

# WHAT IS CORRECTIONAL ABOUT CLINICAL PRACTICE IN CORRECTIONS?

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It is clear that adequate academic and continuing education/training for correctional mental health professionals is imperative if their practice is to be effective. To help shape such training, the clinical and correctional knowledge ranked most meaningful and relevant by psychologists practicing in federal prisons is determined. Overall, results suggest nine core bodies of knowledge representing a mix of clinical (e.g., psychopathology, suicide prevention, psychopharmacology) and prison-based domains (e.g., interdepartmental communications, safety, confrontation avoidance) form the heart of their work. In terms of where such knowledge was obtained, graduate school is frequently endorsed for the more clinical domains, but the correctional domains are transmitted namely through on-the-job training. Recommendations for training psychologists to practice in corrections include the development of a two-tiered training strategy that offers a curriculum in basic psychological knowledge unique to corrections and an advanced curriculum that builds on foundational clinical knowledge obtained in graduate school.

**Keywords:** training; corrections; mental health; psychologist

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The ever-growing need for mental health services in corrections is resulting from an escalation in incarceration rates, the high prevalence of mental illness and substance abuse among offenders, and several decades of social changes that expanded opportunities for mental health professionals in the field of corrections (Bartol & Bartol, 2004; Harrison & Beck, 2004; Diamond, Wang, Holzer, Thomas, & Cruser, 2001; Magaletta & Boothby, 2003; Otto & Heilbrun, 2002). Beyond the application of mental health principles to individuals who “just happen” to be in prison, clinical practice in corrections is a complex enterprise. It requires a keen understanding and broad mastery of the profession’s unique body of knowledge as it is applied in the prison. Considering the salient outcomes in effective clinical practice in corrections (i.e., preventing suicide, self-harm, physical and sexual assault; increasing the likelihood of drug and alcohol recovery and successful community reentry), it is clear that adequate academic and continuing education/training for correctional mental health professionals is imperative (Carter, 1991; Magaletta & Verderyen, 2005).

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Unfortunately, little objective knowledge exists to indicate which core bodies of knowledge should underlie such training. Although academics have a mission partially focusing on generating new and objective knowledge, clinical practice in corrections has rarely been the focus of such knowledge. Equally problematic is the fact that correctional employees typically function under an “action-imperative.” In resolving one crisis after another, they rarely have the time, mission, budget, or human capital needed to generate knowledge regarding effective clinical practices (Kendig, 2004; Magaletta & Boothby, 2003). Adding to this reality are the considerable complexities involved in actually providing, coordinating, or evaluating clinical services in corrections. Offenders display numerous combinations of mental health problems rarely encountered in other settings, and service providers rarely assume just one role. Furthermore, the correctional system itself comprises nested systems, each of which exerts its own unique influence on clinical practice.

Psychologists remain the most frequently employed mental health professional practicing in today’s correctional environment (Camp & Camp, 2000). Studies that have examined such psychologists have mainly focused on their most frequently performed job duties. Since the 1940s, this literature has consistently suggested that psychologists are likely to spend their time providing assessment and treatment to offenders (Boothby & Clements, 2000; Burton, 1948; Corsini, 1945; Corsini & Miller, 1954; Levinson, 1985; Sell, 1955; Silber, 1974; Smith & Sabatino, 1990). More recent research (Boothby & Clements, 2000) has also indicated that administrative tasks consume the largest amount of work time, 30%. Although this literature provides a starting point for understanding the nature of psychologists’ work from a temporal perspective (i.e., what do they spend most of their time doing), the meaning of frequently performed tasks may simply reflect the mandates of policy and the volume of offenders, not the contextual and more nuanced dimensions of the work. Aspects of the work that are important despite their infrequent use remain unexplored, as do those areas that prison administrators expect from their mental health staff, such as the management of risk.

