Corrections today is a high-profile, complex operation that consumes very large portions of the operating budgets of the federal government and virtually all states. At the beginning of the 21st century, approximately 1 in 32 adults in the United States was under some form of correctional supervision (Bureau of Justice Statistics, 2002a). The majority of these (approximately two thirds) were under community supervision, which includes probation, parole, and their many variants. House arrest, electronic monitoring, halfway houses for newly released offenders, day reporting, and intensive supervision are examples of sanctions included under the term community corrections. About 22% of all adults under correctional supervision were being held in prisons, and about 11% were held in jails. These figures, representing more than 2 million persons, also represent a tripling of the rate of incarceration since 1980.

In this chapter, we will focus on the services offered by forensic psychologists to the wide variety of individuals under correctional supervision, particularly in prisons and jails. The chapter begins with this institutional focus, providing an overview of key concepts and the legal rights of inmates that are pertinent to psychological concepts. We then examine the assessment and treatment roles of correctional psychologists as well as aspects of the prison and jail environments that present obstacles to effective treatment. By far the greater research attention is paid to the work of psychologists who work in institutional settings, yet forensic psychologists as a group are more likely to come into contact with persons under community supervision than inmates within correctional facilities. During the latter part of the chapter, therefore, we will focus on community corrections and the contributions of forensic psychologists in that realm.

Institutional Corrections

The United States has the highest incarceration rate of any industrialized country, with the numbers of inmates behind bars having increased steadily over the past quarter century. The greatest population increase has occurred in the federal prison system (Bureau of Justice Statistics, 2002a) and is believed to be largely due...
to the nation’s “war on drugs,” whereby mandatory sentences have been in effect for individuals convicted of drug offenses. However, rising incarceration rates also have been observed in virtually every state, even during periods of declining crime rates. Consequently, by the end of the 20th century, every state was facing overcrowding in at least one, and typically more, of its correctional facilities.

The crimes for which offenders are incarcerated are not only those considered the most heinous. In state prisons, 51% of all offenders were serving time for violent offenses, 20% for drug offenses, 15% for public-order offenses, and 14% for property offenses, such as burglary or larceny (Bureau of Justice Statistics, 2002a). In contrast to what we might expect from media coverage, robbery—not homicide—accounted for the great majority of the violent offenses. Although robbery is a serious crime and its effect on the victim should not be discounted, it does not necessarily include the use of force. The taking of property through threat of force—such as a weapon shown to the victim—is sufficient to classify a crime as a robbery. The point made here is that even the 51% of offenders serving time for violent offenses did not necessarily cause physical harm to their victims.

Women, compared with men, are even less likely to be incarcerated for violent offenses. Yet, since 1990, the number of female prisoners has increased 108% (compared with a male increase of 77%) (Bureau of Justice Statistics, 2001a). Researchers attribute these increases primarily to rising drug crimes among women.

Despite the rising incarceration rate, imprisonment does not seem to deter or rehabilitate a substantial number of offenders. Research on recidivism—typically measured by new arrests, new convictions, or sometimes by self-report data—is not encouraging. A recent government survey of persons released from prison in 15 states found that, over a 3-year period, a very high number were rearrested, particularly those who had been imprisoned for property offenses. For example, 78.8% of motor vehicle thieves, 77.4% of those who possessed or sold stolen property, 74.6% of larcenists, and 74% of burglars were rearrested within 3 years (Bureau of Justice Statistics, 2002c). Although these data suggest that neither the imprisonment itself nor programs offered to inmates had a positive effect on those who reoffended, recidivism data must be interpreted very cautiously.

An arrest does not necessarily mean that an individual has indeed committed an offense. Even if he or she has, however, it does not mean that a former offender has not benefited in other ways from the rehabilitation programs offered in a correctional setting. Nevertheless, recidivism statistics such as those reported above lead some observers to question whether incarceration is the best route to take in dealing with the problem of crime and others to question whether rehabilitation is a realistic goal. Furthermore, many legal scholars and researchers in the social sciences are concerned about the disproportionate confinement of the poor and racial or ethnic minorities. The conditions within many prisons, including overcrowding and violence within the facility, provide further cause for concern. Although few scholars advocate the total abolition of jails and prisons, there are increasing calls for alternatives to incarceration, especially for nonviolent offenders.

Forensic psychologists working in institutional corrections, then, must find ways to do their work within a system that is placed in the position of justifying its operations. The public wants its prisons but is resentful of the fiscal costs. And although public opinion surveys suggest continuing support for rehabilitation, individuals working in corrections have learned that rehabilitation-oriented programs are the first to go when budgets need to be cut. Even with scaled-down programming, it is not unusual for the corrections budget to consume a greater share of state coffers than the education budget. Indeed, college students are often appalled to learn that their own hefty yearly tuition fee may be smaller than the cost of maintaining an inmate in prison for a year.
The psychologist in a correctional setting also must work in an environment that often diminishes the likelihood of therapeutic success. Inmates get transferred to other prisons, correctional officers may not support the psychologist's role, administrators may cut their budgets, there is little time to conduct research, and the limitations on confidentiality suggest to inmates that psychologists are representatives of the prison administration, not advocates for their own interests. We will cover these and other issues later in the chapter. For the time being, it is important to note that the recently updated standards developed by the American Association for Correctional Psychology (AACP, 2000) recognize the challenges presented by prison and jail environments. The AACP has published 66 standards intended to offer direction and support to practitioners. Box 12.1 contains a list of topics covered in the standards, and we will refer to them

**BOX 12.1 AACP Standards**

The American Association for Correctional Psychology (AACP) has developed a set of standards that provide the minimum acceptable levels for psychological services offered to offenders held in local, state, or federal facilities, as well as in the community (Standards Committee, 2000). Below are examples of topics and subtopics covered in the standards. Interested readers are advised to read the original standards, which include a discussion section explaining the rationale behind each one.

**Roles and Services:** Appropriate roles include but are not limited to consultation to correctional administration for mental health program design; psychological screening of security staff employed in specialized mental health units; classification for mental health program assignments; training of staff; assessment, diagnosis, and treatment of mental illness; crisis intervention; and advocacy for and evaluation of mental health programs and services.

**Staffing requirements:** At least one person responsible for psychological services in the facility has a doctoral degree that is primarily psychological in nature, is licensed/certified, and has training/experience in correctional psychology.

**Documentation:** All services and mental health information will be documented and/or maintained in a file specific to the offender in compliance with current professional and legal standards and guidelines.

**Limits of confidentiality:** Inmates will be informed both verbally and in writing of the limits of confidentiality as well as legally and administratively mandated duties to warn.

**Informed consent:** All screenings, assessments, treatments, and procedures shall be preceded by an informed consent procedure.

**Employer and ethical/practice standards conflicts:** There is a documented policy for the resolution of conflicts between the facility and the psychological services staff.

(Continued)
throughout the chapter. In addition, psychologists working in corrections are expected to conform to the ethical code of the American Psychological Association (APA), which was most recently revised in 2003 (APA, 2003a). In addition, forensic psychologists are provided with a set of specialty guidelines that do not have the force of the ethics code but do serve to provide suggestions for practice. Finally, psychologists must be aware of all relevant state and federal laws and regulations. Interestingly, a recent review of standards for conducting research in prisons suggests that the new APA Code of Conduct has deleted sections relevant to prison research, including (1) a section pertaining to compliance with state and federal laws and (2) a section referring to the dignity and welfare of research participants (Kalmbach & Lyons, 2003).

Overview of Correctional Facilities

Persons detained, accused, and convicted, when not allowed to remain in their own homes, are housed in three types of facilities: jails, prisons, and community-based facilities. Jails are operated by local governments to hold persons temporarily detained, held for lack of bail while awaiting trial or other court proceedings, or sentenced to confinement after having been convicted of a misdemeanor. Prisons are facilities operated by the federal government and all states for persons convicted of felonies and sentenced to terms of more than 1 year. Community-based facilities are less secure institutions, such as halfway houses or transition homes, typically intended as intermediate sanctions for offenders deemed to need less security than would be provided in jails or prisons but more than would be available in their own homes. Community-based facilities will be discussed later in the chapter.

On any given day, approximately half of the individuals held in jails are innocent; they are detainees, not convicted of the crime of which they are accused. Approximately another half is serving short-term sentences for misdemeanor offenses. The proportion of detainees and sentenced misdemeanants varies widely by jurisdiction, though. In some facilities, up to 70% of the population comprises pretrial detainees who were unable to afford bail or who were denied bail because they were considered dangerous. Jails also may house a wide variety of individuals awaiting transfer to prison, to a mental institution, to another state, to a juvenile facility, or to a military detention facility, though such individuals usually make up a small portion (rarely more than 5%) of the jail population. In effect, though,
jails hold a collection of persons at various stages of criminal, civil, or military justice processing. In some communities, jails also serve as temporary overnight shelters for individuals whom police arrest on minor charges, believing they need a safe haven.

In the federal system, pretrial detainees are held in detention centers. When space in federal detention centers is not available, persons accused of federal crimes or awaiting sentencing are detained in state or local jails. In fact, about two thirds of federal detainees are held in these state or local facilities (Clear & Cole, 2000). Federal detention centers have been heavily publicized since September 11, 2001, because the government has held an as-yet-undetermined number of individuals for questioning about possible terrorist involvement. “ Makeshift” detention centers were opened, and numerous individuals were turned over to Immigration and Naturalization Services (INS) and deported after secret deportation proceedings before immigration judges. In addition, numerous persons identified by the government as terror suspects were being held at Camp Delta, the detention compound at Guantanamo Bay in Cuba. Civil libertarians have been highly critical of the detentions and deportations, primarily because they occurred in closed proceedings and with minimum due process protections. Moreover, in light of rises in suicide attempts at Guantanamo, human rights organizations have expressed concerns about both conditions of confinement and methods of interrogation. In November 2003, the U.S. Supreme Court announced that it would hear an appeal on behalf of these detainees.

Prisons, operated by states or by the federal government, hold only persons convicted of felonies. They are classified by the level of security maintained over the inmates: maximum, medium, and minimum, with sometimes gradients in between these three main alternatives. Different custody levels are also found within as well as among prisons. Thus, an inmate may be kept in close custody in a medium-security prison for disciplinary reasons, and an inmate in a maximum-security prison may have attained “trustee” status, requiring minimal custody.

In the 1990s, super-max prisons were introduced in the federal government and approximately 41 states. These are extremely high-security facilities (or units within a maximum-security prison) supposedly intended to hold the most troublesome, violent inmates. As we will see later in the chapter, however, numerous concerns have been raised about these facilities. Prison systems also may include specialized facilities, such as work camps, classification centers, and units for inmates with mental disorders. Boot camps, prison farms, forestry centers, and ranches for young offenders who have committed primarily nonviolent crimes are other examples of specialized facilities.

In six states—Alaska, Connecticut, Delaware, Hawaii, Rhode Island, and Vermont—jails are under the control of the state rather than local government, and jail/prison functions are combined. Thus, detainees and sentenced offenders—both misdemeanants and felons—may be kept within the same facility, though they may be placed in separate housing units. A typical approach in these “mixed systems” is to have one or two facilities designated as maximum security, whereas the balance are medium- or minimum-security facilities capable of housing persons accused of crime as well as those who have been convicted and sentenced.

The federal prison system is highly organized and centralized under the Federal Bureau of Prisons (BOP). It consists of a network of facilities that are called penitentiaries, correctional institutions, prison camps, and halfway houses, as well as the detention centers referred to above. They are located on a continuum of five security levels: minimum, low, medium, high, and administrative. The nation’s one federal supermax facility, located in Colorado, is classified at the administrative level. (See Box 12.2 on career opportunities for psychologists in the BOP.)

In addition to the features summarized above, jails and prisons can be contrasted on an important point that affects the work of psychologists. Prisons are far more likely than jails to offer
programs, including recreation, work programs, substance abuse treatment, and a variety of rehabilitative programs. This can be attributed to several factors. First, because a jail stay is relatively short, inmates are less likely to benefit from meaningful programming. Second, most jails are operated by local governments and do not have funds available for much beyond their custodial function. Third, most jails are operated by law enforcement professionals, such as county sheriffs, rather than corrections professionals. The law enforcement community is not trained to provide services to offenders or alleged offenders; it is trained to enforce the law, protect the public, and provide service to the community. Programming for detainees and inmates is not considered a priority. Nevertheless, there are exceptions, and programming can be found in many jails nationwide. Short-term programs, such as those aimed at substance abuse, domestic violence, and prevention of disease, are examples. Furthermore, a professional organization—the American Jail Association—publishes standards for operating jails that include training staff and offering a variety of services to detainees and inmates.

