Where has all the Psychology Gone?

A Critical Review of Evidence-Based Psychological Practice in Correctional Settings

Theresa A. Gannon

and

Tony Ward

Please cite as: Gannon, T. A., & Ward, T. (in press). Where has all the psychology gone? A critical review of evidence-based psychological practice in correctional settings. *Aggression and Violent Behavior*.

Available from: http://www.journals.elsevier.com/aggression-and-violent-behavior/

Author Note

Theresa A. Gannon, Centre of Research and Education in Forensic Psychology, School of Psychology (CORE-FP), Keynes College, University of Kent, Canterbury, Kent, England. Tony Ward, School of Psychology, Victoria University of Wellington, PO Box 600, Wellington, New Zealand.

We would like to sincerely thank Dr Jane Wood, Dr Gwenda Willis, and Ms Helen Butler for their helpful comments on an earlier draft of this manuscript.

Correspondence concerning this article should be addressed to Theresa A. Gannon, Centre of Research and Education in Forensic Psychology, School of Psychology, Keynes College, University of Kent, Canterbury, Kent, CT2 7NP, England. E-mail: T.A.Gannon@Kent.ac.uk.

Abstract

Evidence-Based Practice (EBP) is the gold standard for effective clinical psychological practice. In this review we examine the basic tenets of EBP and consider how—in the context of psychological treatment provision—EBP is able to subsume the overarching guiding theory of offender rehabilitation adopted by correctional policy makers and psychologists worldwide (i.e., the Risk-Need-Responsivity Model, RNR; Andrews & Bonta, 2010a). We also examine ways in which, under the backdrop of RNR, EBP tenets are typically being neglected by correctional psychologists. We examine three key aspects of EBP currently being neglected by correctional psychologists: (a) individualized and flexible client focus, (b) the therapeutic alliance, and (c) psychological expertise. We also highlight two highly related issues responsible for psychologists' neglect of EBP within corrections. The first relates to the dual-relationship problem. That is, the tension that psychologists experience as a result of engaging in psychological practice whilst also obliging the risk and security orientated policies of correctional systems. The second relates to psychologists' response to this tension. In short, psychology, as a discipline appears to have acquiesced to the dual-relationship problem. In our view, this constitutes a 'crisis' for the discipline of correctional psychology and for the provision of best practice treatment within correctional settings. We offer several recommendations for injecting EBP back into correctional psychology for the individual, psychology as a discipline, and correctional policy makers.

Key words: Evidence Based Practice, Risk Need Responsivity, Corrections, Science-Practice Gap.

Where has all the Psychology Gone?

A Critical Review of Evidence-Based Psychological Practice in Correctional Settings

The role of the correctional or forensic psychologist has evolved steadily from decades of struggle between punishment and rehabilitation proponents. Ultimately, the psychologist has secured an important role in contemporary western world corrections. Yet despite correctional psychology having evolved over many decades, we believe that the correctional psychology discipline is facing a crisis. In this manuscript, we highlight one fundamental aspect underpinning this crisis—that is, the correctional psychologists' mounting neglect of Evidence Based Practice (EBP). The lack of attention to EBP within such a highly important field is potentially harmful not only to the profession of psychology but also to society who must inevitably deal with the devastating effects of re-offending associated with inadequate psychological treatment.

In this manuscript, we examine (1) the development of the modern day correctional psychologist; paying particular attention to the highly popular *Risk Need Responsivity Model* (Andrews & Bonta, 2010a), (2) the gold standard EBP model of clinical practice, (3) three key areas of research informing EBP currently being ignored within correctional practice, and (4) key ways in which EBP can be injected into correctional psychology at the individual, discipline, and policy level. A number of previous reviews have critiqued the RNR Model (see Polaschek, 2012; Ward, Melser, & Yates, 2007). However, none have examined how widespread use of RNR–and neglect of the EBP model—is seriously eroding the identity of psychology. We argue that the root cause of EBP neglect stems from misunderstandings about the nature of EBP, as well as psychologists' acquiescence to the risk and security orientated policies of correctional systems. We also argue that—despite inherent contextual challenges—correctional psychologists can and should use EBP in order to conduct best practice psychology within correctional settings.

In this review, we will use the term *correctional psychologist* to refer to individuals who are trained and registered to conduct independent psychological practice within correctional settings (i.e., forensic, clinical, and counseling psychologists).

The Development of the Modern Day Correctional Psychologist

Since the turn of the 20th century correctional systems have been characterized by immense tension between punishment and rehabilitation proponents (Andrews & Bonta, 2010a). Initially, rehabilitation enjoyed a relatively secure place within corrections. In the mid 1970's, however, punishment advocates took center stage when Martinson (1974) published his now famous article in which he analyzed the treatment effects of 231 rehabilitation programs and declared that rehabilitation appeared to have little impact on offender recidivism. Following this article, amidst a backdrop of steadily increasing prison populations and vocal punishment advocates (e.g., von Hirsch, 1976), public and political dissatisfaction with 'ineffective' rehabilitation ensued (Andrews & Bonta, 2010b).