To grow the science in this area beyond analyses of frequently performed job duties, a training survey was developed to obtain a range of relevant, objective information about the knowledge used and training needed by contemporary psychology service providers in the Federal Bureau of Prisons (BOP). The BOP, with more than 187,000 offenders in custody, is now the United States’ largest prison system (Harrison & Beck, 2004). With a doctoral-level hiring standard, the system employs more than 350 psychologists, who provide direct mental health care and consultative services in more than 110 facilities. Facilities range in mission (e.g., detention centers that function like jails and in-house medical centers that provide inpatient medical services) and security level (minimum, low, medium, and high security).

To inform the training, clinical practices, and evaluation techniques used by these BOP psychologists, we empirically examined the core bodies of knowledge that psychologists use in their various roles and duties. In addition, the developmental sequence of training in and for those areas was explored. As such, this work represents an important first step in delineating empirically supported training domains germane to the needs of psychologists practicing in this highly complex environment with one of the neediest mental health populations in the United States.

## METHOD

### PARTICIPANTS

Eligible participants for this study were psychology service providers in all BOP institutions during the summer of 2002 who returned a copy of the training survey.

Of the distributed surveys, 309 were returned, resulting in a 52% return rate. Of the returned surveys, 177 were from doctoral-level psychologists, and 132 were from treatment program specialists. The educational backgrounds and direct services provided by these two groups remain distinct. The present analysis will focus on the frontline mental health/psychology service providers—the doctoral-level psychologists.

A summary profile of all psychologist respondents is provided in Table 1 and reveals adequate representation within each of the professional demographics measured. The modal psychologist who responded to the survey was a licensed, doctoral-level psychologist working at a medium-security facility with about 7.5 years of service. For those psychologists sampled, 38% held a PhD in clinical psychology, another 38% possessed the PsyD in clinical psychology, and 20% had a PhD in counseling psychology. Thirty six percent had completed a predoctoral internship with the BOP and 64% had not. In terms of participants' current positions, there was approximately one third of the sample in each of three core positions: staff psychologist, treatment program coordinator, and chief psychologist.

### INSTRUMENTATION

To conduct this study, the "Federal Bureau of Prisons Training Analysis of Psychology Services and Staff Positions Survey (July 2002)" was created. An expert consensus method was used to generate survey items. Seven senior psychology services staff from the BOP, representing a mix of clinicians and administrators with an average of 16 years with the agency, were recruited for this group. They were asked to construct a comprehensive list of clinical and administrative bodies of knowledge that would characterize the operation of maximally effective psychology service departments. For the purpose of consistency in survey design, these bodies of knowledge were referred to as job functions. Through consensus, similar initial job functions were combined to form a final list of 41 functions. Next, individual items to define each job function were created. These too were refined and combined through consensus until 96 individual items tapping the 41 job functions were agreed on.

Next, two measurement structures, training and descriptive, were created and applied to each job function. Respondents were asked to provide information regarding these structures as they related to their current positions. In the training structure, respondents were asked to indicate the points during their education at which they had received (if at all) training in a job function. Response options included graduate school, internship, post-graduate BOP-sponsored new psychologist training, continuing education, on-the-job, and no training.

In the descriptive structure, information was gathered on three questions for each individual item in the survey. These questions, called importance, frequency, and risk (IFR), allowed for each knowledge domain to be simultaneously assessed from multiple vantage points. In this way, IFR served as a three-dimensional model from which training goals and priorities could be identified. Each of the IFR questions was scaled along a 5-point Likert-type index

**TABLE 1: Profile of Psychologist Respondents (N = 177)**

	<i>Percentage</i>	<i>Frequency</i>
Position title		
Chief psychologist	31.1	55
Treatment program coordinator	32.2	57
Staff psychologist	31.1	55
Direct clinical training	4.0	7
Forensic examiner	1.7	3
Degree held		
Clinical (PhD)	38.4	68
Clinical (PsyD)	37.9	67
Counseling (PhD)	19.2	34
Clinical/counseling (EdD)	2.8	5
Predoctoral BOP internship?		
Yes	36.0	59
No	64.0	105
Licensed?		
Yes	73.4	130
No	26.6	47
Less than 1 year		
1 to 5 years	4.5	8
6 to 10 years	34.5	61
11 to 15 years	33.9	60
16 or more years	18.6	33
16 or more years	7.9	14
Facility type		
Maximum	2.8	5
High	8.5	15
Medium	33.9	60
Low	22.6	40
Minimum	11.9	21
Admin/medical referral	11.3	20
Admin/detention	8.5	15

Note. BOP = Federal Bureau of Prisons.

