Vol. 12, No. 1 January 2005

Crime Scene

Psychology Behind Bars and In Front of the Bench

The Official Organ of Criminal Justice Psychology of the Canadian Psychological Association

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What's Inside

The Editor's Note

2005 and cold. Technically, I think it is bad form to be Canadian and complain about the cold. However, it is a good reason to stay in-doors and get some work done. The first thing that I hope you notice is that we have moved to an Adobe Acrobat format. Some of you had suggested this and it took us awhile to get up to speed with the right software but here it is.

Your Section Executive has gone through the review process for the posters and symposia proposed for Montreal this June. There was a huge number of submissions which will no doubt make for an excellent educational opportunity this summer.

This month Crime Scene kicks off with a guest spot by Bob Ax in Daryl's editorial space. The topic is RxP. Our colleagues to the south have made a full-court press to obtain prescription privileges particularly to help with under-served clientele. With the advent of nurse practitioners in Canada who have been granted increased direct medical responsibilities and authorities coupled with governments seeking to provide more cost effective medical and mental health services, a discussion of RxP is timely for us here in Canada.

In addition to Dorothy Cotton's clinical insight we have a contribution by Ivan Zinger on Human Rights and Actuarial Risk Assessment. Karl Hanson provides us with some valuable information on the relationship of age with sexual re-offending. Marlo Gal provides us with a synopsis of her work on stress within the correctional staff ranks.

I also want to let you know that the Section has grown 11% over the past two years. This is great news so continue to pass on those Crime Scene's to friends and encourage them to join.

JFM

View from the Top

Daryl Kroner, *President*

"The trouble with normal ... it always gets worst"
Bruce Cockburn.

I can't recall which album (younger readers, sorry for the antiquity) this lyric comes from, but point is straight forward. As a profession in criminal justice, we need to be moving forward. To help facilitate this, I have asked Bob Ax to write the Chair's column.

Bob Ax is a licensed psychologist in Virginia, USA. He is a fellow of the American Psychological Association (APA), and has served as both chair of the Criminal Justice Section and president of APA's Division 18 (Psychologists in Public Service). He welcomes your comments at shrinkart@aol.com. You will also have an opportunity to meet him, as he is planning to attend Montreal CPA.

Guest Editorial

Prescription Privileges for Correctional (and Other) Psychologists

by

Robert K. Ax, Ph.D.

I would like to thank Dr. Daryl Kroner for inviting me to write this article. I am pleased and honoured to be a new member of the Canadian Psychological Association and its Criminal Justice Section. There's a great deal I would like to say about prescriptive authority for psychologists (RxP), but here I'll make just a few important points:

Point #1: I believe that prescriptive authority for properly trained psychologists is beneficial for underserved patients, e.g., those in prisons and jails, public hospitals, and on Indian reserves.

I have worked in corrections since 1983, and became an advocate for RxP after being sued in a medication malpractice case 12 years ago. My job involved consulting with our part-time psychiatrist and I was in the room when the patient in question was seen. The suit was eventually dismissed, but it led to an epiphany: Despite my best efforts, it was impossible to maintain clear boundaries between psychiatry's and clinical psychology's areas of expertise and practice in my work setting. After all, the psychiatrist was only at the prison a few hours a week, and therefore had no real sense of the environmental factors impacting patients beyond what they and I could impart in the few minutes available. Nor did that particular individual believe in educating patients. When I prompted them to ask questions about their medications, he often scowled at me (which made me do it more). Inmates in the clinic ordinarily had one appointment every eight to ten weeks, and in the psychiatrist's absence, they came to psychologists with problems about their medications, partly because we were easily accessible, and partly because some of our physicians were uncomfortable dealing with psychotropics.