### BOX 12.2 Career Opportunities in the Federal Bureau of Prisons

Employment opportunities in the Federal Bureau of Prisons (BOP) are expected to increase in light of projected increases in the number of inmates. Psychologists in this setting have doctorate degrees, with about 60% of those employed having completed internships in federal prisons. Psychologists in the BOP are autonomous. They are the main providers of mental health services and—in contrast to psychologists in some state prisons systems and mental hospitals—are not under the supervision of psychiatrists. Staff psychologists have the opportunity to be involved in the following:

- Forensic evaluations for the federal courts
- Psychological evaluations of candidates for the witness protection program
- Hostage negotiation training
- Drug abuse treatment programs
- Suicide prevention program
- Crisis intervention response team for trauma victims
- Predoctoral internship training program
- Employee assistant program
- Inpatient mental health program
- Staff training
- Research

Entry-level positions, for those who have just completed their doctorates, are at the GS-11 salary level but are automatically upgraded after successful completion of the first year. An annual continuing education stipend—currently $10,000—is guaranteed. Other benefits include the Federal Employee Retirement System, which, among other things, provides an attractive pension plan and allows retirement after 20 years provided an individual has reached age 50.

Although psychologists are less likely to be involved in treatment programs in jails than in prisons, their assessment and crisis intervention services are often more in demand in these short-term settings. Some pretrial detainees, for example, need to be assessed for their competency to stand trial and the variety of other competencies that were discussed in Chapter 10. Whether or not competencies are in question, pretrial detainees are often confused, frightened, and worried about their social, legal, and financial status. In a confusing, noisy, often crowded environment, detainees may experience “entry shock” (Gibbs, 1992). This is particularly—but not exclusively—a problem for persons being held in jail for the first time. Suicide is the leading cause of death in jails (Clear & Cole, 2000). Research also documents that suicide rates are higher in jail than in prison; some estimates are at least five times higher (Cohen, 1998; Steadman, McCarty, & Morrissey, 1989). Although screening for suicide risk is typically done by nonpsychological staff upon a detainee’s or inmate’s entry into the facility, mental health professionals are needed to do a more comprehensive assessment and to offer treatment to individuals who are at risk of taking their own lives. Ironically, however, jails are much less likely than prisons to have well-developed mental health services available to inmates (Steadman & Veysey, 1997). It is for this reason that many communities have now begun to experiment with the mental health courts that were highlighted in Box 9.1 in Chapter 9.

Correctional facilities—both jails and prisons—can be violent, noisy, disorganized, demeaning places that promote isolation, helplessness, and subservience through the use of overwhelming power, often through fear. Although this is particularly true of large, urban jails and maximum-security prisons, there are clearly exceptions. Furthermore, correctional professionals maintain that both jails and prisons also can be operated in a humane fashion and can achieve society’s dual hope of protecting the public from crime and rehabilitating offenders.

**Legal Rights of Inmates**

It is a well-established principle in law that inmates do not lose their constitutional rights at the prison gate. In a great number of U.S. Supreme Court decisions, especially during the 1960s and 1970s, the Court specified minimum rights that were guaranteed to inmates under the Constitution. The cases decided by the Court involved procedures, practices, and conditions of confinement in jails and prisons. In addition to federal constitutional protections, inmates also may have rights that are guaranteed under their state constitutions or under both federal and state statutes. In this section, we will summarize the key doctrines that are most relevant to psychologists consulting with correctional systems or offering direct services to inmates. This will, of necessity, omit legal protections that are important to inmates but are at most peripheral to the professional concerns of psychologists. For example, inmates have a constitutional right to receive mail (although it may be censored) and a constitutional right to observe religious practices (including dietary practices) unless those interfere with institutional security or create excessive economic burdens. Readers are referred to the excellent treatises of Cohen (1998, 2000, 2003) and Palmer and Palmer (1999) for comprehensive coverage of correctional law that encompasses many areas not to be discussed here.

The principles to be discussed below have been announced in cases involving prisoners, but they also apply to those serving jail sentences. For this reason, we are using the term inmate throughout this chapter as a more generic term to cover both groups. The rights of pretrial detainees, however, are somewhat different because they have not been convicted of crime. Nevertheless, in the name of institutional security, detainees can be subjected to many of the
same conditions as sentenced misdemeanants, as will be noted shortly.

**Right to Treatment**

A right closely aligned with the interests of psychologists is the constitutional right of the inmate to receive adequate medical treatment. Although the leading case on this matter (*Estelle v. Gamble*, 1976) involved treatment for a variety of physical ailments, it has widely been interpreted to include psychological or psychiatric assistance for serious mental disorders. To deprive the inmate of needed medical care violates the Eighth Amendment ban on cruel and unusual punishment. The question naturally arises, “What is ‘adequate’ medical treatment?” Inmates clearly do not have a right to “state-of-the art” treatment or therapy. In fact, in the *Gamble* case, even failure to obtain an X-ray of an inmate’s lower back was not considered inadequate treatment. Although the Supreme Court in that case made it clear that inmates had a right to treatment, it did not second-guess the judgment of medical professionals who did not order the X-ray.

Gamble, a Texas inmate, was on a prison work assignment when a bale of cotton that he was loading on a truck fell on him. There followed 3 months of repetitive visits to prison medical staff, during which he was provided with muscle relaxants and other medications. By the end of this time period, he had received numerous different medications, blood tests, and blood pressure measurements, along with cell passes permitting him to stay in his cell. At one point, a prescription was not filled for 4 days because the staff had lost it. Eventually, he refused to work, saying that his pain was not dissipating, and he was brought before a prison disciplinary committee and then placed in solitary confinement as punishment. While in solitary, he asked to see a doctor for chest pains; a medical assistant saw him 12 hours later and hospitalized him.

*Estelle v. Gamble* (1976) is an important case because it not only clearly stated that inmates had a constitutional right to medical treatment but also set the standard for deciding whether the Constitution had been violated. Inmates alleging such a violation would have to prove that prison officials were “deliberately indifferent” to their serious medical needs. Simple “negligence” would not be enough to amount to a constitutional violation (although negligence would be sufficient under some state laws). In a later case, *Farmer v. Brennan* (1994), the Court said that a prison official would not be liable unless that official both knew of and disregarded an excessive risk to an inmate’s health and safety. The Court added that if an official should have known of a substantial risk but did not, the official’s failure to alleviate the risk did not constitute cruel and unusual punishment.

Applied in the context of psychological treatment, it is clear that inmates should be offered treatment at least for their serious mental disorders, including psychoses, clinical depression, and schizophrenia. The AACP (2000) standards do not distinguish between serious and milder disorders, suggesting that mental health treatment should be available for all mental disturbances. Moreover, the standards indicate that it is generally inappropriate for inmates needing acute, chronic, or convalescent mental health care to be treated in jails and prisons. Rather, they should be transferred to facilities specifically for these purposes.

In reality, both jails and prisons hold substantial numbers of individuals with severe disorders. The lack of adequate mental health care in jails and prisons across the United States is widely acknowledged by commentators and courts alike (Cohen, 2000; Heilbrun & Griffin, 1999; Morris, Stedman, & Veysey, 1997). Although specialized treatment exists for forensic populations, a great number of individuals with mental disorders continue to languish in jails and prisons without adequate psychological intervention. It has been estimated that 16% of all prison inmates and 10% of jail detainees and inmates are in need of treatment for mental disorder (Ditton, 1999). In some jurisdictions, services are provided to fewer than
25% of the inmates requiring them (Feliciano v. Gonzales, 1998). Studies also indicate that the need among female inmates is even greater than among males (Clear & Cole, 2000). This estimate is somewhat confounded by the fact that women, compared with men, may be more likely to self-disclose their need for mental health services. The adequacy of medical services, including both physical and mental health, is a frequent point of litigation in class action suits brought by incarcerated individuals. (A class action suit is one brought on behalf of a group of people who have all allegedly been harmed by the actions of a defendant.) Interestingly, although there is a right to treatment for physical and mental disorders, there is no right to treatment for alcoholism or other substance abuse, as we will discuss shortly. These programs fall under the rubric of rehabilitation rather than medical treatment.

**Right to Refuse Treatment**

Although inmates have a right to treatment, they cannot be forced to participate in treatment programs. This applies to both physical and psychological treatment. However, if the state has a very strong interest in seeing the inmate’s behavior changed, some leeway exists. In a recent Supreme Court case, McKune v. Lile (2002), the Court allowed prison officials to effectively punish an inmate for refusing to participate in a program, even though the state argued—and the Court agreed—that it was not acting punitively. Lile was a convicted rapist within 2 years of completing his sentence and being released. The state had a strong interest in enrolling him in a sex offender treatment program that required him to disclose his history of offending, but it did not guarantee that the information would be privileged. Lile—apparently concerned that disclosing information could lead to future prosecution for crimes he had not previously been accused of—refused to participate. Prison officials told him that his refusal could lead to him being transferred to a more dangerous prison. In addition, they threatened to curtail a number of privileges, including canteen access and certain work activities. Lile then argued that he was essentially being forced to incriminate himself. In a close decision, a majority of five Justices did not agree. Thus, although inmates still may not be forced to participate in a treatment program, they can be persuaded to do so with threatened loss of privileges, provided that the state’s interest in rehabilitation is high, as it was in this case.

In a similar fashion, inmates have a right to refuse medication, but this right can be overridden. Obviously, inmates cannot refuse treatment for a communicable disease, such as tuberculosis, that poses a risk to the prison population. Perhaps less obviously, the preservation of life may be given more weight than the inmate’s own wishes. In a 1995 case, for example, an inmate with diabetes was forced to submit to monitoring of his blood sugar and to take insulin or other medications if ordered to by physicians (North Dakota ex rel. Schuetzle v. Vogel, 1995). On the other hand, a quadriplegic inmate who wished to die a dignified death was allowed by courts in California to reject force-feeding and other painful medical intervention (Thor v. Superior Court, 1993). One could argue that, had the diabetic inmate been allowed to have his way, the prison system would have been faced with significant medical costs resulting from complications associated with his disease. The quadriplegic inmate presented no such economic threats. The cases were not decided on the economic issue, however, but rather on the right of competent individuals to self-determination of their medical needs balanced against the state’s interest in preserving life.

The U.S. Supreme Court has issued one decision on the right of inmates to refuse treatment in the form of psychoactive drugs (Washington v. Harper, 1990). In Washington state, felons with severe mental disorders were housed in a special unit within the prison system. Antipsychotic drugs were frequently used to control disruptive behavior. If an inmate refused to be treated with these medications, he was allowed to challenge the treatment in an administrative hearing before
a three-person panel comprising a psychologist, a psychiatrist, and a member of the prison administration. Harper and other inmates wanted judicial review, before an independent court, rather than administrative review. They also wished to be afforded a right to counsel, rather than the lay adviser allowed in the administrative hearing. The Supreme Court, in a 6–3 ruling, however, found no fault with the procedure in use. Essentially, prison officials can give an inmate psychoactive drugs against his or her will, but it must be determined in an administrative hearing that such medication is necessary to control the inmate’s disruptive behavior. It is important to note, though, that state statutes may be even more restrictive than this, prohibiting medication that might be more for the convenience of the staff than truly medically necessary.

Courts have also begun to address the issue of forcing an inmate to take medication to render him or her competent to be executed. In 1986, in Ford v. Wainwright, the U.S. Supreme Court ruled that executing a death row inmate who was “insane”—or too mentally disordered to appreciate what was happening to him—violated the Constitution. Since that ruling, many forensic psychologists and forensic psychiatrists have been troubled. Some psychologists resist participating in evaluations of an inmate’s competency to be executed, knowing that their recommendation could facilitate the inmate’s death. Some psychiatrists—who have the authority to prescribe medication—have not wanted to prescribe psychoactive medication that would stabilize the inmate enough to allow him or her to be put to death. Furthermore, lawyers representing these death row inmates argued that they should have a right to refuse the medication. In February 2003, a federal appeals court became the first federal court to rule that death row inmates do not have such a right.

Right to Rehabilitation

People are often surprised to learn that, although there is a right to treatment for physical and mental disorders, an inmate has no constitutional right to rehabilitation in correctional settings. In this context, rehabilitation refers to a variety of programs that presumably should increase the likelihood that the inmate will not reoffend upon release from prison. In a wide range of cases, inmates have asked the courts to grant them constitutional rights to participate in substance abuse programs, job training programs, educational programs, and programs for violent offenders, among many others. They have consistently been rejected. This is not to say that such programs should not exist. In fact, “It is clear . . . that a penal system cannot be operated in such a manner that it impedes the ability of inmates to attempt their own rehabilitation, or simply to avoid physical, mental, or social deterioration” (Palmer & Palmer, 1999, p. 221). Thus, lack of any meaningful rehabilitative opportunities, particularly within a prison system, would be regarded with suspicion by the courts. The key principle is that individual prisoners do not have a constitutional right to participate in any particular program. Corrections officials are given the discretion to decide who will be assigned to these programs.

Prison Transfers

Inmates have no constitutional right to be held in a specific facility, including one in their home state or close to their family. In many prison systems, it is not unusual for prisoners to be moved from one facility to another, often with little or no notice. During the 1990s, some states experiencing prison overcrowding sent inmates to out-of-state facilities, both public and private, and courts generally upheld the policies. Transfers are typically made not only to manage space but also to break up gangs or to send a prisoner to a more or less restrictive setting. Likewise, corrections officials have broad leeway to assign inmates to various security levels within a facility or to assign them to special treatment programs. Generally, courts have upheld these
classification decisions of prison officials unless they are demonstrated to be arbitrary, abusive, capricious, or discriminatory on racial or religious grounds. In addition, if inmates are assigned a special status that would limit substantially their eligibility for parole, work release, or furlough programs, some due process protections are afforded them under many state laws. For example, they may have a right to appear before a neutral decision maker (Palmer & Palmer, 1999). Neutral decision makers, though, are almost invariably within the institution, rather than outside judicial or administrative forums.

