered if I had any words of wisdom from those years of experience that I might share with our readers. Despite the risk of over-generalization and oversimplification, I agreed. As a disclaimer, what follows is the result of my own experiences, and my opinions are not to be construed as reflecting those of the International Association for Correctional and Forensic Psychology (IACFP), its Board of Directors, members, or previous employers.

Then and Now…

When I entered the corrections arena as a clinical psychologist in 1971, I knew nothing of the American Correctional Association or the American Association for Correctional Psychology (now the IACFP). President Nixon had yet to politically connect marijuana, LSD, and heroin, with violent protest and crime to justify his war on drugs, the DEA was not yet established, Martinson had yet to publish his infamous "nothing works" paper (Martinson, 1974), the war on crime had not yet ramped up, and the U.S. Supreme Court had not yet made any decisions about mental health care in prisons. There were a number of clinical staff at my facility, and our job was clear; see and "fix" the troubled juveniles sentenced to our facility. However, I soon learned that our ideas of how to best psychologically manage and treat these youth and institution's administration and staff's ideas were not exactly the same. Efforts to resolve these differences were not well received. While psychological services in our correctional facilities had been administratively established and supported through our Bureau of Clinical Services, the local thematic message was clear: mind your own business and stay out of institution affairs. I eventually came to understand that psychologists were not viewed as legitimate members of the corrections industry, and despite many local and national discussions, it was not clear how that was ever to be accomplished (e.g., see Monahan, 1980).

When I left 18 years later, my impression was that it still wasn't. So I happily transferred to a forensics unit of a state mental health hospital, and I remember driving away my last day, relieved that I was finally going to a mental health facility where "mental health" was not a foreign concept that needed advocacy, and I was actually going to be able to be a psychologist and treat patients. While I received excellent forensic training, 3 years later, I recall being in a meeting in

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which one of my staff asked, "when are we going to get to the 'mental health' part?" I had been struggling with the same question. Judges were very reluctant to release schizophrenic murderers back into their community regardless of what my treatment team said about readiness and the mental health of the patient. I was beginning to catch on, and I didn't like what I was catching on to.

A year later, I transferred back into corrections, thinking that at least corrections was honest; it was clear what its mission and goals were: securing inmates until their sentences were up in ways consistent with the sociopolitical views of offenders of the time, and providing a modicum of care and programming in the interests of institution and public safety (evidence-based or not). There were no pretexts about humane conditions, or about the status and roles of psychologists and mental health services. Our job was still simple: "fix" the mentally ill inmates, but without meddling in the affairs of the system or the institution. By this time, however, the task was becoming increasingly difficult. The wars on drugs and crime were beginning to overwhelm the system with offenders and inmates, a significant number of whom were seriously mentally ill and/or drug-addicted and with no place else to put them. There was little interest in codes of ethics or national standards of care. There was often not enough staff to provide consistent treatment, and more time was spent managing crises than providing treatment. That remains generally true today, only since then, the whole system has been even more overwhelmed and the challenges even more daunting.

I offer this brief backdrop to illustrate two themes that I believe are as true today as they were almost 40 years ago. First, the criminal justice system and departments of corrections have not employed mental health service providers over the years because it was the humane, morally correct, or compassionate, thing to do. It was, however, practical and acceptable as long as it was clear "who was in charge," and the parameters of our services were not breached.

Second, as a response to the first, correctional mental health staff (in contrast to forensic psychologists) strived to claim legitimacy, authority, and role-definition in the criminal justice and corrections fields but without appearing "soft on crime." It has neither been easy nor widely successful, and it took a number of Supreme Court decisions to help get that job done (see Cohen, 1998, 2008). Despite those decisions, many correctional facilities around the country, and the increasingly stressed mental health service providers in their employ, eventually found themselves ill-equipped to meet the needs of increasing numbers of mentally ill inmates and offenders in their facilities (e.g., Human Rights Watch, 2003). That is still true today.