Perhaps you have had similar experiences. In all probability, you have been frustrated at times by the unavailability of psychiatrists when a patient needed a consultation. I have spoken with colleagues who work in veterans' and state hospitals or with Native American populations, and the clear sense is of a need for readily available, competent prescribing professionals. Psychologists working in these settings can do the job. We are already well trained in psychodiagnosis, certainly more so than the non-psychiatrists who write the great majority of prescriptions for psychotropics in the United States. Those who received the additional training and certification could offer their patients psychotherapy and/or pharmacotherapy as appropriate. In advocating for RxP, I am not suggesting that we abandon our traditional competencies rather that we permit those of our colleagues who want RxP to obtain it, so they can complement testing and psychotherapy with medication.

The RxP issue is particularly critical for patients in correctional facilities. They are the most devalued of society's charges, and have often, as a result of the ongoing transinstitutionalization phenomenon, previously been denied access to mental health care in other, less restrictive service settings.

Point #2: *You* believe that prescriptive authority for properly trained psychologists is desirable.

I initially felt somewhat uncomfortable with the idea of guest-writing this column. I didn't want to seem like some buttinski imposing my ideas on an organization I had just joined. Therefore, I was relieved to read the data in St-Pierre and Melnyk's (2004) survey. Prescriptive authority is actually an issue Canadian psychologists care about and which most of those surveyed supported. Further, the majority of respondents thought the training was obtainable, that CPA should support the RxP initiative, and that the attainment of RxP would *not* compromise the delivery of psychological services. However, the data reflected a certain pessimism with respect to the probability that Canadian psychologists would ever attain RxP. Most thought not, which brings me to Point #3.

Point #3: Prescriptive authority is a feasible goal. It's *do-able*!

Don't take my word for this. Wallis and Wedding (2004) provide an excellent account of the lessons our profession can learn from optometry's ultimately successful struggle to win the authority to prescribe therapeutic drugs in the United States. Optometrists did it, and so can we.

Two American states, New Mexico and Louisiana, and the US Territory of Guam have passed prescribing bills to date. By the time you read this, a large group of prescriptive authority

advocates, including several from Canada, will have met to plan the next phase of the initiative, one that will coordinate efforts within and between our respective nations. No question: Gaining RxP will be tough and costly. Organized psychiatry will fight us every step of the way, but down here in the States, we've made a commitment to go for it and there's no turning back now. I believe that CPA and APA can and should work together to make the way easier in both our countries.

Point #4. Prescriptive authority is good for the profession.

Doing good and doing well are not mutually exclusive. Our first responsibility is to do good and if we survive and perhaps even thrive as a result, that's just fine with me. That said, I don't believe that prescriptive authority will save the profession or make us rich. It is simply one of the next steps in the evolution of psychology as a science-based health care profession.

I *do* believe that failing to evolve in accordance with the dictates of science and the needs of patients will render the profession obsolete in the long run. In my agency, old barriers are falling: all of us are being drafted, as it were, into service as health care providers, in a constant effort to maximize the utilization of available resources to treat a growing, aging, and increasingly impaired population. For example, all employees must be certified in cardiopulmonary resuscitation (CPR) and all lieutenants must be qualified in the use of automated external defibrillators (AEDs). Correctional counsellors are now required to run psycho-educational groups (which often morph into something more like what I would call psychotherapy) as part of their job requirements. Well-funded, faith-based rehabilitation programs are now being implemented, including one at my facility.

We must acknowledge the fact that non-doctoral providers have gained a foothold in the mental health care marketplace, in many cases providing the kinds of services we did previously. For those who think a basic retrenchment is in order, that we should "go back to the basics and simply do what we do well," i.e., testing (a litany I have been hearing for nearly 25 years), consider that the more static and definable a job is, the easier it will be to modularize or "manualize" it and give it to someone else to do.

My own guild concern is on behalf of future generations of psychologists. I used to be the training director of a pre-doctoral internship program, and every year, I would hear more concerns from interns about their student debt loads. Beyond the well-being of underserved patients, I want to help create a market niche for psychologists who will practice over the next several decades. RxP is part of a viable future for the profession.