The one type of prison transfer that has constitutional implications is the transfer to a civil mental institution. Inmates with mental disorders who are facing a transfer to a mental health facility outside of the prison system are entitled to a hearing before this occurs (Vitek v. Jones, 1980). Such a transfer, according to the Supreme Court, represents a significant deprivation of liberty, specifically because of the stigma of being in a mental institution and the lack of opportunity to earn good time credits while institutionalized. Therefore, the Court required a variety of due process protections. They include (a) a written notice to the inmate, (b) a hearing at which clear and convincing evidence of the inmate’s mental disorder and dangerousness is provided, (c) an independent decision maker, (d) testimony of witnesses on both sides, and (e) qualified assistance for the inmate (though not necessarily a lawyer). In reality, transfers to mental institutions are rarely challenged (Cohen, 2000). Furthermore, inmates with mental disorders, when transferred, are usually sent to a mental health unit or facility within the prison system. Because it is not clear whether such transfers require hearings such as those outlined in the Vitek case, prison systems sometimes provide them as a matter of policy if the inmate protests the transfer. In addition, the AACP (2000) standards assume that hearings are required: “This requirement is not obviated by the receiving institution being in the same jurisdiction or the special management unit being within the same correctional facility” (Standard 42, Discussion).

Inmates With Mental Disorders

A number of court cases, including U.S. Supreme Court cases, have addressed special situations encountered by mentally disordered inmates in the nation’s prisons. As noted above, inmates with serious mental disorders have a right to treatment under the disease model recognized in Estelle v. Gamble (1976). Although they may be able to refuse treatment, this refusal can be overridden if it shown that the inmate is disordered and dangerous to self or others (Washington v. Harper, 1990). In addition, as we saw above, courts are beginning to allow the forced medication of prisoners who, without the medication, would be incompetent to be executed. We will discuss the assessment of competency to be executed again later in the chapter.

The segregation of inmates with mental disorders raises many legal questions. Courts have allowed severely disturbed inmates to be placed in stripped-down observation cells—sometimes referred to as “safe cells”—for their own protection. They may be kept under extremely stark conditions while awaiting transfer to a treatment facility or until they can be stabilized with appropriate medication, but there are limitations on this type of confinement. A suit against the New York Department of Corrections (Perri v. Coughlin, 1999) is illustrative. Perri was an extremely disruptive, severely disordered inmate in the New York state prison system. He was held in an observational cell on three separate occasions, for a total of 108 days. The cell contained only a sink and toilet, and a brightly glaring light was on 24 hours a day. He had no clothes or blankets and had to sleep naked on the floor. The observational unit provided no opportunity for exercise, recreation, or group therapy. The lengthy confinement, coupled with failure to provide treatment, led to the court’s decision to
hold the New State Department of Corrections liable for damages (Cohen, 2000).

**Privacy and Confidentiality**

Inmates have very little right to privacy in prison or jail settings. Despite the fact that inmates often call their cells their “houses” or “homes,” the law does not treat them this way. In the leading case on this issue, *Hudson v. Palmer* (1984), the Court gave corrections officials wide leeway in conducting unannounced cell searches out of the presence of inmates. Prisoners had asked to be allowed to be present when the cell searches were conducted, arguing that their property—including objects having sentimental value—was sometimes destroyed or was missing after these searches. Although not condoning malicious destruction of property, the Court majority nevertheless left these searches to the discretion of prison officials, in the name of maintaining institutional security.

Some state and lower federal courts have given inmates a right to privacy with respect to supervision by correctional officers of the opposite sex. Female inmates have a right not to be observed by male correctional officers while showering or toileting and vice versa. Body cavity searches by opposite-sex correctional officers also have been prohibited. These searches, generally visual in nature, may be conducted after contact visits with someone from the outside. They also may be conducted during routine searches for contraband.

Confidentiality of psychological records is a topic of more direct concern to the forensic psychologist. Psychologists have an ethical obligation to preserve inmate confidentiality to the maximum extent possible. The AACP (2000) standards indicate that nonpsychological staff should have access to confidential information only on a “need to know” basis and that psychological staff should supervise such releases and interpret information. Standard 28 specifies clearly that inmate workers should never have the responsibility for test administration, scoring, or the filing of psychological data. Interestingly, courts have not provided inmates with a constitutional right to privacy in their records, though corrections officials can be held liable for disseminating information about an inmate that results in his or her being a target of violence by other inmates (Palmer & Palmer, 1999). Courts also have not considered it a constitutional violation when inmate clerks are involved in the filing of medical records. In fact, in some facilities, the “records room” is considered a choice work assignment by inmates because it provides access to information, “one of the most sought-after commodities in prison” (Clear & Cole, 2000, p. 338). “The contents of inmates’ files are confidential, but it is hard to prevent the records room clerk from sneaking a look—or from trading the information for goods or favors” (Clear & Cole, 2000, pp. 338–339). Although psychological and other medical records should be kept separate from the inmate’s history, parole dates, work assignments, and other information, there is no guarantee that some aspect of these psychological and medical records will not make it into the inmate’s general file.

In the event that third parties within or outside the facility are provided with psychological information, release of confidential information forms should be completed by inmates and kept in the files. The standards also make it clear that inmates should be informed verbally and in writing of limits of confidentiality. For example, if a psychologist is made aware of an escape plan or of a plan to harm another inmate, she or he is obliged to notify prison officials. In addition, psychologists should obtain informed consent forms from inmates before conducting an assessment or initiating treatment.

Interestingly, even more basic than confidentiality is the actual adequacy of the records. Despite the fact that lower courts have made it clear that adequate records are prerequisite to continuity of care (Cohen, 1998), there is widespread concern about poor record keeping in many correctional facilities. According to Cohen
(1998), a lawyer and a scholar of correctional law,

In my own work encompassing a large number of prisons, I would say that broadly deficient mental health records is the most consistently encountered problem I uncover. . . . What may be surprising is that even in relatively sophisticated systems, the mental health records are sometimes so deficient that there often is no treatment plan or only an old one that has not been changed or updated; what is there is illegible; there is no medical history or a clinically inadequate one; treatment recommendations are sparse or nonexistent; and there are no follow-up or progress notes. (pp. 10–12)

He adds that “decent treatment” may in fact be occurring in some cases, but this would not be evident from the files.

The limits on confidentiality and requirements for informed consent are problematic to many psychologists who are considering work in correctional settings. According to the AACP (2000), “The correctional psychologist works with the offender, but for the department, facility, or agency, and must be able to differentiate and balance the ethical/legal obligations owed to the correctional organization or agency and the community and the offender client” (Standard 20, Discussion). This can be difficult for the psychologist who is accustomed to working both for and with the same client. Furthermore, some psychologists are concerned that some inmates who “consent” to assessment and treatment do so because they believe they have no choice.

**Solitary Confinement**

Inmates may be isolated from the general jail or prison population for a variety of reasons. We referred above to the isolation of those with mental disorders in observation cells. In addition, inmates may be placed in **disciplinary segregation**, as punishment for violation of rules, or in **protective custody**, to keep them away from other inmates who may prey on them. Super-max or ultra-max facilities hold large numbers of allegedly violent and recalcitrant inmates in **administrative segregation** for years at a time. Courts have allowed corrections officials to segregate inmates but have placed some restrictions on the duration and the conditions of the confinement, particularly in the case of disciplinary segregation.

*Conditions* of segregation have been monitored more carefully than duration by the courts, though they are often considered in relation to the duration. Thus, placement in a stark cell with no opportunity to shower for 48 hours is not legally problematic; placement in the same cell and under the same conditions for 2 weeks would be. Hygiene, nutrition, the physical condition of the cell, and the physical condition of the inmate are all taken into consideration. “It is clear that there is not yet a minimum standard set on the number of days or other conditions that will constitute cruel and unusual punishment in punitive isolation in every situation” (Palmer & Palmer, 1999, p. 80). Thus, although psychologists may be concerned about the effects of isolation on the mental state of the inmate, and although inmates have argued unsuccessfully that isolation is per se cruel and unusual, the courts have placed limits on only the most egregious of situations.

Few limitations have been placed on the duration of protective custody or administration segregation, but again conditions may be scrutinized. The Supreme Court has yet to hear a case involving conditions of confinement in “super-max” facilities, but lower courts have weighed in on this issue. In super-max facilities, inmates are held in cells for 24 hours a day, with the exception of a brief (up to 1 hour) exercise period, usually in a secluded space. They have no contact with other inmates. Food is brought to their cells by guards.

A lower federal court (*Madrid v. Gomez*, 1995) has made it clear that the above conditions
are particularly harmful to inmates who are at psychological risk or are presently mentally disordered. Reviewing conditions in the secure housing unit (SHU) at Pelican Bay State Prison in California, the court found that the following violated the Constitution’s prohibition against cruel and unusual punishment: a pattern of excessive force by correctional officers within the facility, the lack of adequate provision of medical and mental health care, and the holding of inmates with mental illness in the SHU.

Nevertheless, the court did not find a constitutional violation in the SHU for stable inmates:

Conditions in the SHU may well hover on the edge of what is humanly tolerable for those with normal resilience, particularly when endured for extended periods of time. They do not, however, violate exacting Eighth Amendment standards, except for the specific population subgroups [the mentally ill] identified in this opinion.

Pretrial Detainees

Under the law, persons accused of crime and held in jails or detention centers may not be punished. They are considered to be innocent unless and until they are proven guilty. Thus, a detainee cannot be placed in disciplinary segregation and lose good time credits because he or she is not serving time. However, courts allow detainees to be placed in highly restrictive conditions and to suffer significant invasions of privacy in the name of institutional security. In addition, a detainee can be placed in isolation for violating the rules of the facility. In the landmark U.S. Supreme Court case on this issue, Bell v. Wolfish (1979), detainees in a federal facility challenged a number of actions taken by administrators in the name of institutional security. For example, they were placed in two-person rooms and sometimes in makeshift accommodations due to overcrowding. They were not allowed to stand and watch if their rooms were searched. They were not allowed to receive packages containing food items or personal items from outside the institution. The facility had a “publishers only” rule, whereby books and magazines had to come directly from the publisher. Finally, they were submitted to visual body cavity searches after contact visits. In a 6–3 decision, the U.S. Supreme Court ruled that these were not punitive conditions and were justified in the name of institutional security.

In addition to the constitutional protections discussed above, inmates may have certain rights under their state constitutions or laws passed by state legislatures. In some states, for example, inmates have a right to vote in national elections; there is no such constitutional right. Confidentiality of records, rights to participate in rehabilitation programs, and visitation rights are all areas that vary widely from state to state. The psychologist working in a correctional setting, then, must be aware not only of the constitutional principles but also of the law specific to his or her own state.

Correctional Psychologists

Correctional psychologists are sometimes distinguished from psychologists working in correctional facilities. The correctional psychologist typically has “specific academic and/or program training in correctional philosophy, systems, offender management, forensic report writing, treatment aimed at reducing recidivism, and outcome research” (Althouse, 2000, p. 436). Many—if not most—psychologists working in corrections do not have this specific background. Furthermore, not all psychologists hold doctorates, whether PhDs or PsyDs. Although it is estimated that more than 90% of psychologists working in the Federal Bureau of Prisons hold doctorates, it appears that those working in state prisons and local jails are more likely than not to hold master’s degrees or certificates of advanced study. Nevertheless, psychologists at all levels clearly offer valuable services to corrections. For our purposes, therefore, we use the terms correctional psychologist and psychologist working in corrections interchangeably. This is
consistent with the AACP (2000) standards, which note that the same level of professional practice is needed irrespective of the training level or educational background of the service provider.

Estimates of the number of psychologists working in correctional settings vary widely, partly because available surveys do not always include the many settings in which they can be found. According to Boothby and Clements (2000), more recent estimates indicate that more than 2,000 psychologists are now employed. In addition, some surveys count only those psychologists who work full-time within correctional systems. Other surveys maintain the distinction between correctional psychologist and psychologist working in corrections and count only the former. Memberships in professional organizations do not provide definitive answers because many psychologists who would be eligible for membership do not join these organizations.

Boothby and Clements (2000) conducted an extensive survey of 830 psychologists working in state and federal prisons across the United States. The great majority—88%—worked in the prisons full-time, whereas 12% provided services on a contractual basis. The survey did not include those working in jails or in juvenile facilities. Of their sample, 59% held doctorates and 37% were master’s-level graduates. All psychologists working in federal prisons had doctorates, whereas state prisons employed master’s- and doctoral-level psychologists about equally. An overwhelming majority of the psychologists (92%) identified themselves as Caucasian, and 62% were male and 38% female. The psychologists tended to work exclusively with one or the other gender. Thus, 82% worked only with male offenders, 8% only with female offenders, and 10% with both. The prison population itself comprises approximately 93% males and 7% females.