The Risk Need Model (Andrews & Bonta, 1994, 1998, 2003, 2006, 2010)

A decade following publication of Martinson's (1974) article correctional psychology was placed firmly back on the map when Andrews, Bonta and colleagues undertook a series of systematic research studies showing psychological treatment to be efficacious within correctional settings (see Andrews & Bonta, 2010a, 2010b; Andrews, Bonta, & Hoge, 1990; Andrews, Zinger, Hoge, Bonta, Gendreau, & Cullen, 1990). The key rehabilitation theory that resulted from this work was the *Risk-Need-Responsivity* model (or RNR; Andrews & Bonta, 2010a). RNR specified that effective correctional rehabilitation required adherence to three main principles of risk, need, and responsivity. In brief, the *risk* principle stated that higher intensity programs were required for offenders deemed to be at higher risk of reoffending, the *need* principle stated that treatment should focus on criminogenic needs (i.e., those needs empirically associated with recidivism reduction), and the *responsivity* principle stated that treatments should be molded to ensure good fit with the characteristics and learning abilities of offenders. Finally, a fourth principle of *professional discretion* indicated that practitioners could override any of the principles under exceptional circumstances. The RNR is incredibly popular within correctional rehabilitation programs worldwide (Craig,

Dixon, & Gannon, 2013) and is widely regarded to be "the received or orthodox position concerning rehabilitation" (Ward, Collie and Bourke; 2009, p.299).

RNR's popularity with policy makers appears to rest on three key factors. First, research shows that program adherence to all or even some of the RNR principles significantly reduces recidivism (Andrews, Zinger et al., 1990; Bonta & Andrews, 2007; Hanson, Bourgon, Helmus, & Hodgson, 2009) enabling policy professionals to make accountable decisions. Second, RNR principles are simple, and so can be implemented to large groups of offenders within highly structured cost effective manualized treatment programs. Third, the key focus of RNR is on risk reduction and management which resonates well with the security oriented culture of correctional establishments (Ward et al., 2007; Ward & Salmon, 2009).

There is no doubt that evidence-based RNR helped to reintroduce the value of offender rehabilitation—and of the psychologist—to corrections. However, the RNR was never intended to replace correctional psychologists' governing models of clinical practice. Instead, Andrews and Bonta (2010a) intended the RNR to provide policy makers with a clear focus for correctional policy in the form of program selection (Andrews & Bonta, 2010a).

Correctional Pressures

Over the past few decades, incarceration rates have increased dramatically. For example, in the US, around 220 individuals in every 100,000 were incarcerated in 1980 (Cahalan, 1986). By 2010, however, despite falling official crime rates (Zimring & Hawkins, 1991), this figure had risen threefold (i.e., to over 700 in every 100,000; United Nations Human Development Program, 2007). Although the number of US employed correctional psychologists increased with the advent of RNR, due to dramatic rises in prison numbers the US psychologist to offender ratio has remained poor (i.e., about 1:750; Boothby & Clements, 2000). A complex interplay of factors have facilitated increased incarceration rates (see Cullen, 2007; Jonson, Cullen, & Lux, 2013) including politicians' attempts to win the confidence of the public via 'get tough' policies (e.g., US three strikes laws). Against such a backdrop, politicians and corrections face extreme

negative publicity over security failures; especially those resulting in real or potential risk of reoffending within the community (Jonson et al., 2013; Wood, 2009). The result is correctional systems that are bursting at the seams; running at full capacity to ensure a high level of security under extreme economic pressures.

The Dual Relationship Problem

Although pioneering, the proliferation of RNR-based psychology programs, paired with correctional pressures, has resulted in a severe *identity* problem for correctional psychologists that has come to be known as the *dual relationship problem.* By *dual relationship*, we are referring to the conflict in roles experienced by psychologists who must engage in the competing roles of (1) conducting client-focused therapeutic psychological work, and (2) detecting risk and upholding security principles as prioritized within highly politicized correctional settings (Greenberg & Shuman, 1997; Ward, 2013). Psychologists facing the dual relationship problem within corrections are at heightened risk of 'ethical blindness' (Ward, 2010; Ward & Syverson, 2009; Ward & Willis, 2010). That is, prioritizing security and risk concerns as though they were therapeutic issues. Correctional psychologists, like any profession, gain their professional identity from a variety of sources including the key theories and political climate governing their practice, as well as the key values espoused within their workplace (Adams, Hean, Sturgis, & Clark, 2006; Griel & Rudy, 1983; Pratt, Rockmann, & Kaufmann, 2006). Metaphorically, the advent of RNR has acted as a double-edged sword for correctional psychologists. On the one hand, RNR played a key role in placing rehabilitation, and the correctional psychologist, back on the map within correctional systems. On the other hand, policy makers' widespread implementation of RNR has placed significant pressures on the modern day correctional psychologist to succumb to a simplistic catch all interpretation of RNR as their governing model of practice.