As Nicholson (2004) noted, the training and practice environment for psychology is also changing in Canada. Hospital internships are closing. There is the looming prospect of an influx of doctoral-level students due to the higher standards for independent practice now mandated in Quebec and the possible introduction to Canada of Psy.D. programs. Where will all these students find internships? (Quick sidebar: What about starting internship programs in correctional facilities?) Where will they find jobs afterwards? The profession can change with the times or be changed by them. Seeking RxP is an appropriately proactive step on our part.

Ultimately, there is no compelling argument that can be made on behalf of prescriptive authority to those who are firmly entrenched in their opposition. However, those individuals are part of a shrinking minority, and the momentum is with the RxP initiative. Let's work together to accomplish this worthy goal, and if you can't support RxP, please don't oppose it. Let those who want it go for it. It's a good thing for our patients and our profession.

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In The Trenches: the practical experience of forensic and correctional psychology.

By Dorothy Cotton, Ph.D.

I have to say, I really like the new WAIS-III. I suppose it really isn't that new anymore, but for those of us who have been through various incarnations of Wechsler Tests, it has some pretty nifty features. For one thing, you can computer score it. I suspect this helps cut down on measurement error significantly. The person who originally trained me to administer tests always said "the most common cause of mental retardation is scoring error."

But aside from the practicality, I really like the factor scores. The old verbal/performance IQ's were pretty messy and you were never quite sure what you were getting. It really helps to be able to get at aspects of cognitive function that are little "purer" and thus give you a little more direction about where to go clinically.

I was assessing a guy the other day who provided a good example. He was involved a high intensity sex offender program and the people running the group could not put their finger on it, but he just didn't seem to quite "get it" much of the time. He seemed bright enough--reasonable educational background, no history of learning disability, well-spoken--seemed to have a good vocabulary. At first they thought it was a memory problem as he was always asking people to repeat things. But subjectively, his memory seemed fine. What was the problem?

So they sent him to me. I did a bunch of tests but the first clue came from the WAIS-III and it seemed to hit the nail on the head. He was high average in almost all areas--except processing speed. There, he was at the low end of low average.

A little light bulb went off in my head. He just couldn't keep up to the group.

The rest of the assessment pretty well bore out this observation. He was very verbal and well able to express himself. In spite of a previous head injury, his memory on testing was fine, in almost all aspects. All the spatial and perceptual scores were fine. He even did well on measures of frontal lobe/executive function kinds of things. It just took him a little longer to do things. It took him longer to do the cognitive part of information processing, and it took him longer to make a motor response.

I asked him about his tendency to ask people to repeat things. He looked a little sheepish and confessed it was just a way to buy time. It turns out that he was quite aware that his mind seemed to work a little slower than other people's. He described that when he was in a group and he was asked a question, he needed a few seconds to understand the question and to formulate a response. He was too embarrassed to say something like "Wait...wait..it's coming...hold on..." so he would just ask people to repeat things.

I will point out that had I simply looked at the VIQ and PIQ I would not have found this little anomaly.

I spent a few minutes with this gentleman when we were finished the assessment, talking about the ways he had learned to cope with his "slowness" and I suggested a few other things he might try. I also spent some time with the people running the group, talking about how to adjust things a little to make sure that he keeps up. Whenever possible, they give him a little "heads up" before he is asked to respond to a question. Last I heard, things were running a little more smoothly.

But this individual really did make me stop and think about the whole responsivity issue with offenders. All of our programs tend to be cognitive behavioural--and thus, based on learning theory. Learning theory presupposes (duh) you are able to learn. That is not the case for many of the people we work with in forensic and correctional settings. Whether it is because of a major mental illness, a head injury, or simply the luck of the draw, many of these folks have some cognitive impairment. It just helps to remember that!