For some psychologists, a limitation of working in correctional settings is the amount of time they are able to allocate for research. Psychologists in the Boothby and Clements (2000) study reported that research endeavors occupied approximately 2% of their time. The AACP (2000) standards recognize the difficulty of setting aside time for research due to the increasing demand for psychological services. Nevertheless, Standard 64 encourages applied and/or basic research, and its discussion section recommends that full-time psychologists be engaged in “at least one evaluation project having practical relevance for correctional psychology” (Standard 64, Discussion).

In a follow-up study, Boothby and Clements (2002) reported on the job satisfaction of the psychologists in their survey. Satisfaction was measured on 18 job dimensions, including such items as opportunity for advancement, job security, salary, clear definition of roles, access to and influence on decision making, and safety. Overall, the psychologists were “moderately satisfied.” They were most satisfied with safety, job security, and relationships with clients, and they were least satisfied with opportunities for advancement and professional atmosphere. The respondents were also asked to rate the importance of these 18 dimensions. All dimensions but one (job status or prestige) received average ratings of 3 or above on a 5-point scale, indicating that all of the 18 dimensions were important. However, the most important were autonomy, personally meaningful work, and achievement (although recognition of such achievement was not that important). Not surprisingly, salaries and the number of inmates in a facility were also correlated with job satisfaction, with high salaries and crowded conditions having opposite effects. Demographic variables such as age and gender were unrelated to job satisfaction. Correctional psychologists working in federal prisons were significantly more satisfied than those working in state systems on 8 of the 18 dimensions. These were opportunity for advancement, appropriate level of responsibility, job security, salary, achievement or success in job, status/prestige of job, professional atmosphere, and safety. Boothby and Clements concluded their report with a discussion of the implications for recruiting and retaining psychologists for work in correctional settings. (See Box 12.3 for examples of job ads for correctional psychologists.)
We now turn our attention to the main tasks performed by correctional psychologists. For purposes of organization, these will be divided into two distinct but interrelated topic areas, assessment and treatment.

**Psychological Assessment in Corrections**

Psychological assessment refers to all of the techniques used to measure and evaluate an individual’s past, present, or future psychological status. Assessment usually includes but is not limited to the use of psychological tests or measuring devices. The last two decades of the 20th century saw a large increase in the number of commercially available measures and tests specifically intended for use in forensic settings. This includes a variety of tests that are presently in use in prisons and jails across the United States. In addition to tests and other measurement instruments, assessment involves interviews with the individuals being assessed, interviews with others, direct observations, and reviews of case records.

In corrections, assessment is warranted at a minimum at several points in an inmate’s career: (1) at the entry level, when he or she enters the correctional system; (2) when decisions are to be made concerning the offender’s exit into the community; and (3) at times of psychological crisis. A more specialized type of assessment is also performed in death penalty cases, when

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**BOX 12.3  Help Wanted: Correctional Psychologist**

The following are employment ads representative of attempts to recruit psychologists for state prison systems or other divisions of correctional services:

Prison Health Services has an exciting full-time career opportunity for a PhD-level psychologist. Responsibilities will include overseeing the care of acute and chronic mental health patients in a 60-bed mental health unit with an adult male population. Corrections experience is preferred. We offer excellent compensation, a complete benefits package, and flexible scheduling.

National behavioral health care agency seeks well-rounded professionals to join our mental health staff in an urban detention facility. Opportunities to be involved in creative program development and provide assessment, treatment, and a variety of forensic mental health evaluations to a diverse population. Candidates should have a background in testing, skills in rapid assessment and crisis intervention, experience in forensic mental health, and knowledge of brief therapy. Positions available at several levels (e.g., MSW, LCSW, doctorate in psychology). Specialized forensic supervision available, competitive salary and benefits.

The Department of Corrections is seeking to fill two positions to provide direct treatment services to female inmates in a medium-security facility where rehabilitation is emphasized. Both crisis intervention and short- and long-term treatment skills are required. Experience working with women offenders and experience in substance abuse treatment preferred. The ideal candidate will hold a PhD/PsyD in psychology, but other degrees combined with relevant experience will be considered.

We now turn our attention to the main tasks performed by correctional psychologists. For purposes of organization, these will be divided into two distinct but interrelated topic areas, assessment and treatment.
questions are raised about an offender’s competency to be executed. Beyond these very minimal requirements, however, reassessments should be done on an ongoing basis. “Behavioral changes in inmates, which occur as time is served, demand constant reassessment and reassignment” (Palmer & Palmer, 1999, p. 307).

For the correctional system intent on pursuing both security needs and rehabilitative goals, assessment also is a key component to providing treatment. James Bonta (1996) has identified three generations of assessment for the purpose of offering treatment. During the first generation, assessment was performed chiefly by individual clinicians who relied on their own professional experience and judgment. In the second generation, standardized assessment instruments were adopted, although these included primarily static risk factors (such as prior record or number of violent incidents within a facility) focused primarily on making decisions about an offender’s custody level. The third and present generation of assessment includes both risk and needs factors. Thus, a standardized risk/needs assessment instrument takes into consideration both prior violent incidents (a risk factor) and an offender’s attitude toward authority (a needs factor). We will discuss risk/needs assessments in more detail shortly.

**Initial Inmate Screening and Classification**

As a matter of institutional or systemwide policy, correctional facilities require entry-level assessments so that inmates can be “psychologically processed” and assigned to a particular facility or unit. Ideally, no individual should be placed in the general correctional population without having been screened for evidence of problem behaviors or mental states. Thus, screening should be done as soon as possible after entry into the facility.

In jails, especially for pretrial detainees, this screening process may be very cursory. It will focus on whether the inmate is a suicide risk, indications of substance abuse, history of hospitalizations and medications, and indicators of violence. Because few facilities have psychological staff available round the clock, initial screening may be done by corrections staff, such as caseworkers or corrections officers. The AACP (2000) standards condone this practice as long as these individuals have been trained by psychological staff and this staff reviews all written reports. If there is evidence of mental disorder, suicide ideation, or depression or anxiety greater than would be normally expected, the individual should be referred for a more extensive evaluation. It appears that initial psychiatric evaluations are available to inmates in virtually all jails (Steadman et al., 1989).

In prisons, screening and classification becomes more complex. In many states, an offender is first sent to a classification or reception center, which may or may not be within the facility to which the offender is eventually sent. States with large prison systems (e.g., Texas, New York, California, and Florida) have centralized processing centers. The new prisoner may spend several days or even many weeks in this assessment center, separated from those already in the system, until assigned to an institution based on security needs as well as to specific programs. The classification committee may recommend, for example, that a prisoner be assigned to an aggression management program or an educational program to improve his reading level. The committee might recommend that another prisoner be offered substance abuse treatment and that contacts with her children be facilitated.

The reception unit in many prisons includes psychologists, psychiatrists, social workers, or other professionals who administer tests, interview the offender, review records, and offer programming and treatment recommendations. The AACP (2000) standards recommend that all newly committed prison inmates be given a brief, routine psychological evaluation within 1 month of admission to the facility. Included in this evaluation should be behavioral observations, record
reviews, group testing to screen for emotional and intellectual abnormalities, and a written report of initial findings (Standard 30). If the results of this brief screening indicate the need for further assessment, a comprehensive psychological evaluation should be completed within 14 days. The more detailed evaluation would include record reviews, contacting prior psychotherapists or family physicians, and an extensive diagnostic interview. Although recognizing that such an approach may well tax the staff and resources of a correctional facility, the standard indicates that this is crucial if psychologists are to conform with ethical and practice standards associated with their profession.

Needs Assessment

In corrections, it is important to assess both needs and risks, particularly if a treatment regimen is to follow. Andrews and Bonta (1994) have identified two main categories of needs: criminogenic and noncriminogenic. Criminogenic needs are dynamic factors (Gendreau, Cullen, & Bonta, 1994), subject to change. An offender’s attitude toward employment or her or his degree of alcohol use is an example. “The importance of criminogenic needs is that they serve as treatment goals: when programs successfully diminish these needs we can reasonably expect reduction in recidivism” (Gendreau et al., 1994, p. 75). Noncriminogenic needs are those that may be subject to change but have been found to have little influence on an offender’s criminal behavior. Psychological states such as depression, anxiety, or low self-esteem are examples. Although these states may lead to adjustment problems for the individual, they are not strongly correlated with criminal behavior in the great majority of offenders.

One of the foremost risk/needs scales available in corrections is the Level of Service Inventory—Revised (LSI-R) (Andrews & Bonta, 1995), which is widely used in Canadian correctional facilities and is slowly being introduced in American corrections. Surveys suggest that psychologists in the United States seem less inclined to use actuarial instruments (Boothby & Clements, 2000; Gallagher, Somwaru, & Ben-Porath, 1999). Nonetheless, there is indication that instruments with good predictive ability will increasingly be sought, particularly as courts demand more scientific accountability (Otto & Heilbrun, 2002). The LSI-R, an instrument that has garnered considerable research (e.g., Gendreau, Little, & Goggin, 1996; Simourd & Malcolm, 1998), samples 10 different domains relevant to criminal conduct, including personality characteristics, procriminal attitudes, family/marital history, and substance abuse.

Unfortunately, too many correctional systems use the classification process primarily for management purposes. Classification for custody, rather than classification for treatment, becomes the dominant goal. Therefore, estimates of dangerousness and potential escape risks become very important. Furthermore, classification decisions are often based on the institution’s needs more than those of the offender. Thus, although an offender might benefit from learning computer skills, she or he might be assigned to housekeeping duties because the facility has a great need for inmates performing institutional maintenance. Psychologists involved in the classification process, then, may find it extremely frustrating when their recommendations for treatment are not followed because resources are not available.

Release Decision Making

As prison inmates approach the end of their sentence, or as they approach a parole date, the psychologist may be called on to assess the inmates’ risk of reoffending. Similar assessments also may be conducted when prison officials are considering a change in the offender’s status, such as shifting him or her from a medium- to a minimum-security level. Because this is pertinent to the classification issues discussed above, it is important to keep in mind that the various assessment instruments to be covered below may
be used for classification as well as release decision making.

Assessments for release decisions are usually prepared at the request of state parole boards (Brodsky, 1980), particularly in the case of inmates who have a history of mental disturbance or predatory behavior. The psychologist typically meets with the inmate, reviews his or her prison files, and administers psychological tests. As we have seen in previous chapters, psychology has made substantial progress in developing risk assessment instruments over the past 20 years (e.g., Monahan, Steadman, et al., 2001; Steadman et al., 1989). The Boothby and Clements (2000) survey, however, suggests that risk assessment instruments are not widely used. Nevertheless, instruments recommended for this purpose include the revised Psychopathy Checklist (PCL-R), discussed in Chapter 4, and the Violence Risk Appraisal Guide (VRAG) and the Historical/Clinical/Management Risk Scale (HCR-20), which were discussed in Chapter 10 (see Box 10.5). Also mentioned in Chapter 10 were the instruments developed specifically to assess sex offender risk, a particularly intractable problem.

Use of Risk Assessment Instruments

Despite the proliferation of risk assessment instruments, it is doubtful that they are being used extensively by many forensic psychologists working in correctional settings. In fact, risk assessments themselves may not be performed that frequently. In the Boothby and Clements (2000) study, respondents reported that their most frequent assessments were of personality characteristics (42%), followed by intellectual assessment (19%). Only 13% of their assessments were risk assessments. The few psychologists who reported conducting risk assessments typically did not specify the instruments they used; when they did, the most commonly indicated was the PCL-R. By far, the most common instrument used by the correctional psychologists in the study, though, was the Minnesota Multiphasic Personality Inventory (MMPI), which was used in a variety of contexts by 87% of the respondents. “It seems that many correctional psychologists rely on instruments such as the MMPI regardless of the referral question” (Boothby & Clements, 2000, p. 724).

Crisis Intervention

Inmates in both jails and prisons are susceptible to facing a wide variety of psychological crises that may require the assessment and treatment skills of the forensic psychologist. Psychologist Hans Toch has written extensively about the “mosaic of despair” that can overwhelm some inmates and even lead them to injure themselves or take their own lives (e.g., Toch, 1992; Toch & Adams, 2002). Crises of self-doubt, hopelessness, fear, or abandonment are not unusual in an incarcerated population. In addition, any inmate may be confronted with a situation that warrants a psychological consultation. Victimization by other inmates, news of the death of a loved one, and denial of parole are all examples of situations that can precipitate a psychological crisis in an otherwise stable inmate. When such a crisis occurs, prison officials are interested in obtaining from the psychologist both an immediate resolution of the crisis and long-range solutions that will help avoid a similar problem in the future.

In their research on psychological crises that result in self-directed violence (such as self-mutilation or suicide attempts), Toch and Adams (2002) found age, cultural, and gender differences. They state that young, White and Latino inmates are the most likely groups to face acute psychological crises. Married inmates feel more vulnerable in jail, whereas single inmates suffer more in prisons. Women are most likely to have problems with loneliness, whereas Latino inmates are distressed if they face the abandonment of relatives. They emphasize, though, that response to the jail or prison environment is very individualistic, which suggests that correctional
officials must be carefully attuned to the risks of suicide among particular inmates.