Frustrations

While the scope of our professional responsibilities in corrections has become more well-defined (screening and treating the seriously mentally ill or suicidal inmate) as well as correspondingly document laden, our integration into a correctional facility's programming and autonomous ability to provide mental health services to offenders still depends on a variety of other variables, many of which are often beyond the professional's ability to control. These range from the availability of economic resources, the facility administrator's management and correctional philosophy and opinion about psychologists and their appropriate role in the facility, strained relationships with security and other institutional staff who may harbor anti-offender attitudes and biases, numbers and qualifications of other mental health services providers, limited availability of treatment and support resources, controlled access to inmates, stressed relationships with community agents, and limited availability of community mental health resources.

While these barriers vary around the country, over time they can be significant sources of professional burn-out. I have seen more than one mental health professional cope with these stressors in one of three ways: (a) eventually continuing to work just to maintain employment ("just get through the day" or "staying out of the spotlight") rather than striving to make a real difference in an offender's life, perhaps risking being targeted by an administrator for "rocking the boat" on important ethical or practice issues and/or seen as being "soft on crime" in the doing, (b) "joining the other side," finding professional alignment with the correctional philosophy and/or correctional administrators, becoming more punitive and less treatment oriented in their dealings with inmates (e.g., "they're all antisocial personality disorders"), and/or (c) seeking legitimacy by providing specialized research and/or treatment in the politically "hot" areas of the time (e.g., criminal personalities, psychopaths, sex offenders, substance abusers,

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domestic violence, etc).

The secret, if there is one, to managing these frustrations is to keep one's career goals and expectations realistic by understanding the mission and goals of the criminal justice system and one's employer. It is very easy to be conceptually critical of the exigencies and seemingly counterproductive policies and activities of our criminal justice system, or become emotionally entangled in the frustrations and stress it causes staff, offenders, and the public. It is, after all, essentially a sociopolitical process—the ultimate concern of which is pubic safety—that does not pretend to have compassion for offenders, even mentally ill ones. All that said, there are potential rewards, albeit limited, for the aspiring correctional mental health professional.

Rewards

The first and perhaps most obvious reward is job security. Many departments of corrections are becoming increasingly sensitive to civil rights litigation regarding inadequate mental health care, and are making an effort to put into place policies and procedures in keeping with court decisions and recommended standards of care (e.g., American Association for Correctional Psychology (2000), the American Correctional Association (2002), and the National Commission on Correctional Health Care (2008), and interface more effectively with community resources. To this end, many departments of corrections around the country are actively seeking qualified mental health service professionals, offering reasonable salaries and benefits.

Second, correctional mental health services providers have many opportunities to provide authoritative moral role models in correctional settings, standing for and modeling ethical and professional conduct for staff and inmates, and objectively advocating for the professional and humane treatment of offenders by the system, even if not our immediate clients (see Hess, 2009). The accumulation of these opportunities can, bit by bit, contribute to better policies and procedures, and in the end, a greater social good.

The third, and perhaps most powerful, is being able to facilitate real and meaningful improvement in the lives of individuals who might otherwise not have access to mental health treatment and related services, and to see them succeed in their communities. While these experiences may be too few and far between for many, when they occur, they can be very rewarding and keep one professionally interested even through difficult times. They were for me.

Our struggles are not over. In the end, while psychologists and other mental health providers have much to offer, we each have to find our own professional path. Careful and realistic expectations can allow it to be one that provides us opportunities for contributions accompanied by professional satisfaction. With those caveats in mind, it is possible to have a rewarding career as a mental health services provider in corrections.

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Richard Althouse, Ph.D., is President of IACFP and recently retired from the Wisconsin Department of Corrections af-

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ter 37 years as a psychologist. A portion of his 37 years was spent working with juveniles in the Wisconsin Department of Health and Social Services, Division of Corrections. He also supervised an adult forensics unit for the Wisconsin Department of Health and Human Services, Division of Care and Treatment Facilities.

ASSOCIATION UPDATES

FROM THE EXECUTIVE DIRECTOR JOHN L. GANNON, PH.D.

John L. Gannon, Ph.D.—*Contact:jg@aa4cfp.org*

In addition to continuing our collaborative and partnering efforts with like-minded groups and associations over the past year, we are currently working with SAGE and others on a number of projects and developments including:

•Establishing timelines for our marketing efforts and getting our working partners to submit timely articles, SAGE Alerts, and news for *The Correctional Psychologist.*

•A Facebook page.