Actuarial Risk Assessment and Human Rights: A Commentary

Ivan Zinger, LL.B., Ph.D.
Carleton University

In recent years, criminal justice professionals have increasingly endorsed actuarial measures of risk as the most reliable predictive instruments for decision-making (Ericson & Haggerty, 1997; Hanna-Moffat & Shaw, 2001). The poor performance of clinical judgement (i.e., determination of risk based on professional opinion and expertise) in predicting criminal behaviour compared to actuarial risk assessment is by now well documented (Bonta, Law & Hanson, 1998; Grove & Meehl, 1996; Grove, Zald, Lebow, & Nelson, 2000). Some have even argued that failure to conduct actuarial risk assessment or consider its results is irrational, unscientific, unethical and unprofessional (Grove & Meehl, 1996; Quinsey, Harris, Rice, & Cormier, 1998).

For many psychologists working in criminal justice, and a few psychiatrists, actuarial risk instruments are a part of their daily work routine and preoccupations (Bonta, 2002). Developing an instrument may result in considerable profit and prestige, and in some rare instances, even celebrity (see the 2003 motion picture *The Corporation* produced by Achbar & Abbott, and featuring Dr. Hare's PCL-R (1991)). In short, actuarial risk assessment in the context of the criminal justice system is now big business.

While the performance of different actuarial risk assessment measures in predicting risk and recidivism is a matter of continuing professional inquiry and debate, the degree to which these instruments are determinative of the range of retained rights and proscribed freedoms of offenders has generated comparatively less commentary. There is little doubt that a negative actuarial risk assessment (i.e., high-risk) can have far-reaching liberty implications for offenders. When the human rights implications of risk assessment are considered, there is a need – indeed an obligation – to ensure these instruments are not only predictive of risk, but also applied in an ethical manner.

Although decisions based on actuarial risk assessment are superior to clinical judgement, in the race to develop the best predictive instrument very few researchers have considered whether their scale, most often initially developed using large samples of (white) male offenders, could inadvertently discriminate against specific subgroups, such as women, Aboriginal people, members of racialized communities, or special need populations (e.g., persons with disabilities, including mental illnesses). The fact that a scale has been found to have predictive accuracy on these subgroups does not speak to the issue of whether the scale contributes or not to direct, indirect or systemic discrimination.

One may argue that many scales include items that indirectly capture societal disadvantages and corresponding coping strategies of disadvantaged subgroups, such as women, the disabled and Aboriginal people. A simplistic analysis would suggest that actuarial risk assessments penalize members of these subgroups by classifying them as higher risk based on situational factors that are, for the most part, outside their control. However, there is increasing evidence that these factors (gender, ethnicity) are unrelated to affiliation with one of those subgroups (Andrews & Bonta, 2003; Bonta, 1989; Holsinger, Lowernkamp, & Latessa, 2003).

The most difficult challenge is to understand why some subgroups, such as Aboriginal people, have higher prevalence of criminogenic need factors and how to remedy the situation. Aboriginal status, or belonging to any particular race in general, does not make individuals more criminal, but more Aboriginal people live in disadvantaged and marginalized situations than non-Aboriginals. In theory, a Caucasian male who lives in a similar socio-economic situation is at similar risk of criminality. However, unlike Aboriginal people, Caucasian men are not the target of the well-documented systemic racism and prejudice prevalent in Canadian society (UN Special Rapporteur on Indigenous Peoples, 2004; UN Special Rapporteur on Racism, 2004). Some Aboriginal persons may respond to prevailing social, cultural and economic conditions differently, seeing little choice but to respond with aggression, hostility, and substance abuse (i.e., criminogenic need factors). These responses can also affect other parts of their lives, such as employment, family relationships, educational achievement, financial situation, etc. (i.e., criminogenic need factors).

Similarly, the rate of (sexual) violence and abuse against women is very high. For women, the risk of being criminally victimized by men, particularity known men in their lives, may have serious impacts in their daily lives (Chan & Rigakos, 2002). Many women report psychological and emotional problems with their long-term health and well-being, and in some cases, feelings of anger and fearfulness may develop, and some women may turn to drugs and alcohol to cope with their circumstances (Chan & Rigakos, 2002). It is clear that further work needs to be done on the relationship of "proxy variables" (or triggering variables) that affect criminogenic need factors among disadvantaged subgroups.