Assessment of Correctional Personnel

“For the most part, a psychologist’s role in the employment selection process is not extensive” (Correia, 2001, p. 60). Although correctional officer candidates in prisons are likely to have taken entry-level examinations at correctional academies or at on-site facilities, these exams typically attempt to measure aptitude for the work and attempt to screen out major behavioral problems. Little research is available on the extent to which psychological tests are administered prior to employment. Those prison systems that administer psychological tests have predominantly used the MMPI and a test specifically designed for correctional officer use, the Inwald Personality Inventory (IPI) (Inwald, Knatz, & Shusman, 1982). Research on both suggests that they should be used with caution, however. The MMPI is intended primarily to identify gross mental disturbances; it is not helpful in “screening in” or identifying ideal characteristics in candidates for employment. The IPI, though validated for corrections officers, was found by its author to successfully predict the retention or termination of only 73% of the candidates in the research sample (Shusman, Inwald, & Landa, 1984). In the same study, MMPI profiles were found to predict 63%. No further published research on the IPI is apparently available, though Inwald has published a later study dealing with the IPI administered to law enforcement officers (Inwald, 1992).

Psychological screening of correctional officer candidates has also been resisted by correctional officer unions and challenged in a number of court cases. Psychological screening of officers in jail settings is rare. Although professional jail organizations such as the American Jail Association (AJA) recommend the careful selection of correctional officers, candidates for these positions are typically screened primarily for prior criminal records and aptitude for the work.

The AACP (2000) standards suggest that it is desirable for psychologists to be involved in staff screening (Standard 55), but no details are offered. Staff screening, staff training, and assignment of staff to various duties are all examples of the broad services that can be offered by psychologists to improve the jail or prison environment for the incarcerated offender. For example, psychologists can make recommendations—and sometimes even select—corrections officers for participation in a treatment program for certain offenders. Boothby and Clements (2000), in their review of the tasks performed by correctional psychologists, noted that less than 10% of their time was spent at staff training. It is unclear whether screening and selection were included in this figure.

Competency to Be Executed

One very specialized area demanding the assessment skills of some correctional psychologists revolves around the death penalty. The Constitution prohibits the execution of an offender who is so mentally disordered that he or she is unaware of the punishment that is about to be imposed and why he or she has to suffer it (Ford v. Wainwright, 1986). Most recently (Atkins v. Virginia, 2002), the Court also ruled that some mentally retarded persons could not be executed. Specifically, if they had IQ scores below 70 and were unable to care for themselves independently, it would be cruel and unusual punishment to put them to death. Thus, if an offender on death row challenges the execution on the basis of his or her mental disorder or retardation, the forensic psychologist may be called in to perform an assessment of the offender’s competency for execution. Together, the two Supreme Court decisions reignited a longstanding philosophical debate on the critical role of mental health professionals with respect to offenders sentenced to die (e.g., Bonnie, 1990; Brodsky, 1980; Mossman,
1987; Radelet & Barnard, 1986). As we saw earlier in the chapter, a recent decision allowing the forced medication of such inmates will certainly keep the controversy raging.

The great majority of psychologists working in correctional settings will never be asked to conduct an evaluation of a death row inmate’s competency to be executed. First, in states with the death penalty, the death row population is usually kept at one maximum-security facility, at least as these inmates approach their execution date. Only a small minority of psychologists work in or contract to these facilities. Second, prisoners under sentence of death are far more likely to appeal their death sentence on other grounds (e.g., inadequate assistance of counsel) than to raise the issue of incompetency. It is too early to tell whether the Court’s recent case prohibiting execution of the mentally retarded will significantly increase the numbers of offenders who challenge their execution on this basis.

Both the American Psychological Association and the American Psychiatric Association say that the ultimate decision as to whether the offender is competent to be executed should be made by the court and that adversarial expert witnesses are essential in this context. In other words, the psychologist or psychiatrist conducting the evaluation should neither be the sole examiner nor the decision maker.

A number of forensic psychologists have offered suggestions to their colleagues who may be conducting evaluations of competency to be executed (e.g., Heilbrun, 1987; Heilbrun et al., 2002; Small & Otto, 1991). In a model report published by Heilbrun et al. (2002, p. 96), psychologist Mark Cunningham used the following techniques in his competency assessment:

- clinical and forensic interview of the prisoner;
- psychological testing, including the MMPI-2 and the Personality Assessment Inventory (PAI);
- interview of a corrections officer on the death row unit;
- cell observation;
- a second interview with the prisoner;
- telephone interviews with friends, relatives, the prisoner’s ex-wife, and his spiritual adviser, which ranged in length from 70 minutes to 12 minutes; and
- reviews of numerous legal, health, military, and prison records, as well as journal entries and letters in support of clemency.

Small and Otto (1991) note that it is important to inform the prisoner of the purpose of the evaluation, describe its procedure, and explain who will get the results and the implications of the findings. In addition, they recommend videotaping the assessment to document that the above steps have been taken, under the assumption that a court may scrutinize the evaluation process itself. Central to the evaluation, they say, is the clinical interview, in which the clinician should try to determine whether the prisoner understands that he or she was convicted and is about to be executed.

Treatment and Rehabilitation in Correctional Facilities

A dominant task of the psychologist in the correctional system is to provide psychological treatment, a term that encompasses a wide spectrum of strategies, techniques, and goals. Boothby and Clements (2000) reported that direct treatment took up approximately 26% of psychologists’ time, second only to administrative tasks. Among the most common treatments used within correctional institutions are person-centered therapy, cognitive therapy, behavior therapy, group and milieu therapy, transactional analysis, reality therapy, and responsibility therapy (Kratcoski, 1994; Lester, Braswell, & Van Voorhis, 1992). It should be noted that psychologists are just one of several professional groups providing this therapy. Psychiatrists, social workers, and mental health counselors are also involved in most correctional facilities.
This is an important point because the method of treatment used depends largely on the professional training and orientation of the clinician. Psychiatrists, for example, are more likely to favor psychoactive drugs as part of a treatment regimen, although recent studies suggest that this approach is increasingly being supplemented with individual therapy (Heilbrun & Griffin, 1999). Social workers are more likely to use group treatment approaches, in which inmates talk about their concerns, experiences, and anxieties while the clinician generally directs and controls the topic flow. As indicated by the Boothby and Clements (2000) study, group therapy does not seem to be the norm among psychologists in correctional facilities, but it is still widely used by other clinical professionals. Sixty percent of the treatment provided by the psychologists in that study was in an individual format. The researchers found this problematic, given the high need for mental health services in the nation's jails and prisons.

A different survey of 162 professionals representing a range of professional groups (Morgan, Winterowd, & Ferrell, 1999) indicated a far greater use of group therapy. In that study, 72% of the respondents offered group therapy to inmates, and their time was about equally divided between group and individual treatment. These practitioners also estimated that 20% of all inmates in their facilities received some group therapy. When delivered effectively, group therapy has several advantages over individual therapy in correctional settings. It is, of course, more practical, given the limited treatment staff and high prison population. In addition, group therapy provides inmates with opportunities for socializing, group decision making, developing altruism, and developing functional peer relationships that individual treatment typically does not provide (Morgan et al., 1999).

On a more negative note, few professionals in the above study (only 16%) reported that their departments were conducting research on the effectiveness of group or other therapy. Perhaps more sobering, 20% indicated that no supervision was offered to therapists who facilitated group therapy sessions.

Common Psychological Treatment in Corrections

A wide variety of treatment options are available to forensic psychologists offering therapy in correctional settings (Kratcoski, 1994). The treatment model—or treatment approach—adopted by a given professional may be influenced by a host of factors, including the psychologist’s training, perceptions of “what works,” and, of course, the available resources within the facility. In the Boothby and Clements (2000) study, a large majority of respondents (88%) reported using a cognitive model, whereas 69% used a behavioral model and 40% a rational-emotive approach. As is obvious from these percentages, psychologists used more than one model, depending on the situation.

Behavioral Models

In the 1960s, psychologists consulting with correctional facilities made extensive use of behavior modification as a means of encouraging inmates to change (Bartol, 1980). Behavior modification included rewarding inmates for “good behavior” within the facility and removing privileges when behavior was unacceptable. For example, an inmate who had no disciplinary violations for a month might be given an increase in visits to the commissary, or prison store. Disruptive behavior might result in a loss of visiting privileges. By themselves, approaches that are based on such reinforcement strategies have shown little effectiveness. The main objection to such approaches is that change generated within the facility did not generalize to the real world, once inmates were released. Furthermore, in some facilities, legal advocates argued that the punishments imposed were sometimes arbitrary and in violation of inmate rights. Behavior modification as the sole approach to treatment eventually lost favor.
Cognitive-Behavioral Models

Cognitive models seek to change the very beliefs and assumptions that are at the core of an individual’s behavior. Strongly based on social learning theory, they encourage inmates to examine their beliefs and assumptions, recognize problems in judgment that have led them to criminal activity, develop self-awareness, and accept responsibility for their actions. Once this has been accomplished, inmates are taught decision-making strategies and social skills, as needed, for replacing behaviors that got them into trouble with prosocial behaviors. Because cognitive programs often have components that resemble aspects of behavioral programs, the term cognitive-behavioral is used. For example, many cognitive-behavioral programs make use of contracts and token economy systems, whereby individuals gain points when they demonstrate prosocial behaviors.

This cognitive-behavioral approach appears to have the most promise in a variety of treatment contexts. Pearson, Lipton, Cleland, and Yee (2002) performed a meta-analysis on the 69 primary research studies on the effectiveness of behavioral and cognitive behavioral treatment and found the latter significantly associated with lower recidivism rates. The effect was mainly due to the cognitive components rather than the behavior modification interventions, however. That is, such aspects as problem solving, interpersonal skills training, role-playing, and negotiation skills training—all associated with a cognitive approach—were linked with effectiveness. Token economies, contingency management, and behavioral contracts—all associated with behavior modification—had little effect.

Rational-Emotive Models

Nearly 50 years ago, psychologist Albert Ellis (1962) developed a model of therapy that has considerable similarity to the cognitive approaches discussed above. Rational-emotive therapy (RET) presumes that if a person holds “rational beliefs” rather than “irrational beliefs,” the person will deal appropriately with difficulties in his or her life. Emotions such as sorrow, annoyance, or regret were considered appropriate; emotions such as depression, anxiety, and extreme anger were inappropriate (Haaga & Davidson, 1993). One goal of RET, then, is to teach patients to confront and forcefully dispute their irrational beliefs. An example of an irrational belief might be, “If I fail at this task, I must be a bad person.” Another might be, “If I don’t show her who’s boss, she won’t think I’m a real man.” Therapists who use the RET approach often give their clients “homework assignments” aimed at disputing their beliefs.

According to Haaga and Davidson (1993), rational-emotive therapy was in the historical forefront of the cognitive trend and remains widely used in psychotherapy. Recall that this approach was used by 40% of the respondents in the Boothby and Clements (2000) survey. Nevertheless, its scientific status is less clear. Irrational beliefs are both difficult to define and difficult to measure, and evaluation results have been mixed. Haaga and Davidson note that the treatment has not been sufficiently tested. “Perhaps it is time to consider the possibility that RET is not susceptible to traditional scientific outcome evaluation” (Haaga & Davidson, 1993, p. 219).

Treatment of Special Populations

Like the general population, inmates vary widely in their background experiences and their needs. Although treatment should be individualized as much as possible to recognize these differences, programs are often established to address common needs of groups of offenders. For example, prisons—and to a lesser extent jails—may offer programs for inmates who are HIV positive, elderly inmates, women who killed their abusers, sex offenders, psychopaths, inmates who are parents, substance abusers, inmates with
developmental disabilities, and inmates under sentence of death. Although we will not cover all of these categories below, readers are advised that a wide variety of literature in correctional psychology is available (e.g., Ashford, Sales, & Reid, 2001; Kratcoski, 1994).

**Violent Offenders**

Violent behavior has been defined as the intentional and malevolent physical injuring of another without adequate social justification (Blackburn, 1993). Psychological services to inmates who have committed violent crimes or who otherwise demonstrate propensities toward violent behavior are common in many correctional facilities. Corrections officials place a high priority on both controlling such behavior within prison and jail settings and reducing its likelihood once an inmate has been released. Therefore, programs that address this problem in the inmate population are appreciated, if not always well funded. As a group, however, violent offenders are extremely challenging. “When compared to other offenders, they tend to be less motivated for treatment, more resistant or non-compliant while in treatment, have higher attrition rates, demonstrate fewer positive behavioral changes while in treatment, and demonstrate higher recidivism rates posttreatment” (Serin & Preston, 2001, p. 254).

Serin and Preston (2001) note that a major impediment to treating violent offenders has been confusion over the definition of the population along with failure to recognize that violent individuals are not all alike. This lack of homogeneity, Serin and Preston emphasize, requires differential treatment, but differential treatment is rarely offered. Programs for violent offenders too often do not distinguish, for example, between offenders displaying instrumental aggression and offenders who have anger control problems. Instrumental aggression is coolly committed for the purposes of achieving a particular goal. Thus, it makes little sense to place an offender who commits his crimes using instrumental aggression into a program teaching him to control his anger. On the other hand, anger control is an important skill to develop in individuals who are impulsive, have substance abuse problems or mental disorders, or lack social, relationship, or parenting skills. Although differential treatment is an important goal, it is practically very difficult to achieve, particularly within an institutional setting. As Serin and Preston acknowledge, few settings have the resources—both financial and human—to provide multiple programs for different types of violent offenders. Even when more than one program is offered, the identification and matching of offenders with specific programs are challenging tasks. In addition, the population of violent offenders who qualify as psychopaths requires different strategies, as we will see shortly.