•With the help of SAGE and Dr. Althouse, we now have a blog site on the IACFP website. Our blogmeister is Dr. Althouse, with Tom Mankowski from SAGE providing the technical and reviewing oversight.

•Podcasts.

•Rich Site Summary (RSS) feeds.

•Membership surveys to determine what is important to them as professionals, what they value about their membership, and what we might do to improve member services and values.

•Complimentary IACFP membership to selected individuals.

•Strategies to contact university chairs to increase IACFP student members.

•With Dr. Bartol's approval, continuing efforts to increase *Criminal Justice and Behavior* citations.

•Regular content and artwork for the Association website.

•An Internet Ethics Hotline.

•Registration on our website for dual member conferences and membership promotions.

•A committee to track national and local legislation with the intent of writing letters of support on issues of importance to correctional and forensic psychology.

•Consideration of expanded possibilities for CEs for our members and others is under review.

•Better strategies for our job and conference posting pages on the website.

•A stronger relationship with correctional psychologists in California. There are over 500 psychologists now working for the California Department of Corrections and Rehabilitation (CDCR). We have been making contact with some leaders of the psychologists and will continue to explore ways of bringing more CDCR psychologist on board.

•A program to donate out of print or obsolete editions of textbooks and other correctional/forensic materials to developing countries through partnerships with SAGE, ACA, and ICPA.

•A Wikipedia-like approach to soliciting correctional program descriptions and making them available to readers.

•Extensions of publish before print.

John L. Gannon, Ph.D., is IACFP Executive Director/Affiliate Liaison and is a private consultant in Pismo Beach, California.

CONFERENCES

The International Corrections and Prisons Association (ICPA) will hold its 11th Annual General Meeting (AGM) and Conference in Bridgetown, Barbados, October 25-30, 2009. Last year, ICPA celebrated a decade of lessons learned. This year the AGM and Conference will launch the beginning of another decade by exploring the theme "New Horizons." Full registration will cost $735 U.S. (Daily rates are also available). A companion program for friends and family will also be available for $295 U.S. Visit icpa.ca.

ITEMS OF INTEREST

In 1984, Japan had 40,000 criminal offenders in prison with a general population half ours. In 2009, Japan's prison population almost doubled to 71,000, while ours quadrupled to 2.3 million. In the last 20 years, the U.S. has incarcerated more offenders for nonviolent crimes and for behaviors driven by mental illness or drug dependence. The U.S. Department of Justices estimates that 350,000 offenders in our prisons and jails suffer from mental illness. Visit doj.org.

ITEMS OF INTEREST

CORRECTIONS SYSTEM HAS CAREER OPPORTUNITIES

Nicole R. Gross and Philip R. Magaletta, Ph.D.—*Contact: pmagaletta@bop.gov*

The U.S. Federal Bureau of Prisons (BOP) houses more than 200,000 inmates and remains the nation's leading correctional system. With a doctoral level hiring standard for psychology service providers, the bureau currently employs more than 450 psychologists to address the multifaceted needs of federal inmates.

Far beyond the simple importation of psychological principles and their application to those behind the walls, the clinical practice of these correctional psychologists requires a broad and general understanding of mental health, substance abuse and systems principles within individuals and across the embedded systems that form the typical correctional institution. For many psychologists this challenging type of work has led to stable, rewarding and lifelong careers.

It is hard to envision another practice environment where a psychologist could find the diversity in population or job responsibility as in corrections. Psychologists rarely have one repetitive practice area, as they are often responsible for conducting suicide risk assessments, crisis intervention, brief counseling, individual and group treatment, drug abuse, sex offender treatment, and clinical supervision of treatment staff. This list is by no means exhaustive as the roles of the clinical practitioner changes with the dynamic needs of the inmate population and the mission of the prison.

How does one develop the expertise for such a challenging career? Clinical knowledge and the application of that knowledge are learned and developed through graduate education in counseling and clinical psychology. Such education lets one to transition smoothly into a chosen area of practice.

The same is true for individuals who decided to apply their clinical skill set to inmates in prison systems. Working in a prison requires a strong foundation in general clinical competencies (psychopathology, suicide assessment, individual and group counseling skills) and the ability to learn about the complex and unique prison system in which they will be applied.