Many valid questions have been raised in government reports and by some scholars related to the validity and reliability of certain risk assessment items used by the Correctional Service of Canada, the need to reflect unique situations of disadvantaged subgroups, setting of appropriate cut-off scores and the relationship between criminogenic need factors and "proxy variables." These are valid concerns that need to be further examined. However, the degree to which these matters can be addressed through further research and policy without calling into question the basic soundness of the actuarial risk assessment approach *per se* warrants some comments.

For its critics, actuarial risk assessment is described as a politically motivated tool for social control (Chan & Rigakos, 2002; Hannah-Moffat & Shaw, 2001; Pratt, 2001; Robert, 2001) that discriminates against disadvantaged groups and which is responsible for the over-representation of incarcerated Aboriginal people and the oppressive regime imposed by correctional authorities. While conceding that actuarial risk assessment is not perfect, these unsubstantiated criticisms and blanket condemnations are reminiscent of those that fuelled years of unproductive debate on the "nothing works" controversy (Martinson, 1974).

There are some indications that those who dismiss actuarial risk assessment are: (1) not examining the issues with the necessary scholarly rigour; (2) overstating the scope of the problem; and, (3) not fully appreciating the ramifications for discarding actuarial risk assessment. First, academics that reject the use

of actuarial risk assessment in the correctional setting often pay little attention to evidence contrary to their respective theoretical frameworks. Similarly, many important Canadian government reports do not cite any significant references on the extensive (Canadian) literature on actuarial risk assessment (CHRC, 2003; & Auditor General of Canada, 2003).

Second, only a handful of Canadian criminal cases and one American case have questioned the overall scientific validity of actuarial risk assessment instruments (Cole & Angus, 2003). A review of reported Canadian case law performed by the current author did not reveal any case arguing that an actuarial risk assessment scale violated section 15 of the *Canadian Charter of Rights and Freedoms*. Even in the United States, arguably one of the most litigious countries in the world, legal challenges have primarily focused on the disparity in programming opportunities for women offenders, and not on the vulnerability of classification systems for women offenders (Brennan, 1998). If actuarial risk assessment instruments were responsible for the kind of alleged flagrant discrimination reported by some authors, Canadian and American courts would have likely already rendered judgments on their use.

Finally, with few exceptions (e.g., Brennan, 1998), those who espouse strong negative views regarding actuarial risk assessment rarely offer any constructive alternatives (e.g., Côté, 2001; Hannah-Moffat & Shaw, 2001). Failing to rely on the best predictive method to assess risk might jeopardize public safety (Samra-Grewal, Pfeifer, & Ogloff, 2000), the paramount legal consideration in the correctional process.

(For the complete commentary, please see *Canadian Journal of Criminology and Criminal Justice*, October 2004. 46(5): 607-620.)

Research Brief

Age and sexual recidivism: Early identification of persistent offenders and burn-out.

R. Karl Hanson, Ph.D.
Ministry of Public Safety and Emergency Preparedness Canada

There has been considerable debate both in the courts and in the scientific literature concerning the effects of age on sexual recidivism potential (Barbaree, Blanchard & Langton, 2003; Hanson, 2002). For high risk offenders considered for release, advancing age is widely considered a protective factor. Although everyone agrees that age is at least somewhat related to recidivism risk, much of the evidence comes from cross sectional studies. Consequently, it is possible that the observed relationships with recidivism risk are based on the age of the offenders at the time of their involvement with the law rather than their current age. Most offenders have relatively short criminal histories, which means that "current age" is highly correlated to "age at first involvement with crime". In particular, Marnie Rice and Grant Harris (personal communication) have argued that age of first involvement with crime is a more important risk factor than burn-out effects due to advancing years.