Programs vary widely in their approach. However, many have two common features: (a) teaching techniques for self-regulating aggression and (b) addressing cognitive deficits. In the first category, motivated offenders are taught relaxation skills or “stress inoculation” approaches to reduce the arousal that results in inappropriate aggression. In the second category, motivated offenders are challenged to confront the irrational beliefs or biases that lead to violence. Defining problems in hostile ways or failing to anticipate the consequences of aggressive behavior are examples. Programs that address cognitive deficits, therefore, strive to change the thinking patterns of offenders by persuading them that the approaches they have used to this point have not resulted in successful outcomes in their relationships with society or with others in their environment. A prerequisite to a successful program outcome, however, is the motivation of the offender.

Although a variety of violent offender programs have produced some positive treatment effects, “few provide the rigor (i.e., control groups) to conclude that intervention for violent adults reduces violent recidivism” (Serin & Preston, 2001, p. 260). Advocates of violent
offender programs maintain, however, that such programs at the least reduce the risk of future violence and should ideally be followed up with community supervision and treatment once inmates are released. Furthermore, even when studies do not demonstrate positive posttreatment effects, the design of the study itself—not the treatment offered—may be the problem. As always, more methodologically sound research is needed to continue the progress toward effective programming.

Interestingly, some research indicates that it is far more difficult to provide intensive treatment for high-risk offenders in the community than in a controlled prison environment. Despite the numerous challenges within an institutional setting that were discussed above, the clinician has more control within a residential program. In addition, milieu treatment—such as can be found in therapeutic communities within the facility—is a possibility. A major disadvantage of institutional treatment is the difficulty in generalizing it to noninstitutional settings (Quinsey et al., 1998).

It should be mentioned that pharmacological approaches are also used in the management of violent offenders, particularly those for whom violence can be attributed partially to biological factors. These would include some individuals with brain injuries, schizophrenia, dementia, and clinical depression, among other disorders. Antipsychotic medications are often used in prison settings to control acute violent behavior in a crisis situation, such as a psychotic episode. Nevertheless, the vast majority of violent offenders neither require nor would benefit from pharmacological treatment (Serin & Preston, 2001). When such treatment is indicated, it should also be accompanied by psychological interventions mentioned above.

Criminal Psychopaths

As we discussed in Chapter 4, individuals who qualify as criminal psychopaths present special challenges to society as well as to prison administrators. It has been a longstanding conclusion that psychopaths are essentially untreatable and continually demonstrate low motivation in treatment or rehabilitation programs. Hare (1996) asserts,

There is no known treatment for psychopathy.... This does not necessarily mean that the egocentric and callous attitudes and behaviors of psychopaths are immutable, only that there are no methodologically sound treatments or "resocialization" programs that have been shown to work with psychopaths. Unfortunately, both the criminal justice system and the public routinely are fooled into believing otherwise. (p. 41)

Psychopaths often volunteer for various prison treatment programs, show "remarkable improvement," and present themselves as model prisoners. They are skillful at convincing therapists, counselors, and parole boards that they have changed for the better. Upon release, however, there is a high probability that they will reoffend, and their recidivism rate is not usually reduced following treatment (Porter et al., 2000). “Treatment participated in by many psychopaths may be superficial, intended mainly for impression management” (Porter et al., 2000, p. 219).

Some evidence even suggests that psychopaths who participate in therapy are more likely to engage in violent crime following treatment than psychopaths who did not receive treatment. Rice, Harris, and Cormier (1992) investigated the effectiveness of an intensive therapeutic community program offered in a maximum-security facility. (The concept of therapeutic communities will be discussed later in the chapter.) The study was retrospective, in that the researchers examined records and files 10 years after the program was completed. Results showed that psychopaths who participated in the therapeutic community exhibited higher rates of violent recidivism than psychopaths who did not. For
nonpsychopaths, the results were the reverse: Nonpsychopaths were less likely to reoffend if they had participated in the program. Rice et al. admonish that the psychopaths in their study were an especially serious group of offenders, with 85% having a history of violent crimes. It is possible that a group of less serious offenders would show better results. Nevertheless, the researchers concluded, “The combined results suggest that a therapeutic community is not the treatment of choice for psychopaths, particularly those with extensive criminal histories” (Rice et al., 1992, p. 408). Hare (1996) suggests that group therapy and insight-oriented treatment programs may actually help the psychopath develop better ways of manipulating and deceiving others. It should be mentioned that the treatment program reported on in the Rice et al. (1992) article had controversial features, including emotion-laden encounter groups among inmates in the facility.

Some recent preliminary data by Skeem et al. (2002) do suggest, though, that under certain conditions, some psychopaths do benefit from treatment. Specifically, both the level of violence and the frequency of offending can be reduced. The key appears to be the intensity of the treatment. Skeem et al. found that psychopathic psychiatric patients who received seven or more treatment sessions during a 10-week period were approximately three times less likely to be violent than psychopathic patients who received six or fewer sessions. These results support earlier findings reported by Salekin (2002), who also discovered that a range of treatment interventions appeared to be moderately successful for psychopaths, especially if the treatment was lengthy and intensive.

Likewise, Bonta (2002) has suggested that psychopathy should be considered a dynamic factor, not a static variable. “Antisocial personality . . . does not need to be viewed as such a stable, intractable aspect of the person” (Bonta, 2002, p. 369). He argues that certain features of the antisocial personality—impulsiveness, risk taking, callous disregard for others, shallow affect, pathological lying—can be linked with realistic treatment goals. Obviously, much more research is needed before we can make any far-reaching conclusions about the effectiveness of treatment programs directed at criminal psychopaths.

**Sex Offender Treatment**

As we discussed in Chapter 6, sex offenders are an extremely heterogeneous group. Most of the research has focused on two predominant groups, rapists and child molesters. These are the two sex offender groups that are the most likely to be imprisoned and the more difficult to treat, although within each group, some types of offenders are more amenable to treatment. Recall that we gave considerable attention in Chapter 5 to the typologies developed in an attempt to understand these offenders. It should be noted that extreme care should be used in applying these typologies, very few of which have been submitted to empirical validation (Heilbrun et al., 2002). As we stated in Chapter 10 while discussing sex offender evaluations, a negative label (e.g., sadistic rapist) may have unfair consequences for the individual so labeled. In prison, it may hinder his adjustment to incarceration, may affect his security level, or limit his chances for an early release. In addition, although many psychologists believe the risk assessment instruments specifically devised for sex offenders are useful, these instruments also have many limitations (Campbell, 2003).

The number of sex offenders under correctional supervision has reached alarming proportions. By the end of the 1990s, approximately 296,100 individuals convicted of rape or sexual assault—including assault of children—were in this category, with about 40% of them in jails or prisons (Bureau of Justice Statistics, 2001a). Observers have noted, however, that these figures represent the offense for which an offender was convicted and sentenced; an undetermined number of additional inmates also have offended sexually in the past but are not incarcerated for
sex offenses (Burdon & Gallagher, 2002). In addition, some prison inmates are clinical sex offenders but not legal sex offenders. That is, they have a clinically diagnosable paraphilic disorder that may or may not have resulted in a conviction (Burdon & Gallagher, 2002). Paraphilia is a relatively new term for a variety of sexual deviations, where sexual arousal cannot occur without the presence of unusual imagination or behaviors.

Psychologists and other clinicians have responded to the above figures by continuing to search for effective strategies to prevent future crime among sex offenders who, as a group, are highly resistant to changing their deviant behavior patterns (Bartol, 2002). After an extensive review of the research and clinical literature on the subject, Furby, Weinroth, and Blackshaw (1989) were forced to conclude, “There is as yet no evidence that clinical treatment reduces rates of sex reoffenses in general and no appropriate data for assessing whether it may be differentially effective for different types of offenders” (p. 27). The Furby et al. review included all variants of therapeutic approaches.

Despite this pessimistic appraisal, other reviews have been more favorable. Recent meta-analyses of the sex offender treatment literature have indicated that, on the whole, sex offenders are better treated than untreated (e.g., Gallagher et al., 1999). In addition, some approaches have shown more promise than others. The cognitive-behavioral approaches discussed above, in particular, have received more favorable reviews (Laws, 1995). The cognitive-behavioral approach contends that maladaptive sexual behaviors are learned according to the same principles as normal sexual behaviors are learned and are largely the result of attitudes and beliefs. Cognitive-behavioral therapy, compared to traditional verbal, insight-oriented therapy, has demonstrated short-term effectiveness in eliminating exhibitionism and fetishism (Kilmann, Sabalis, Gearing, Bukstel, & Scovorn, 1982), some forms of pedophilia (Marshall & Barbaree, 1990), and sexual violence and aggression (Hall, 1995; Polizzi, MacKenzie, & Hickman, 1999). Cognitive-behavioral treatment currently offers the most effective method in the temporary cessation of deviant sexual behavior in motivated individuals. (See Box 12.4 for common features of cognitive-behavioral treatment programs.)

**BOX 12.4 The Cognitive-Behavioral Approach: Key Elements**

Of the many therapeutic interventions that have been tried in corrections, the cognitive-behavioral approach seems to hold the most promise. It consists of counseling (group and individual) and training whereby offenders develop cognitive skills that will presumably help them to adopt alternative, prosocial behaviors rather than the antisocial behaviors that resulted in their criminal convictions. There is no universally implemented cognitive-behavioral treatment program; rather, treatment providers decide on an approach consistent with their own training and the needs of the offenders under their care. Any or all of the following elements might be found in a cognitive-behavioral treatment program:

- Social skills development training (e.g., learning to communicate, be assertive rather than aggressive, and resolve conflicts appropriately)
- Decision making (e.g., learning to weigh alternatives, learning to delay gratification)
- Identifying and avoiding “thinking errors”—misguided assumptions that facilitated criminal offending (e.g., “women want to be shown who’s boss”)

(Continued)
The key words relative to the success of cognitive-behavioral treatment are temporary cessation and motivated individual. There is now widespread agreement among researchers and clinicians that sex offenders cannot be “cured.” The problem of cognitive-behavioral therapy—and all therapies for that matter—is not in getting the motivated offender to stop the deviant sexual patterns but in preventing relapse across time and situations. It is analogous to dieting. Although most dieting regimens are effective in getting the motivated individual to lose weight initially, the real problem is the eventual relapse into old eating patterns. Thus, a treatment approach demonstrating much promise in the treatment of sex offenders is called Relapse Prevention (RP). “RP is a self-control program designed to teach individuals who are trying to change their behavior how to anticipate and cope with the problem of relapse” (George & Marlatt, 1989, p. 2). The program emphasizes self-management; clients are considered responsible for the solution of the problem.

Sex offender treatment programs exist in virtually every state and in the federal prison system, but the number of inmates who actually receive treatment is unknown (Burdon & Gallagher, 2002). They vary widely in approach, in the extent to which they are evaluated, and in the degree of success when evaluation research is conducted. Treatment programs are less likely to be available to jail inmates because of the short-term nature of jail confinement. However, inmates who are subsequently released to the community may be referred to community treatment programs.

**Women Offenders**

In recent years, women’s rates of incarceration have increased faster than men’s rates, although very few scholars predict that they will ever “catch up.” Presently, women make up 6.6% of all state and federal prison inmates and approximately 10% of all jail inmates and detainees (Bureau of Justice Statistics, 2001a). Although increasing research attention is now being given to women inmates, they still remain forgotten offenders compared with males.

Scholars agree that problems faced by female prisoners are similar to but also distinct from the problems faced by male prisoners. For example, due to the small numbers of women in prison, there are far fewer correctional facilities available, thus severely restricting opportunities to be near

**BOX 12.4 (Continued)**

- Training at solving problems (e.g., interpersonal problems with one’s intimate partner)
- Self-control training and anger management (e.g., avoiding hostile attribution)
- Building self-esteem (e.g., recognizing good qualities and providing self-reinforcement)
- Cognitive skills training (e.g., learning to reason)
- Relapse prevention (learning to avoid situations that might lead to further offending)
- Practical skills training (e.g., applying for work)

As noted in the text, the cognitive-behavioral approach has shown success when programs are properly implemented and carried out and offenders are motivated to change. It is not perfect. However, although other therapeutic approaches (e.g., behavior modification; therapeutic communities) have had unpromising results (with some exceptions), cognitive-behavioral therapy gives reason to hope.
their families or to have occupational, educational, or social activities while incarcerated. More important, their relationships with their children are often severely hampered, resulting in a more severe deprivation than typically found for the male parent (MacKenzie, Robinson, & Campbell, 1989). This parent-child deprivation is especially severe for long-term women inmates, who may lose their major source of identity when they lose their parental role (Weisheit & Mahan, 1988). Weisheit and Mahan (1988) note that women inmates have on average two children and often are the head of their household. Moreover, they are likely to be poor, poorly educated, and members of a racial or ethnic minority. Female inmates are also more likely than male inmates to have experienced sexual abuse as a child and physical abuse as an adult (Owen, 2000).