(from 0 to 4). The importance question read, "How important is this [job function] in your current position? How central is this knowledge, skill, or ability in fulfilling your role or completing the tasks assigned to you?" and was scored 0 = *no importance*, 1 = *blank*, 2 = *average importance*, 3 = *blank*, and 4 = *greatest importance*. The frequency question read, "How frequently do you use this [job function] in your current position?" and was scored 0 = *never*, 1 = *quarterly*, 2 = *monthly*, 3 = *weekly*, and 4 = *daily*. The risk question read, "How risky/critical is this [job function]? In your current position, to what degree would it compromise the safe and orderly running of an institution if the knowledge were lacking or ability/skill were deficient/negligent?" and was scored 0 = *low risk*, 1 = *blank*, 2 = *moderate risk*, 3 = *blank*, and 4 = *high risk*.

#### PROCEDURE

A research team located in the Psychology Services Branch of the Correctional Programs Division designed, distributed, and collected the survey by mail in the summer of 2002. Approximately 595 surveys were distributed in packets to 99 institutions. Each packet was addressed to the chief psychologist of the institution's psychology services

department. A cover letter was enclosed that invited the chief to participate voluntarily in the anonymous survey and to invite all treatment staff (doctoral-level psychologists and nonpsychologist correctional treatment program staff) to complete the enclosed surveys as well. Treatment staff included doctoral-level psychologists and non-psychologist correctional treatment program staff. The latter staff are nondoctoral providers, usually substance abuse treatment specialists.

Several data analytic strategies were used to create manageable, parsimonious, and meaningful units of analysis and thus meet the primary objective of identifying job functions most salient in terms of IFR. In the interest of parsimony, once the internal consistency of the individual-level items was obtained, item-level measurements were aggregated within each job function by using participants' mean ratings for each of the IFR measurement dimensions. These job function-level mean scores for each category were then rank ordered, and the top 10 most important, most frequently used, and highest risk (conceptualized as the most critical) bodies of knowledge were retained for the next level of analysis.

Next, one-sample *t* tests were used against the grand means of the top 10 job functions within each IFR 10 job functions to help identify the items that stood out as being the most important, frequently used, and critical. In other words, individual job function means were compared to the overall mean for the top 10 functions within each IFR category. Job functions ranked as more important, frequently used, or riskier than the grand means of the top 10 functions in the respective IFR category were selected for inclusion as a core body of knowledge. In addition, to determine if operationally meaningful trends existed in the data, job functions that were simultaneously endorsed in each of the top 10 IFR, regardless of whether they emerged as significantly higher than the grand mean of the top 10 items in any IFR categories, were also selected for inclusion as a core body of knowledge. Once each core body of knowledge was selected, the types of training received for each was explored.

## RESULTS

### CORE BODIES OF KNOWLEDGE

Overall, 9 of the original 41 job functions emerged as core bodies of knowledge. The titles of the core bodies of knowledge are listed in Table 2, and the individual items that made up each core body are delineated in Table 3. The two core bodies of knowledge rated as most important were psychopathology and suicide prevention (for means higher than the grand mean of the top 10 job functions in the importance category, see Table 2). Psychopathology and interdepartmental communications/relationships were tapped almost daily and were the most frequently used core bodies of knowledge (for means higher than the grand mean of the top 10 job functions in the frequency category, see Table 2). Environmental factors (special housing unit; SHU),<sup>1</sup> suicide prevention, psychopathology, safety, and confrontation avoidance were the top job functions in the risk category (for means higher than the grand mean of the top 10 job functions in the risk category, see Table 2). Participants indicated that these were the areas most likely to compromise the safe and orderly running of an institution if in their current position the knowledge were lacking or ability/skill were deficient/negligent.