In order to examine the relative contribution of "first involvement" and "current age", secondary analyses were conducted of the three samples reported in Hanson (2002; CSC Pacific Region; Millbrook; Her Majesty's Prison Service). This combined sample of 1415 was selected because information was available on the necessary variables: age at first arrest (mean = 25 years, range 9 – 81, SD = 12), age at first arrest for a sexual offence (mean = 30, range 11 – 81, SD = 12), age at release (mean = 36, range 15- 83, SD = 12) and prior sex offences coded à la Static-99 (68% had no priors, 19.4% one prior conviction,

9% had 2-3 prior convictions, and 3.6% had 4 or more prior convictions). Age at release correlated .84 with age at first sex offence. The sexual recidivism rate was 25%, with a follow-up period that ranged from 7 to 30 years.

Sexual recidivism correlated with age of first arrest (r = -.097), age of first arrest for a sexual offence (-.157), and current age (-.100). The strongest correlation was for early onset of sexual offending, although none of the correlations were significantly different from each other. (The 95% confidence interval for the correlations was ± .05). A different pattern emerged, however, in the partial correlations that controlled for the number of prior sex offences. In this case, age at release was a stronger predictor of sexual recidivism (r = -.132) than age of first arrest for a sexual offence (-.099) or age at first arrest for anything (-.057).

When age at first sex offence and age at release were simultaneously entered into Cox regression, both variables significantly predicted sexual recidivism, but in different directions. Young age at first sex arrest was associated with increased recidivism (B = -.045, SE = .008) whereas older age at release was associated with increased recidivism (B = .017, SE = .007). This odd effect is due to the hidden influence of prior sex offences. When prior sex offences were entered into Cox regression, the direction of the age effects reversed: old age at release was now associated with decreased recidivism (B = -.034, SE = .011) whereas older age at first sex offence was associated with increased recidivism, although the later effect was non-significant (B = .010, SE = .012).

So what do all these bouncing numbers mean? In cross-sectional data, older offenders are less likely to sexually re-offend than younger offenders. Age at first sex offence and current age are highly correlated with each other and both are valid predictors of sexual recidivism.

How should evaluators choose between these two indicators? In most cases, no choice is necessary. When there are no prior sex offences, the numbers will be essentially the same (except for the minority of offenders who serve very long sentences). When offenders have a prior sex offence, then age at first sex offence will likely be a slightly better predictor than current age. When considered in conjunction with offence history, then current age is probably the better predictor.

Early onset of crimes identifies a subset of particularly troublesome offenders, and it appears that even the most persistent offenders are better behaved as senior citizens than as teenagers. Further research is required to determine the effects of aging among sexual offenders serving very long sentences.

References

Barbaree, H.E., Blanchard, R., & Langton, C.M. (2003). The development of sexual aggression through the life span: The effect of age on sexual arousal and recidivism among sex offenders. In R.A. Prentky, E.S. Janus & M.C. Seto (Eds.). *Sexually coercive behavior: Understanding and management.* Annals of the New York Academy of Sciences, Vol. 989. New York: New York Academy of Sciences.

Hanson, R. K. (2002). Recidivism and age: Follow-up data on 4,673 sexual offenders. *Journal of Interpersonal Violence, 17,* 1046-1062.

Recently Defended Doctoral Dissertation

An Investigation of the Impact of Chronic Work Stress and Critical Incidents on Correctional Staff and the Factors that Moderate it

Marlo Gal, B.A. (Adv.), M.A.
Carleton University

Work related stress is increasingly recognized as one of the most serious occupational health hazards (Cummins, 1990; Spielberger & Reheiser, 1995). The effects of job stress include health-related problems, absenteeism, decreases in productivity, long-term disability, burnout and high staff turn-over rates. It has been suggested that the correctional environment is one of the most stressful work environments due to the inclusion of exposure to critical incident stress in conjunction with normal work stress. While the impact of work stress has been studied in the correctional environment (e.g, Lariviere, 2000, Milson, 1999; Rosine, 1992), the scope has been limited to generic work stress measures that do not reflect the nature of the stress that individuals working in a correctional environment are exposed to. The present study explored the types of stressors that correctional staff are exposed to, the perceived impact that these stressors have, and the psychological and physiological impact of being exposed to these stressors. Overall, correctional staff are exposed to a number of stressors that included both workplace systemic stress, offender generated violent incidents and critical incidents. Exposure to these stressors has a negative impact on both the mental and physical health of staff which is reflected in the outcome measures. Psychological well being and social support are found to buffer the effects of stress, particularly under conditions of high stress.