Evidence Based Practice (EBP)

The *Boulder Conference* of 1949 led to the development of the scientist-practitioner concept; a highly influential model espousing that research and practice should co-exist as complementary and informative partners (DiLillo & McChargue, 2007; Richardson,

2009). For many years, psychology trainees have been taught the importance of adopting scientist-practitioner values. More recently, however, psychology has embraced the Evidence Based Practice (EBP) model as the gold standard implementation of science as practice (DiLillo & McChargue, 2007; Lilienfeld, Ritschel, Lynn, Cautin, & Latzman, 2013). EBP represents an important development of the scientist-practitioner model since it is able to integrate the concepts of science and practice within a conceptually richer framework (DiLillo & McChargue, 2007). In recognition of this, the American Psychological Association has officially endorsed the EBP as the governing model of best practice applied psychology (APA Presidential Task Force on Evidence Based Practice, 2006).

The three central principles of EBP are that: (1) research evidence is fundamental to guiding good practice, (2) clinical expertise and decision making should be used when applying research to clinical situations and in situations in which research is ill-fitting or unavailable, and (3) client individuality in the form of preferences and values should be considered when allocating interventions (Lilienfeld et al., 2013; Spring, 2007). In terms of weighting EBP tenets, consensus exists that all three facets are critical for defensible evidence-based practice (APA Presidential Task Force on Evidence Based Practice, 2006; Lilienfeld et al., 2013; Thyer & Pignotti, 2011). The EBP model proposes that *research evidence* may be viewed along a continuum in which best-designed research studies (i.e., randomized controlled trials or meta analyses) should be afforded more weighting within clinical decision making than research designs that hold more room for interpretation or error (e.g., correlational designs; Ghaemi, 2009; Lilienfeld et al., 2013; Thyer & Pignotti, 2011). As Lilienfeld et al. (2013) have noted, EBP should not be confused with the concept of *empirically supported treatment*s which have been empirically supported through clinical trial research and represent one strand of research evidence within the EBP model (APA Presidential Task Force on Evidence Based Practice, 2006). Thus, *clinical experience* and discretion are viewed within the model as essential in bridging the gap between research evidence base and practice. Finally, in terms of *client individuality*, the psychologist is expected to use their knowledge base of best practice to

consider key client values in treatment selection. Lilienfeld et al. (2013) provides the example of a client experiencing anxiety disorder who refuses the best available empirically supported treatment (i.e., behavioral flooding) as a result of intense fear necessitating the psychologist to select another empirically supported but slightly less efficacious treatment (i.e., graded exposure) that will ultimately ensure client engagement.

Why EBP is Inherently Superior to RNR

Both prior to and since the development of RNR, the concept of EBP has gained significant standing, not only in the field of medicine, but also within clinical psychology more generally. Despite espousing commitment to EBP, corrections focus predominantly on the provision of RNR-based psychology. Here, we examine three key reasons why EBP is able to subsume RNR and may be considered ultimately superior to RNR as an overarching model of psychological practice within corrections.

1. EBP acknowledges a breadth of research. RNR was developed from a series of systematic research studies examining treatment effectiveness within correctional settings with the overall intention of guiding policy (Andrews & Bonta, 2010a, 2010b; Andrews, Bonta, & Hoge, 1990; Andrews, Zinger et al., 1990). In taking such a specific focus, scores of research studies examining the general features required for treatment effectiveness have been missed. For example, research shows that *flexibility* (Beutler, Harwood, Michelson, Song, & Holman, 2011; Johansson et al., 2012), and *a strong therapeutic alliance* (Ackerman & Hilsenroth, 2003; Elvins & Green, 2008; Horvath, 2001; Horvath & Luborsky, 1993) are critical for maximizing treatment effectiveness. On the contrary, EBP explicitly promotes the use of a wide breadth of research in clinical decision making ensuring that psychologists focus on Risk Need and Responsivity yet do not become overly focused upon one strand of research. This includes research and available literature examining ethical practice with offender client groups (Chudzik & Aschieri, 2013; Greenberg & Shuman, 2007; Gutheil & Gabbard, 1993, 1998; Pope & Keith-Spiegel, 2008; Smith & Fitzpatrick, 1995) which is notably

absent from RNR and yet most likely to protect psychologists from engaging in therapeutically damaging decisions associated with the dual relationship problem.