**TABLE 2: Means (SDs) for Top 10 Rated Items Within Importance, Frequency of Use, and Risk Categories for Various Job Functions**

	<i>Importance [GM = 3.53 (.22)]</i>	<i>Frequency of Use [GM = 3.08 (1.14)]</i>	<i>Risk Level [GM = 3.19 (.35)]</i>
Psychopathology <sup>a</sup>	3.80 (.42) <i>t</i> = 8.63	Psychopathology <sup>a</sup>	Environmental issues/SHU <sup>a</sup> 3.64 (.63) <i>t</i> = 11.60
Suicide prevention <sup>a</sup>	3.80 (.44) <i>t</i> = 8.26	Interdepartmental	Suicide prevention <sup>a</sup> 3.34 (.85) <i>t</i> = 4.03
Environmental issues/SHU	3.61 (.85) <i>t</i> = 1.32	Cross-cultural issues	Psychopathology <sup>a</sup> 3.13 (.99) <i>t</i> = .64
Safety issues	3.61 (.68) <i>t</i> = 1.62	Clinical management	Safety issues <sup>a</sup> 3.05 (1.11) <i>t</i> = -.41
Ethical issues	3.58 (.64) <i>t</i> = 1.08	Medical/psychopharmacology	Confrontation avoidance <sup>a</sup> 3.03 (.81) <i>t</i> = -.84
Confrontation avoidance	3.52 (.72) <i>t</i> = -.19	Environmental issues/SHU	Clinical psychopathy 3.02 (1.13) <i>t</i> = -.67
Medical/psychopharmacology	3.42 (.69) <i>t</i> = -2.06	Cognitive behavioral	Ethical issues 3.00 (1.08) <i>t</i> = -1.02
Screening/assessment/testing	3.31 (.68) <i>t</i> = -4.38	Appropriate services	Self-mutilation 2.99 (1.03) <i>t</i> = -1.17
Clinical psychopathy	3.23 (.80) <i>t</i> = -4.93	Ethical issues	Medical/psychopharmacology 2.88 (.99) <i>t</i> = -2.71
Self-mutilation	3.19 (.92) <i>t</i> = -4.83	Clinical psychopathy	Screening/assessment/testing 2.80 (1.03) <i>t</i> = -3.58

Note. *N* = 177 participants who were not psychology treatment program specialists. SHU = special housing unit.

a. Items were significantly higher than the grand mean (GM) for the top 10 items in that category (one-sample *t* tests).

**TABLE 3: Individual Item-Level Means and Cronbach Alphas Among the Nine Core Bodies of Knowledge**

<i>Job Function</i>	<i>Item</i>	<i>Importance</i>		<i>Frequency</i>		<i>Risk</i>	
		<i>M</i>	<i>Alphas</i>	<i>M</i>	<i>Alphas</i>	<i>M</i>	<i>Alphas</i>
Psycho pathology	Knowledge of the signs and symptoms of mental disorders commonly found in correctional populations	3.86	.67	3.68	.85	3.58	.87
	Knowledge of how the correctional environment affects the symptom presentation of mental disorders	3.74		3.60		3.49	
	Knowledge of how to identify and assess a suicidal individual	3.94	.83	2.86	.93	3.77	.86
	Knowledge of how to treat a suicidal patient	3.89		2.60		3.74	
Suicide prevention	Knowledge of how to document the risk assessment process	3.65		2.50		3.26	
	Knowledge of how to conduct the appropriate follow-up	3.73		2.47		3.43	
	Knowledge of the psychologist's role in managing mentally ill inmates in SHU	3.61	n/a	3.02	n/a	3.59	n/a
	Knowledge of various departments (i.e., unit management, religious services, correctional services), their policies and procedures (i.e., reviewing Lt. Log, standing mainline), and how these interact with the psychology services mission	3.13	.85	3.40	.79	2.47	.90
Environmental factors/SHU Interdepartmental communications/relations	Knowledge of how to collaborate with other institution departments to maximize the delivery of psychology services	3.23		3.27		2.49	
	Understanding the need for self-protection strategies when applying psychology interventions to inmates with violent histories	3.58	.93	2.42	.89	3.47	.94
Safety	Knowledge of clinically appropriate responses to threatening or intimidating offender behaviors	3.64		2.23		3.48	