For more information please contact Dr. Marlo Gal by email at GalMA@csc-scc.gc.ca

Recent Publications

Bourgon, G., & Armstrong, B. (in press). Transferring the Principles of Effective Treatment into a "Real World" Prison Setting. *Criminal Justice and Behavior.*

The principles of risk, need, and responsivity have been empirically linked to the effectiveness of treatment to reduce re-offending, but the transference of these principles to the inside of prison walls is difficult. Results from a sample of 620 incarcerated male offenders, 482 who received either a 5-Week, 10-Week, or 15-Week prison based treatment program and 138 untreated comparison offenders, found that treatment significantly reduced recidivism (odds ratio of .56; effect size *r* of .10) and that the amount of treatment (e.g. "dosage") played a significant role (odds ratios between .92 and .95 per week of treatment; adjusted effect size *r* of .01 and .02). These results indicate that prison based treatment can be effective in reducing recidivism, that dosage plays a mediating role, and that there may be minimum levels of treatment required to reduce recidivism that is dependent upon the level of an offender's risk and need.

Section Membership Facts

2002 - 227 members
2003 - 246 members
2004 - 252 members

11% increase over 2002

Members on the Move

Dr. Ivan Zinger has accepted a position with the Office of the Correctional Investigator as Senior Policy Advisor and Counsel effective January 20, 2005. Ivan's new address and contact numbers are below.

Office of the Correctional Investigator, Government of Canada/Bureau de l'enquêteur correctionnel, Gouvernement du Canada
P.O. Box 3421, Station "D",
Ottawa, ON K1P 6L4/
Tel/Tél: (613) 990-2690
Fax/Télécopieur: (613) 990-9091
zingeriv@oci-bec.gc.ca

Upcoming Conference

Mental Health in Corrections Consortium Symposium

April 11 - 13, 2005
Marriott Country Club Plaza Hotel
Kansas City, Missouri

This year's theme is "Integrated Mental Health Skills and Services: The Total Correctional Population"

Offering pre-conference workshops on MCMI-III for Correctional Psychologists, Offender Treatment, and Suicide Risk Management.

There are many concurrent session, plus a poster session.

For more information call (417) 823-3477 or visit the website at www.forest.edu and select the MHCC icon.

Employment Opportunity

Correctional Service of Canada
Pacific Region

www.csc-scc.gc.ca

Psychologist
$ 55,598 - $ 67,621
($ 12,000 / per annum terminable allowance for PhD registered in BC)
($ 6,000 / per annum terminable allowance for MA registered in BC)
Salary currently under review

Psychological Assistant
$ 47,299 - $ 59,864
Salary currently under review

Psychologist Qualifications – MA or PhD with a specialization in clinical, forensic/clinical or counselling psychology. Registration for autonomous practice with the College of Psychologists of British Columbia. Additional consideration will be given to candidates with forensic experience.

Psychological Assistant Qualifications – graduation with a minimum of an MA with a specialization in clinical, forensic/clinical or counselling psychology. Additional consideration will be given to candidates who are eligible for registration by the BC College of Psychologists for the practice of psychology in BC.

Preference will be given to Canadian citizens. Qualified applicants will be placed in an inventory for consideration in future vacancies. As part of her/his duties in the Regional Mental Health Cluster, the incumbent may be required to work in and be assigned to different sites/locations in the Pacific Region.

Send your resume and a letter of application, quoting the applicable position (i.e. Psychological Assistant or Psychologist) to:

Psychology Inventory – Personnel Office
Regional Headquarters (Pacific)
P.O. Box 4500
Abbotsford, B.C. V2T 5L7
Fax: (604) 870-2598

The Correctional Service of Canada is committed to achieving a skilled, diversified workforce reflective of Canadian society and, therefore encourages members of employment equity groups to apply.