Some observers have estimated that more than 60% of the female prison population requires mental health services and that a vast majority of women offenders have a need for substance abuse services (e.g., Owen, 2000). Many women serving time have had a history of victimization—often violent victimization and often at the hands of fathers, spouses, and/or intimate partners. As Owen (2000) observes, “Closely related to mental health problems is the need to recognize the impact of the physical, sexual, and emotional abuse experienced by women offenders” (p. 196). Approaches that increase their self-confidence, recognize their victimization but enable them to take charge of their lives, and teach them life skills offer the best hope for women incarcerated.

**Treatment in Jail Settings**

Psychological treatment of inmates in jail settings is considerably different from treatment in prisons. The short-term nature of the jail stay—on average 11 days—suggests that crisis intervention and limited treatment goals are typical. Moreover, treatment in jail settings is far more likely to consist of stabilizing medication rather than therapy. Nevertheless, the treatment models discussed above can still be implemented, even in short-term jail settings.

Steadman et al. (1989) have provided a helpful but dated description of mental health services offered in 43 jails in 26 states. All jails in their study offered psychotropic medication, and almost all offered psychological evaluation and competency examinations (98% and 93%, respectively). Far fewer (60%) offered drug and alcohol treatment. Therapy or counseling was offered by 30%, whereas a mere 16% provided case management services for general mental health at release. Steadman et al. (1989, pp. 48–49) identified, described in detail, and provided illustrations of four basic types of service arrangements for mentally disordered inmates:

- “ad hoc,” in which services were offered only on an emergency basis;
- “identification,” in which correctional officers only identified disturbed inmates;
- “identification and treatment,” in which disturbed inmates were both identified and were provided with treatment; and
- “comprehensive,” in which identification, treatment, and referral services were all available.

The above taxonomy was not the researchers’ main concern, however. Rather, they wished to examine the linkages between community resources and the delivery of mental health services to the jailed population.

Instead of viewing the jail as a self-contained or closed system, an inter-organizational approach to program development and evaluation looks beyond the jail to its linkages with a variety of other organizations in its environment, such as state mental hospital, psychiatric units in general hospitals, community mental health centers, and other health and human service agencies. (Steadman et al., 1989, p. 73)
Many of the existing programs offered services outside the jail, such as by transporting inmates to community clinics or offices. Internal programs, which were less in evidence, place heavier demands on staffing, budgets, and institutional security.

A key finding of the research was that conflict between correctional staff and mental health staff was far less evident than the researchers had expected. Although some conflict existed, particularly when services were provided within the jail under the joint auspices of correctional and mental health personnel, the two professions shared the convergence of two goals: custody and therapy. Correctional staff indicated that therapists made their jobs easier, and therapists respected the needs of the custodial staff to keep the jail secure. Steadman and his colleagues (1989, p. 102) attributed this to the short-term nature of a jail stay, essentially leaving no time for the huge ascendancy of one type of goal over the other, such as is more likely to occur in prison settings. They note that the jail is truly the client:

If individual treatment were more ambitious, much more therapy in the form of individual counseling and group sessions would become more pervasive, and conflict, as well as service costs, would probably increase dramatically. However, given the nature of the jail, such treatment goals are unrealistic, while safety management needs are acute. (p. 103)

Providing treatment services to the nonsentenced jail population—the detainees—is especially challenging. First, it is impossible to predict how long the individual will remain in detention because pretrial release is a continuing possibility for the majority of detainees. Other detainees may have charges dismissed or may plead guilty to their offenses, thus meaning that they will be placed on probation or transferred to prison. Second, even while in custody, numerous disruptions will occur in the individual’s schedule. For example, court appearances, visits, meetings with attorneys, population head counts, and even recreational opportunities are unpredictable. Third, treatment services must be generic and not tied to criminal activity because the detainee is only charged with, not convicted of, crime. Thus, sex offender treatment or a program for domestic abusers is inappropriate when applied to detainees who are presumed innocent until proven guilty. Even sentenced inmates provide challenges to the forensic psychologist, largely due to the short-term nature of their sentence. The therapist therefore must forgo long-term goals, even if he or she believes such goals are in the greater interest of the client. “Mental health professionals who are willing to work toward less traditional treatment goals can function within the jail with minimal goal conflict” (Steadman et al., 1989, p. 103). They are advised to develop release-planning goals that will link the individual to community-based mental health agencies. In addition, they are urged to keep in mind that the jail environment itself is crowded, noisy, and lacking in privacy and that inmates have very little control over their lives. Such conditions can exacerbate mental disorder. Not surprisingly, therefore, “the primary treatment goals for jail inmates will usually be crisis stabilization and maintenance at an appropriate level of functioning while in custody” (Cox, Landsberg, & Paravati, 1989, p. 223).

As discussed in the beginning of this chapter, jails—sometimes even more than prisons—have a number of features that can impede efforts to offer treatment. Today, limited budgets and overcrowding are major concerns. Bowker and Schweid (1992) have written about a program for retarded offenders in Cuyahoga County, Ohio. A mentally retarded offender (MRO) pod was started “to prevent more intelligent inmates from victimizing retarded offenders during their incarceration” (Bowker & Schweid, 1992, p. 499). A counselor would meet with the offenders weekly in group meetings to help them adjust to their environment and would consult with a team to address their needs. Overcrowding necessitated the closing of the special unit, and retarded inmates then were shifted to a medical/
neither the victimization of inmates by staff nor the victimization of staff by inmates can be overlooked or tolerated.

For many reasons, psychological services to correctional officers are almost invariably delivered outside of the facility, on a contractual basis with the correctional system, and with guaranteed confidentiality. An exception might be on-site crisis counseling following a critical incident within the facility, such as a hostage-taking situation or the killing of a correctional officer. In such a situation, the facility’s mental health professionals as well as professionals working in the community might conduct group debriefing sessions with affected correctional officers. For the most part, however, prison and jail systems contract with mental health professionals within the community. Alternately, correctional officers are left to seek help on their own. Peer counseling programs, with or without guidance from psychologists and other mental health professionals, are also becoming increasingly available in correctional facilities. A recent report prepared for the Department of Justice (Abt Associates, 2000) describes approximately a dozen programs designed to address correctional officer stress in prisons, jails, and youth facilities. Although we emphasize in this chapter the assessment and treatment offered to inmates, it is obvious that forensic psychologists must continue to make their services available to correctional staff as well.

Obstacles to the Treatment of Inmates and Staff

The correctional environment itself creates numerous challenges for the clinician offering services both to inmates and to staff. In this section, we discuss some of the main obstacles.

Confidentiality

As noted in earlier chapters, forensic psychologists often find that they cannot guarantee total
confidentiality to the persons whom they assess or treat. This is especially true of psychologists working in correctional settings, particularly prisons and jails. For example, when the security of the institution is at stake, the inmate presents a threat of suicide, or a third party is in danger, confidentiality cannot be guaranteed. Limits of confidentiality include “knowledge of escape plans, intentions to commit a crime in prison, introduction of illegal items (e.g., contraband) into prison, in addition to suicidal or homicidal ideation and intention, court subpoenas, and reports of child or elder abuse or neglect” (Morgan et al., 1999, p. 602). As we noted earlier in the chapter, psychologists and other treatment providers are advised to inform inmates of these limitations on confidentiality prior to the provision of assessment and treatment services. As a result of these limits, the inmate may perceive the treatment provider as a representative of the administration. When this happens, the work of psychologists in correctional facilities becomes especially challenging (Milan, Chin, & Nguyen, 1999).

Confidentiality is also a critical factor when psychologists are treating correctional officers. There are countless anecdotal reports of correctional officers (as well as law enforcement officers) who resist seeking help for psychological problems—from mild to very severe—because they fear that supervisors or coworkers will learn of this and lose confidence in their abilities to do their job. For this reason, prison and jail systems sometimes go to great lengths to guarantee the anonymity of the officer being treated. In one program described in the Abt Associates (2000) report, for example, a chaplain assigns a number to an officer needing professional treatment. The officer then calls a psychologist, and all subsequent billing for services is done using only the number as identification. The chaplain serves as the intermediary, receiving bills and forwarding them to the appropriate fiscal office. In this way, correctional administrators presumably are never made aware of which officer has sought treatment.

Although patient-therapist confidentiality is sacrosanct, the fact that an individual has sought treatment may eventually be revealed, however. This is particularly the case when a civil suit is brought against the facility or agency and an individual officer is an essential part of the legal action. When a clinician is called to testify as a witness in a legal proceeding, confidentiality is not protected. An officer sued for excessive force, for example, cannot expect to keep confidential the fact that he or she has sought psychological treatment, either before or after the alleged incident. Even an officer using justifiable force may be subjected to some legal scrutiny. The content of the therapist-patient communication is privileged, but the fact that such communication took place is not (Jaffe v. Redmond, 1996).

Coercion

Another obstacle to successful treatment, particularly treatment of inmates, is its coercive aspect. Institutional treatment often—although not invariably—operates on the principle that psychological change can be coerced. Conversely, traditional forms of psychological treatment have been successful only when subjects were willing and motivated to participate. This basic principle applies regardless of whether the person is living in the community or within the walls of an institution that has overwhelming power over the lives of its inmates. Thus, although inmates have a right to refuse treatment, their refusal can create far more problems than their grudging acceptance. For example, refusal may mean transfer to another facility, delay in being released, or a restriction on privileges (McKune v. Lile, 2002).

In recent years, however, some researchers have begun to question the conventional wisdom that coercion and treatment cannot coexist (see generally, Farabee, 2002). The critical variable appears to be not the fact that the individual is incarcerated but rather the individual’s willingness to participate or perceived need for treatment. In addition, some studies indicate that even a recalcitrant inmate can eventually benefit
from treatment programs (e.g., Burdon & Gallagher, 2002; Prendergast, Farabee, Cartier, & Henkin, 2002).

Environment

Another obstacle to effective treatment in prisons and jails is the unusual nature of the prison environment itself. The list of negative features ranges from overcrowding, violence, and victimization by both other prisoners and staff to isolation from families and feelings of a lack of control over one’s life.

In the late 1950s and 1960s, a number of psychologists working in correctional settings helped establish “therapeutic communities” (TCs) for inmates facing adjustment problems in prisons (Toch, 1980). These TCs were special living quarters where inmates would be housed separately from the rest of the prison population and would be involved in decision making, group therapy, and operating their own living quarters within the broad prison setting. Although these inmates did not have significantly better recidivism rates than other inmates (Gendreau & Ross, 1984), prison life was made more tolerable for them, and job satisfaction for the staff improved.

Today, few prison programs offer therapeutic community settings, primarily because of budgetary constraints and space limitations. When available, they are more likely to be offered to inmates with substance abuse problems. Recall from our discussion of psychopaths that they do not appear to be good candidates for a therapeutic community approach. In general, research has documented the effectiveness of therapeutic communities when they are intensive, behavior based, and focused on targeting an offender’s drug use (MacKenzie, 2000).

Many observers note that prison environments are worse today than they were in the 1960s, when therapeutic communities were first proposed. Overcrowding, violence, and deteriorating physical conditions characterize a substantial number of the nation’s prisons and jails. By the end of the 20th century, for example, state prisons as a group were operating between full capacity and 15% above capacity, and federal prisons were operating at 31% above capacity (Bureau of Justice Statistics, 2001a). The overcrowding problem in jails was even more severe. Violence is also endemic in many prisons. It has been estimated that about 25,000 nonsexual assaults and close to 300,000 sexual assaults occur each year in the nation’s jails and prisons (Clear & Cole, 2000). It is impossible to know the true number because assaults may not be reported.

Living conditions for inmates who are kept in isolation for disciplinary reasons or presumably for their own protection (e.g., inmates with mental disorders) are particularly problematic. Although it would be unfair to suggest that the typical jail or prison faces these seemingly intractable problems, correctional psychologists encounter them all too often, and they contribute significantly to the stress experienced by both inmates and staff.

Treatment is also made difficult by other aspects of even the most humane jail or prison environment. Jail sentences are typically short, so continuous treatment is highly unlikely to occur. In both jails and prisons, inmates “miss” appointments with clinicians for a wide variety of reasons. Even when inmates themselves want to attend, they may be prevented from doing so for security or disciplinary reasons. A cellblock may be locked down for a day, for example, while officials conduct cell searches, investigate a disturbance, or conduct medical tests. An inmate involved in an altercation may be placed in disciplinary segregation, making it unlikely that visits to a therapist will be allowed. For security reasons, prison inmates are transferred to other facilities with little warning. Finally, budgetary constraints in many facilities result in cutbacks to all but the most essential services.