(continued)

TABLE 3: (continued)

<i>Job Function</i>	<i>Item</i>	<i>Importance</i>		<i>Frequency</i>		<i>Risk</i>	
		<i>M</i>	<i>Alphas</i>	<i>M</i>	<i>Alphas</i>	<i>M</i>	<i>Alphas</i>
Confrontation avoidance	Knowledge of BOP policy on the “use of force” model The ability to intervene with an inmate to avoid further confrontation	3.36	.79	1.78	.81	3.30	.89
		3.68		2.18		3.47	
Ethical issues	Knowledge of the most common ethical issues faced by psychology services staff in a correctional setting (e.g., limits of confidentiality regarding inmate information and confidentiality of staff EAP contacts) Understanding the most appropriate way of dealing with ethical dilemmas	3.58	.89	3.00	.86	2.90	.95
		3.58		2.75		2.86	
Medical/psychopharmacology	Understanding how to use psychiatric consultation with an offender population	3.50	.81	2.99	.82	2.95	.87
		3.35		3.06		2.70	
Clinical psychopathy	Understanding the categories of psychotropic medications Knowledge of the psychopathy construct Knowledge of psychopathy’s correlation with violence	3.24	.91	2.83	.97	2.91	.97
		3.24		2.77		2.93	

Note. SHU = special housing unit; BOP = Federal Bureau of Prisons; EAP = employee assistance program.

Among this aforementioned list of statistically significant job functions, six remained unique (psychopathology, suicide prevention, interdepartmental communications/relationships, environmental factors [SHU], safety, and confrontation avoidance). Psychopathology actually appeared in each IFR category, and suicide prevention appeared in the importance and risk categories. Thus, there were only six statistically significant job functions that were retained among the core bodies of knowledge and examined in subsequent analyses.

To further determine if nonstatistically significant but operationally meaningful trends existed in the data, job functions that were simultaneously endorsed across each of the top 10 IFR categories were captured. Overall, three knowledge bases met these criteria and were added to core bodies of knowledge: ethical issues, medical/psychopharmacology, and clinical psychopathy.

The item-level measures for the core bodies selected were generally highly consistent within the core body of knowledge and IFR categories. Table 3 presents item-level labels, mean scores, and Cronbach's alpha scores among items within the core body of knowledge and IFR category for the nine core job functions.

## TRAINING

After the core bodies were selected, the types of training received for each area were explored (see Table 4). The frequency endorsement for each type of training is provided and reveals that along the educational continuum from graduate school to continuing education at the postdoctoral level, most psychologists had some exposure to each of the core bodies, and that regardless of the core body content, on-the-job training (OJT) was the most frequently endorsed training modality. It is interesting to note that graduate school exposure was reported by at least 75% of the sample in the areas of psychopathology, suicide prevention, ethical issues, medical/psychopharmacology, and clinical psychopathy. For areas requiring a keener understanding of the prison environment (environmental factors/SHU, interdepartmental communications, safety, and confrontation avoidance), the mean level of exposure in graduate school was 20%.

## DISCUSSION

Findings from this study provide a basic empirical answer to the question, "Just what is correctional about clinical practice in corrections?" At least in part, the answer is the prison environment itself. The core bodies reflect the reciprocal influence of individual-level psychopathology and the correctional environment in the day-to-day clinical practice of correctional psychology. These discrete bodies of knowledge can serve to shape the training of those who wish to enter clinical practice in corrections or have already begun their public service careers in corrections.