Prisons are practice environments that build upon the broad and general skills obtained in graduate school. Through on-the-job experience one learns about the unique aspects of the corrections environment and the individuals who live inside its walls. The need for mental health services is often present within individuals before they enter the prison. However, that need can be both provoked and exacerbated by the environment of the prison.

This is where knowledge of the functioning of the correctional facility is an important feature of clinical practice. The nature of living arrangements (the unit an inmate is on), disciplinary actions received, and other institution-imposed structures all have the ability to affect one's functioning. Receiving collateral information from those who are in contact with the individual on a daily basis (correctional officers, unit staff, etc.) is an important means of detection of psychiatric symptoms that may need to be addressed.

In sum, inmates often represent an underserved population in grave need of mental health intervention. It is the mission of the Psychology Services Branch in the BOP to apply expertise in a manner that maintains a safe and humane environment for both inmates and staff. Psychologists ensure that all inmates with an identified need for mental health services have access to the appropriate level of care. The implementation of empirically-based practices is used to foster the development of behaviors that allow the inmate to safely acclimate to incarceration and to become productive members of society upon

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ITEMS OF INTEREST

CAREER OPPORTUNITIES (Continued from page 16)

release.

Loan repayment programs in certain locations, the possibility of living in many geographically diverse regions of the United States, accelerated and early retirement benefits, and overall safety are among the top factors that bureau psychologists describe when expressing satisfaction with their careers.

In addition, the overall pay scale that can range from $54,000 to $120,000 depending upon location and experience provides a nice incentive for seriously considering this line of work. With the opportunity to provide meaningful public service on one hand and the stable human resource benefits on the other, many established and newly minted psychologists are choosing clinical practice in the BOP as a career for life.

Nicole R. Gross is completing her master's degree at Marymount University and is a volunteer research assistant/intern in the Psychology Services Branch, Federal Bureau of Prisons, Washington, D.C.

Philip R. Magaletta earned his Ph.D. in clinical psychology from St. Louis University. He has administered and practiced correctional psychology for more than a decade with the Federal Bureau of Prisons and currently serves the agency as clinical training coordinator for the Psychology Services Branch. He is also a faculty associate at Johns Hopkins University.

This article does not contain the official policy or opinion of the U.S. Department of Justice or the Federal Bureau of Prisons. Counseling and clinical psychologists interested in learning more about employment opportunities in the Bureau of Prisons should go to bop.gov, and click on the career link for clinical psychologist. References for this article are available from the authors. This article originally appeared in the March/April 2009 issue of *The National Psychologist.* Subscriptions for *The National Psychologist* are available online at: nationalpsychologist.com.

ITEMS OF INTEREST

SENATE BILL 678 REGARDING JUVENILE JUSTICE AND DELINQUENCY PREVENTION INTRODUCED

On March 24, 2009, Senate Bill 678 (S. 678) the Juvenile Justice and Delinquency Prevention Reauthorization Act was introduced in the U.S. Senate. For the past 30 years the Juvenile Justice and Delinquency Prevention Act (JJDPA) has helped protect youth in the juvenile justice system through its four core protections:

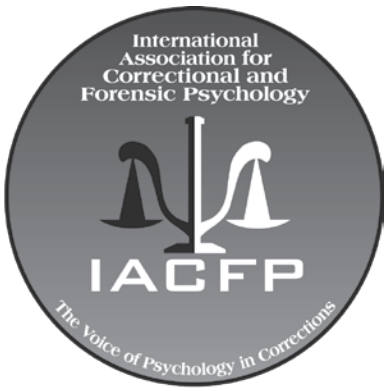
1. Jail Removal: Juveniles should not be placed in adult jails except in very limited circumstances.

2. Sight and Sound: If juveniles are temporarily held in adult jails they must be separated from adult inmates.

3. Deinstitutionalization of Status Offenders: Prohibits the incarceration of youth whose behavior would not be criminal if committed by an adult (e.g., truancy).