Community-Based Corrections

As we noted at the beginning of the chapter, the great majority of adults under correctional
supervision remain within the community, either in their own homes or in transitional or group homes, camps, ranches, and similar facilities. Community-based placements other than one’s own home generally hold individuals for less than 24 hours a day, allowing them opportunity to work, attend school, participate in job training, or attend counseling or treatment sessions. Community-based facilities are operated by state or federal governments or by private organizations under government contract. In the criminal justice literature, such placements are referred to as “intermediate sanctions,” representing points on a continuum between probation and jail or prison, as well as between prison and parole. They may also be referred to as “probation plus,” or “parole plus.” The offender who lives in a halfway house upon release from prison, for example, is on parole with the added restrictions imposed by the rules and supervision of the halfway house administration. Interestingly, in February 2003, the federal government announced that it was removing from federal judges the authority to send sentenced offenders to halfway houses rather than to federal prisons when the federal sentencing guidelines prescribed a prison sentence. Offenders who were most likely to benefit from judicial discretion were those convicted of white-collar offenses. The government indicated its goal was to end favorable treatment for these individuals.

Intermediate sanctions are also used with offenders who remain in their own homes, such as offenders assigned to house arrest or electronic monitoring. The forensic psychologist offering services to offenders under community correctional supervision, therefore, soon learns that they have a variety of living arrangements as well as conditions of release.

A common condition of release is the requirement that an offender attend counseling or therapy. Thus, many community psychologists have on their caseload individuals who have been ordered to seek treatment. We will not revisit here the issue discussed earlier in the chapter, revolving around whether change can be coerced. Although it is not irrelevant in this context, the coercion here is not as clear-cut as coercion within the institutional environment of the jail or prison, particularly the latter. Nevertheless, the forensic psychologist should be alert to the fact that her or his clients might not be seeking help but for the fear that they could be incarcerated if they do not meet the conditions of release.

Like the psychologist working with detainees and inmates, the psychologist working in community settings performs both assessment and treatment tasks. Evaluations of an individual’s competency to stand trial or competency to participate in a variety of judicial proceedings are often performed in the community, as we noted in Chapter 10. In addition, the community psychologist may assess an offender’s appropriateness for a particular treatment program, such as a program for sex offenders. Risk assessments are increasingly being performed within the community as well. For example, before downgrading a probationer from an intensive supervision program to “regular” probation, the court or the probation authority may ask the psychologist to assess the risk to the community if the probationer is no longer supervised as diligently as has been happening. The principles associated with risk assessment, as well as with risk/needs assessment discussed earlier in the chapter as well as in Chapter 9, will not be repeated here. As we will see shortly, recent commentators are strongly advocating an assessment of an offender’s criminogenic needs before undertaking community treatment.

The role of the forensic psychologist in treating offenders in the community deserves our careful attention. In most ways, the principles applied and the standard of practice are no different from what the psychologist would adopt in the treatment of any other client. Nevertheless, a number of factors render the correctional client distinctive. The common thread among all of these factors is the importance of communication between the psychologist and the representatives of the criminal justice system. First, as noted above, the coercive nature of the treatment
may create problems, although it is far less coercive than treatment in jails and prisons. Second, the psychologist may be placed in the untenable position of being an "enforcer," similar to the probation officer. Thus, if the client misses an appointment, the psychologist must decide whether to report this lapse to the probation officer, who may or may not see this as a serious problem. Third, in a somewhat related vein, the psychologist may be called on to make decisions involving privileges that he or she would rather not have to make. A parolee receiving treatment may wish to attend the out-of-state wedding of a sibling, for example, a decision that would typically be left to the supervising officer. Community psychologists are not infrequently called on to render opinions on such matters, which many believe are out of their purview. Fourth, the limits of confidentiality must be recognized and communicated to the individual. Typically, the client in these situations is not the offender but the supervising agency, which may be a court or a probation/parole department. In some jurisdictions, the court imposing the conditions of release may require periodic progress notes from the treating clinician. In addition, in the event that probation or parole is revoked, summary notes from the psychologist’s records may be subjected to court scrutiny. Fifth, the criminogenic needs of the offender require continual assessment and addressing.

The last decade of the 20th century saw some promising work describing and evaluating the work of psychologists vis-à-vis conditionally released offenders in community settings. Heilbrun and Griffin (1999), describing a number of well-regarded programs in the United States, Canada, and the Netherlands, concluded that there was no single “ideal” program; rather, it was important to use the full range of treatment modalities that have been developed during the past decade. By employing treatments such as recently developed psychotropic medications, psychosocial rehabilitation, skill-based psychoeducational interventions designed to improve relevant areas of deficits, and relapse prevention, it is likely that treatment response in a forensic program will be enhanced. (Heilbrun & Griffin, 1999, p. 270)

Heilbrun and Griffin (1999) provide illustrations of community-based programs in eight states as well as Canada. Most of the programs described provided services to a hybrid population of individuals with mental disorders, including individuals found not guilty by reason of insanity (NGRI) as well as probationers and parolees assigned to treatment programs as a condition of their release or referred by probation/parole officers. Thus, most contacts were on an involuntary basis. Included were both outpatient and residential rehabilitation programs, with outpatient clinics offering both assessment and treatment. Some clinics offering substance abuse treatment also accepted voluntary clients.

In summarizing the programs they describe, Heilbrun and Griffin (1999) note that all emphasized the treatment of psychopathology and the management of aggressive behavior. "In order to meet both goals, programs may refuse to accept high-risk patients, who are generally regarded as more antisocial individuals" (p. 264). Interestingly, it is precisely high-risk offenders who benefit the most from intensive treatment programs.

This is a finding that has consistently emerged from research focusing on the variant of intermediate sanctions known as intensive supervision. Intensive supervision programs (ISPs) were intended for high-risk probationers and parolees who were nevertheless deemed not to require incarceration if a less costly alternative were available. (In reality, low-risk offenders were placed in these programs as well [Tonry, 1990].) Probation or parole officers supervising offenders on ISPs have smaller caseloads, provide around-the-clock team supervision, make frequent contacts, and presumably are less tolerant of any failure on the part of the offender to meet
the conditions of release. Alcohol and illegal drug use are monitored closely and without notice. Despite these punitive conditions, evaluations of community ISPs have not been promising, and they have not proved cost-effective (Gendreau, Paparozzi, Little, & Goddard, 1993; Tonry, 1990).

Gendreau et al. (1994) have proposed intensive rehabilitation supervision (IRS) as a “second-generation” approach to community supervision. “Based on the existing empirical evidence, a persuasive case can be made for abandoning intensive supervision programs that seek only to control and punish offenders in favor of programs that give equal primacy to changing offenders” (p. 74).

Because of their potential for frequent contact with high-risk offenders, IRS programs are likely to be able to match the risk level of offenders with their criminogenic and noncriminogenic needs. Recall that many criminogenic needs are dynamic risk factors or factors that can change over time, such as an individual’s attitude toward authority or employment. Recall also the following comment: “The importance of criminogenic needs is that they serve as treatment goals: when programs successfully diminish these needs, we can reasonably expect reduction in recidivism” (Gendreau et al., 1994, p. 75). Targeting noncriminogenic needs (e.g., anxiety, depression, and self-esteem) is less likely to produce significant reductions in recidivism (Andrews & Bonta, 1994).

Bonta, Wallace-Capretta, and Rooney (2000) conducted an experiment in which they assessed the effectiveness of an intensive rehabilitation approach operating in Newfoundland. The Learning Resources Program (LRP) provides such services to offenders as anger management, a cognitive-behavioral approach to substance abuse, individual counseling, and errors in thinking that might facilitate criminal activity. Bonta et al. compared three groups of offenders, two receiving treatment by the LRP and one receiving no treatment. The two groups receiving treatment were IRS participants and probationers who were chosen by probation officers as needing treatment. The third group consisted of incarcerated inmates who did not receive treatment but who would have been considered eligible for IRS had it been available. In other words, they qualified as high-risk inmates. Results at first showed no significant differences in recidivism between the two treated groups and the nontreated inmate group. However, when researchers divided the groups into high-risk and low-risk participants (using the LSI-R), a significant interaction effect was found. “The high-risk offenders who received relatively intensive levels of treatment showed lower recidivism rates than untreated high-risk offenders (31.6% vs. 51.1%)” (p. 325). In addition, low-risk offenders who received intensive treatment demonstrated higher recidivism than nontreated low-risk offenders (32.3% vs. 14.5%). This last finding did not surprise researchers because prior studies have indicated that low-risk offenders do not seem to benefit by intensive treatment and may, in fact, be hurt by it (Andrews & Bonta, 1998; Andrews et al., 1990).

Gendreau and his colleagues (1994) have identified a number of features associated with the effective rehabilitation of high-risk offenders, including those in the community. For example, the intensive rehabilitation services provided to the high-risk offender should occupy 40% to 70% of the offender’s time for 3 to 9 months. The goal of treatment should be to reduce criminogenic needs—thus obviously necessitating an initial risk/needs assessment. Both the style and the mode of treatment should be matched to the offender’s personality—thus, an anxious offender might work better with a relaxed, calm clinician. Gendreau et al. suggest also that the treating psychologist should advocate for the offender and link the offender with other community agencies, as long as these agencies offer appropriate services.

Thus, Gendreau and his colleagues (1994) have faith in community corrections treatment, particularly if it is targeted specifically at high-risk offenders and uses the intensive treatment approach. “The empirical evidence regarding
ISP’s is decisive: without a rehabilitation component, reductions in recidivism are as elusive as a desert mirage” (p. 77).

This is not to suggest that nonintensive treatment is not effective for low-risk offenders, however. As studies reviewed by Heilbrun and Griffin (1999) have demonstrated, substance abuse treatment and assistance in working toward independent living can be beneficial for motivated low-risk offenders. Programs with strong community ties, written contracts, group meetings, vocational resources, and assistance at tasks of daily living, such as managing money, have garnered positive research results.

**Summary and Conclusions**

The chapter has provided a description of the work of forensic psychologists working primarily with adult offenders (and sometimes with detainees) in both institutional and community settings. We began with an overview of jails and prisons, focusing on distinctions between the two that are most relevant to the psychologist. Because of their short-term nature, for example, jails offer fewer programs and are less likely to enable the psychologist to have long-range treatment goals. Jails also produce crisis situations, such as suicide attempts by detainees. The chapter also included an early review of those legal rights of inmates that are most likely to affect the work of psychologists. The right to treatment, the right to refuse treatment, and discussions of what constitutes cruel and unusual punishment are examples.

The work of psychologists in adult corrections can be divided into the two broad but overlapping areas of assessment and treatment. We reviewed the many situations under which psychologists are asked to assess various abilities of detainees and inmates, as well as their mental states. In recent years, psychology has seen the development of many assessment instruments for use in these forensic settings; studies indicate, however, that psychologists are not making extensive use of these instruments, preferring more traditional measures such as the clinical interview and the MMPI. At a minimum, assessment is needed when inmates enter the facility, before they are released, and when they are in crisis situations. Ideally, though, assessment should be a continuing enterprise and should occur as indicated throughout the inmate’s stay.

The assessment of a death row inmate’s competency to be executed is unlikely to involve the typical correctional psychologist. Nevertheless, this is an area of immense importance and one that has engendered considerable debate. Some psychologists who are philosophically opposed to the death penalty believe they should not be involved in such assessments or in the subsequent treatment that may be needed. Others believe it is their professional duty to offer the services as they are required. Furthermore, because a federal court has now given authorities the go-ahead to force medication on a death row inmate to render him stable enough to be executed, this issue will undoubtedly trouble some clinicians even more. In states where psychologists have or will have prescription privileges, the matter will be especially salient. We did not cover this debate in detail within the chapter, but we discussed suggestions given to those forensic psychologists who conduct competency for execution assessments. With the Supreme Court’s recent decision in *Atkins v. Virginia* (2002), assessments of cognitive ability may become more frequent as well.

Psychologists are only one of several professional groups offering treatment services to inmates, both individually and in groups. The treatment model—or treatment approach—that tends to be the most favored is the cognitive-behavioral approach, although others are also in evidence. Cognitive-behavioral approaches—which have received the most positive evaluation results—are based on social learning theory. They assume that criminal behavior is learned much like other behavior and that the motivated inmates can “unlearn” the behavior. Consequently, these approaches encourage inmates
to identify their thinking patterns, their assumptions, and their expectations and to recognize the consequences of their behavior both on themselves and on their victims. Research indicates that motivated inmates can benefit by these approaches, which are often used with a wide range of offenders, including violent offenders, sex offenders, and substance abusers. Among the least motivated inmates for such treatment are persistent violent offenders and psychopaths, although we hesitate to draw generalizations, particularly about the first group.

Features of the prison and jail settings can present numerous obstacles to effective treatment, so much so that some psychologists prefer not to approach this challenge. Limitations on confidentiality, budgetary restraints, violence and overcrowding within the facility, inmate schedules and inmate transfers, and sometimes lack of support from administrators and correctional officers are not unusual. Yet many psychologists find immense satisfaction performing this work. Professional organizations, such as the American Association for Correctional Psychologists, have offered guidelines and provided support, and increasingly more research is published identifying effective strategies and approaches in a wide variety of situations.

The chapter ended with a review of community treatment programs with offenders who are on probation, on parole, or under intermediate sanctions, such as intensive supervision. In recent years, we have begun to see more descriptions and evaluations of community programs within the psychological literature. Although community programs provide their own special challenges (e.g., offenders not appearing for their treatment session), they also have the advantage of being in a more realistic environment that does not present the numerous obstacles of institutional settings.