At the center of the psychologist's work, only one core body of knowledge was statistically significant in each of the three IFR categories. Psychopathology was statistically distinguished from other core bodies of knowledge by being of greatest importance, being used daily, and being of high risk when knowledge in that area was absent. It is clearly the body of knowledge around which much of the BOP psychologists' work is organized. Indeed, many of the other knowledge bases selected (e.g., suicide prevention, environmental factors/SHU,

**TABLE 4: Psychologist's Training Background Percentages for the Nine Core Bodies of Knowledge (N = 177)**

	<i>Grad School</i>	<i>Intern</i>	<i>New Psychology</i>	<i>Continuing Education</i>	<i>On the Job</i>	<i>None</i>
Psychopathology	93.8 (166)	91.0 (161)	41.2 (73)	90.4 (160)	81.4 (144)	0.6 (1)
Suicide prevention	85.9 (152)	85.3 (151)	79.1 (140)	78 (138)	87.6 (155)	0.0 (0)
Environmental issues (SHU)	14.1 (25)	34.5 (61)	39.5 (70)	9.0 (16)	80.8 (143)	5.1 (9)
Interdepartmental communications/relations	23.7 (42)	38.4 (68)	22.0 (39)	12.4 (22)	89.9 (159)	9.0 (16)
Safety issues	19.2 (34)	41.2 (73)	31.6 (56)	21.0 (37)	87.0 (154)	5.1 (9)
Confrontation avoidance	23.7 (42)	36.2 (64)	22.6 (40)	20.9 (37)	87.6 (155)	7.3 (13)
Ethical issues	96 (117)	82.5 (146)	7.8 (120)	81.9 (145)	66.1 (117)	0.0 (0)
Medical/psychopharmacology	76.3 (135)	70.6 (125)	8.5 (15)	66.7 (118)	81.4 (144)	2.3 (4)
Clinical psychopathy	80.2 (142)	72.3 (128)	29.9 (53)	76.8 (136)	75.1 (133)	2.3 (4)

*Note.* SHU = special housing unit.

psychopharmacology) are conceptually linked to a deep understanding of psychopathology. An examination of the item-level comparisons and alpha coefficients in this core body of knowledge reveals that similar weights were applied to the importance, frequency, and risk for understanding mental disorders and understanding the correctional environment in which they are manifested. This finding reiterates the necessary link between clinical- and prison-based knowledge for clinical practice in corrections.

Overall, the finding that the knowledge of psychopathology is important and frequently used in the correctional environment is of little surprise. Once thought of as an indicator of "special need," the presence of psychopathology in correctional populations has actually become one of their defining features. A recent summative review on the topic suggested that the prevalence of mental illness in prisons is higher than in the community and that comorbidities are common (Diamond et al., 2001). With psychologists increasingly involved in the biological aspects of mental health treatment, psychopharmacology was also found in each of the top 10 IFR rankings. Given that psychologists continue to serve as liaisons in prison psychiatry clinics through telehealth (Magaletta, Fagan, & Ax, 1998) or with psychiatrists consulting directly in BOP institutions (Morgan, 2003), the need for and interest in this knowledge is only expected to increase. Furthermore, Fagan et al. (2004) recently found that interns and training directors (combined) in correctional settings were more interested in pursuing prescription privileges than their counterparts in other surveyed internship programs (e.g., at Veterans Affairs Medical Centers). Not coincidentally, Ax and Morgan (2002) found that most BOP internship programs were already offering training in psychopharmacology, highlighting an increasing ability to meet training with need and interest.

An interesting pattern emerged when considering the IFR pattern for interdepartmental communications/relations. Although it is not even ranked in the top 10 for importance or risk, it makes a statistically significant entry with its weekly use. Knowledge of the prison environment and its interrelated systems (Magaletta et al., 1998) is used daily and remains an essential resource for carrying out or supporting the content of other important and/or risky work (e.g., suicide prevention and working in segregation).

Ranked among the most important and riskiest bodies of knowledge, suicide prevention remains a major focus of BOP psychologists' work. Every year, psychologists train all new and existing staff in the identification and referral of suicidal inmates. During the 5-year period from 1999 to 2003, the number of completed suicide risk assessments rose 32%. In 2005, BOP psychologists completed more than 4,100 suicide risk assessments and 1,700 suicide watches.<sup>2</sup>

The core body of knowledge ranked highest in the risk category was environmental factors, or knowledge of managing the mentally ill in SHU. This finding again highlights the degree to which an understanding of both psychopathology and the correctional environment itself undergird clinical practice in corrections. Given the historical trend of completed suicides and other acting-out behaviors often witnessed in segregation units (Rhodes, 2004), it is not surprising that this knowledge base entered through the risk category. The risk management work that psychologists perform in segregation remains most crucial to prisons' dual mission of custody and care. More than any other, it is their work in SHU that distinguishes psychologists as specialists and requires the use of their unique training and knowledge (Magaletta, Ax, Patry, & Dietz, 2005).