4. Disproportionate Minority Contact: States must address racial disparities in their juvenile justice systems.

The Senate Reauthorization Bill, S. 678, as introduced, makes many critical improvements to these four core protections. The Act 4 Juvenile Justice (ACT4JJ) Campaign, comprised of hundreds of juvenile justice, child welfare and youth development organizations throughout the country, would like your support to ensure that a strong JJDPA is passed by Congress this year. Please visit act4jj.org for more information on how S.678 improves the JJDPA and how you may help.



ASSOCIATION UPDATES

International Association for Correctional and Forensic Psychology

(formerly American Association for Correctional and Forensic Psychology)

Join today and receive FREE ONLINE ACCESS to the *SAGE Full-Text Collections in 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.**

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ITEMS OF INTEREST

IN BRIEF...TAKEN FROM A VARIETY OF NEWS SOURCES

•BEHAVIOR MODIFICATION FOR OFFENDERS....

The National Curriculum and Training Institute offers an extensive library on and resources for behavioral change curriculum for both overt and cognitive behavior. The NCTI and the American Probation and Parole Association recently collaborated on a behavior modification project in Salina, Kansas, with excellent results. Contact Jeff Koenig at jkoenig@ncti.org for more information.

•CHILDREN....

According to the U.S. Department of Justice, children transferred to the criminal justice system are likelier to commit future crimes compared to those who remained in the juvenile system. Contact Campaign for Youth Justice, 1012 Fourteenth Street Northwest, Suite 610, Washington, DC 20005 or info@CFYJ.org.

•WOMEN....*CAUGHT IN THE NET: THE IMPACT OF DRUG POLICIES ON WOMEN AND FAMILIES* reports that there are now more than one million women behind bars or under control of the justice system. Contact fairlaws4families.org.

•THE U.S. PRISON SYSTEM....

The U.S. has the world's highest incarceration rate. With only 5% of the world's population, the U.S. now has 25% (2.3 million) of the world's reported prisoners. The U.S. currently incarcerates 756 inmates per 100,000, a rate five-times the world-wide average of 158 inmates per 100,000. Also, in the U.S., more than five million more people who recently left prison, remain under correctional supervision including parole, probation, and other community sanctions. Today, one out of every 31 adults in the U.S. is in prison, in jail, or on supervised release.

•CE WORKSHOPS ON THE MMPI....

•Hollywood, FL, August 29: MMPI-2-RF Workshop.
•Indianapolis, IN, September 25: MMPI-2-RF Workshop.
•Dallas, TX, Ocotber 8-11: Public Safety Employment Workshop and MMPI-2 and MMPI-2-RF Workshops.
•Skokie, IL, November 7: MMPI-2-RF Workshop.
Visit personassessments.com/news/shows.htm.

•111TH CONGRESS SCORECARD....

The 111th Congress began in January 2009. To become law, these bills will have to be passed by both the House and Senate and signed by December 2010. Contact thomas.gov for a copy of the bill.

-**H.R. 68**...Jackson-Lee...No More Tulias: Drug Law Enforcement Evidentiary Standards Improvement Act is a response to targeting 16% of African-Americans in Tulia, Texas. Later, they were found not guilty.

-**S. No Number**...Spector introduced in 110th Congress...Pilot program to increase the present federal tax credit of $2,400 to $10,000 for hiring an ex-felon. Also, employer must pay 150% of minimum wage and provide health benefits.

-**H.R. 69**...Jackson-Lee...Reforms eviction from public housing in regard to those with felonies.

-**H.R. 1064—S. 435**...R. Scott & Castle, S. Casey & Snowe...Youth PROMISE Act provides evidence-based practices of prevention and intervention relating to juvenile delinquency and gang activity.

-**H.R. No Number**...Rush introduced in 110th Congress...Authorizes grants to youth-serving organizations that do child-parent visitation programs for children with incarcerated parents.

-**H.R. No Number**...Payne...Gives grants to organizations that provide reentry services to prisoners released because they were determined to be factually innocent.

-**H.R. 1133**...Rush...Directs the Federal Communications Commission to consider prescribing rules regulating prisoner telephone service rates.

-**S. No Number**...Webb...Creates panel to study ways to overhaul the criminal jusice system.

-**H.R. 105**...Conyers...Comprehensive voting reform that includes all people to vote in federal elections except those currently serving a felony in prison.

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JOIN US

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 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.

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