Confrontation avoidance was measured along two risk-related dimensions in this study. One definition was the first step in the progressive use of force model: active listening/verbal

communication/crisis intervention. Because most use of force occurs in segregation units (Collins, 2004), this core body is thought to link very closely to segregation knowledge. The second item tapping confrontation avoidance dealt more globally with knowing how to intervene with an inmate to avoid further confrontation. At this more general level, confrontation avoidance suggests a quality, process, or aspect of effective management and treatment conducted with offenders.

Conceptually linked to this second definition of confrontation avoidance and again through the risk category was safety. When confrontation avoidance is effective, it prevents harm to staff and inmates and assists in maintaining the orderly running of the institution. An examination of the item-level comparisons and the high alpha coefficients suggests that psychologists conceptualize safety along both clinical and custodial lines, just as they do confrontation avoidance. Consistent with previous and more recent literature, safety is conceptualized as an important risk area even among psychology graduate students who are considering working at a secure facility (Morgan, Beer, Fitzgerald, & Mandracchia, in press; Norton, 1990). It is interesting that safety is one of the most salient factors leading to job satisfaction among correctional psychologists (Boothby & Clements, 2002).

Consistent with their status as mental health care professionals and their assumption of a public trust, BOP psychologists clearly identified ethics as a core body of knowledge. Clinical practice in corrections presents several unique professional features (Dignam, 2003), including multiple roles, and psychologists continue to endorse an understanding of ethical issues and how to resolve them for its importance, frequency of use, and risk if absent.

#### **TRAINING AND BUILDING KNOWLEDGE FOR CLINICAL PRACTICE IN CORRECTIONS**

The data clearly show that those entering clinical practice in corrections can be expected to arrive with solid academic exposure to core clinical areas such as psychopathology, suicide prevention, psychopharmacology, psychopathy, and ethics. For these clinicians, the "already received" academic training/exposure areas should be reinforced with specialized training. This may be conceptualized as moving from the mastery of knowledge to the application of skills for effective correctional practice. For example, clinicians could build on knowledge of standard suicide risk markers. They could be taught to query correctional staff as part of the suicide risk assessment process and to investigate if the offender has been giving away their possessions, a behavior recognized as a suicide risk factor in correctional work.

It does appear that aspects of graduate school curriculums are tapping and exposing students to areas of knowledge relevant to correctional work. For faculty and students interested in correctional work, these aspects can be highlighted and condensed to form a specialized course of study. In addition, for those students already involved in a correctional practicum or predoctoral internship, didactics might be revised to align with, emphasize, and build on the core domains outlined in this study.

A second trend seen in the training data was observed for areas more central to working in the prison environment, such as managing the mentally ill in segregation, confrontation avoidance, and staying safe on the job. For these areas, low reported rates for the more formal training (i.e., academic or continuing education training) and very high rates of OJT were observed. In fact, less than 25% of the sample received exposure during graduate school for any of these areas. This finding warrants further consideration and suggests that

at least some of the knowledge needed for clinical practice in corrections is generated and transmitted by the prison itself. That is, although psychologists may understand the importance of this work and the risk related to it, they actually gain the knowledge by doing the work. For better or for worse, this knowledge is transmitted experientially as they use first-hand experience as the vehicle for learning.

Beyond the uniqueness of the prison environment itself, another possible reason for the heavy emphasis on experiential learning is that very little formal textbook knowledge or research concerning best clinical practices in this environment exists. For example, no published studies have been found in the literature of psychology, criminology, or sociology that dictate the use of particular assessment tools or intervention techniques within a segregation unit. In essence, those providing services in this highly specialized environment must rely largely on experience and clinical impression that are neither supported nor refuted on scientific grounds.

To meet the challenges that this poses, it is imperative that psychologists involved in correctional work become increasingly involved in the development of such knowledge and flowing from that, its dissemination through continuing education workshops, pre-employment training, and written media.

Our findings are not suggestive of a comprehensive and exclusionary list. In fact, many of the services delivered in the prison that did not make it into the top IFR categories have ample evidence of being performed routinely by BOP psychologists. What have been captured in this study's approach are the critical domains of practice seen through the eyes of clinicians. That being said, it can still be observed that several seemingly critical bodies of knowledge included in the survey remained absent from the nominated core bodies list and warrant further discussion.

First, the judicious use of OJT and the absence of "supervision" as a nominated core body of knowledge are notable. More specifically, the question of who is providing the OJT and whether this actually represents formal or informal supervision and/or mentoring needs to be explored. This point is particularly salient, as an examination of Table 4 clearly reveals that OJT is the premier ongoing modality for all training areas.

Given the discipline of psychology's increased interest in what is termed *forensics* (Boothby & Clements, 2002; Morgan et al., in press; Otto & Heilbrun, 2002), it was interesting to note that forensics was not nominated to any of the top 10 IFR categories. Consistent with previous literature (see Ax & Morgan, 2002; Magaletta & Verdeyen, 2005), there are distinctions and differences between what is termed *forensics* and clinical practice in corrections. It may be useful for graduate training departments to give further consideration to this distinction. Although forensic psychology is the point where psychology intersects with the law, clinical practice in corrections represents the plane of psychology services needed through an offender's entire incarceration. It is graduate students' mastery of core clinical concepts, subsequently applied in the unique prison setting, that will yield effective service to such offenders.

Last, not one of the core bodies of knowledge was administrative in nature. This was curious, particularly in light of the Boothby and Clements (2000) work suggesting that administrative duties were allocated the most amount of time in a workday. One implication of this observation is that all psychologists, including chief psychologists who are involved in many administrative tasks are engaged daily in clinical tasks despite their human resource designation as managers. It would be an error to assume that they carry no clinical load or are the equivalent to other similarly paid administrators who perform only administrative tasks.

Several caveats concerning the present study's data and design are warranted. Although the summative review of participants suggests equal representation across numerous professional demographics, it remains unclear how representative they are of all BOP psychologists. Findings should also be interpreted with a reminder that they might not extrapolate to other jurisdictions (e.g., state prisons) or types of facilities (e.g., jails or half-way houses). In addition, because personal demographics (e.g., ethnic identifications, age, gender) and institutional social climate were not known, it is hard to determine if professional demographic differences actually represent differences in personal demographics or institutional practices among prisons. Finally, conceptual similarity among the 41 original job functions may have resulted in a lack of sensitivity to the differences among them. Future research efforts should address these limitations while expanding the scope of sampling to include mental health professionals working in state facilities and jails as well as those working with particular populations (e.g., females, juveniles, lockdown units).

These caveats notwithstanding, a matrix of knowledge has been constructed for clinical practice in corrections. Being informed by a constellation of knowledge reflecting the reciprocal influence of individual-level psychopathology and the correctional environment, the knowledge that informs clinical practice in corrections can be described as ecological. The master correctional psychologist draws on knowledge of the individual (e.g., psychopathology, psychopathy), the environment (e.g., segregation, other departments), and the processes between the two (i.e., how to stay safe, resolve ethical dilemmas, conduct suicide risk assessments). Delineating and organizing these core bodies of knowledge allows psychologists to define empirically what they know and what they do, thus providing an effective way of communicating the exact nature of their competencies to others (Kaslow, 2004). The task ahead is to develop these concepts and applications empirically so we can better prepare the psychologists and service delivery systems of our collective future.

## NOTES

1. Known by different names in different prison systems (e.g., lockdown, secure housing unit, segregation unit), a federal SHU typically maintains protective custody, administrative, disciplinary, and "in-transit/holdover" populations in a 23-hr lockdown environment. These units are not to be confused with supermax facilities, which can be thought of as maximum security, mission-specific prisons.

2. These frequency data are drawn from an electronic mental health record system used by psychology service providers in the BOP, the "Psychology Data System, PDS."

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