2. EBP acknowledges the psychologist as active facilitator. Within RNR, research-based risk and need principles take center stage in governing program provision and the psychologist is viewed as a passive implementer whose discretion should be utilized only in *exceptional* circumstances. This over reliance on risk related research fails to acknowledge the role of correctional psychologists as *expert* professionals. EBP, on the other hand, views the psychologist as critical in bridging the gap between research and practice through expert interpretation, adaptation, and application (Lilienfeld et al., 2013; Spring, 2007). Thus, the EBP model is consistent with the wider research showing that behavior change is associated with competent professionals who are expert in their ability to both detect and adapt to varying client needs (Luborsky, Crits-Christoph, Mintz, & Auerbach, 1988; Marshall & Burton, 2010).

3. EBP promotes psychological identity. All governing codes of conduct for psychologists prioritize client need and avoidance of client harm (e.g., American Psychological Association's Ethical Principles of Psychologists and Code of Conduct, 2002; 2010 amendments). Policy makers typically have little experience of treatment implementation (Brayford, Cowe, & Deering, 2010). As such, their efforts to translate RNR into practice are often dominated by an overreliance on risk-related research and a neglect of wider areas of psychological research. Correctional psychologists—especially those who hold little experience of mainstream psychological settings—can feel pressured to acquiesce to policy officials' demands. Thus, over time, correctional psychologists can begin to experience problems with their identity as a psychologist and begin espousing attitudes, values and behaviors more akin with correctional security principles (i.e., the dual relationship problem). EBP, on the other hand, encourages psychologists to critically examine the wider psychological research literature governing their practice. This ensures a strong professional identity through promoting the importance of clinical expertise and decision making in the treatment process (DiLillo & McChargue, 2007).

In sum, the EBP model is able to subsume RNR and may be considered ultimately superior to RNR through requiring interventions to be anchored in a much broader framework of research knowledge and through viewing the professional judgment, training, and identity of psychologists as paramount. Appropriate use of EBP enables standardized and defensible expert psychological practice that is aligned with mainstream psychology and incorporates client values and preferences. In the following section, we examine three key areas of research—flexibility, therapeutic alliance, and expertise—that individually inform all three conceptual strands of the EBP model. We argue that, due to the widespread dominance of policy implemented RNR and the failure of psychologists to assert a strong psychological identity, these crucial factors are notably and disconcertingly absent within current correctional psychology.

Where Has all the Psychology Gone?

Individualized Focus and Flexibility

Evidence has accrued across various psychological disciplines to show that treatment specifically tailored to client need is more successful in diminishing problem behaviors—including criminal behaviors—than less tailored interventions (e.g., Barlow, 2011; Beutler et al., 2011; Boswell et al., 2011; Johansson et al., 2012; Marshall, 2009; Marshall & Serran, 2004; Serran et al., 2003). Individualized case-based assessment and formulation represents the 'cornerstone' of psychological treatment and is associated with increased treatment effectiveness (Koerner, Hood, & Antony, 2011; Kuyken, 2006). Practitioner flexibility is essential for the formulation of an individual client's potential treatment needs, responding appropriately to such needs, and detecting other clinical requirements as therapy progresses (Nelson, Steele, & Mize, 2006). Skilled psychologists are aware of their client's individuality at all times and adjust treatment and practices appropriately (Hofmann & Asmundson, 2008). A critical indicator of practitioner flexibility is the ability to respond to unanticipated needs as they evolve within therapy (Norcross, 2002; Shirk & Karver, 2011). The skilled psychologist is able to deal with genuine client catastrophes; either by stepping outside of the therapy aims to deal with the issue at hand or through linking the experience to aspects examined within therapy

(Gannon & Lockerbie, 2014; Nelson et al., 2006). Thus, effective treatment provision is flexible and constructed upon a broad based understanding of each client's particular needs (Koerner et al., 2011; Norcross, 2002; Persons, 2006, 2008; Persons & Tomkins, 2007; Spruill et al., 2004; Sturmey, 2009; Whiston & Coker, 2000).

Neglect of Individualized Focus and Flexibility within Correctional Settings

The flexibility-oriented principles of RNR (i.e., *responsivity* and *professional discretion*) were not well developed in the original RNR (Polaschek, 2012) and so have not translated into strong features of correctional-based group psychological work with offenders (Casey, Day, Vess, & Ward, 2013; Marshall & Serran, 2004; Ward & Gannon, 2006; Ward & Stewart, 2003; Ward et al., 2007). Consequently, contemporary psychological practice within corrections does not meet the gold standard of EBP for three key reasons.

1. Stringent manualization. In line with Andrews and Bonta's (1994, 1998, 2003, 2006, 2010a) recommendations, external policy makers have implemented evidence-based RNR practice on a large scale via highly structured manuals that fully specify offence-related assessment structure, session topics, exercises, and procedures, as well as treatment time. While the overarching goal of treating large numbers of offenders using evidence-based standardized treatment is laudable, such highly structured manuals suppress EBP clinical flexibility and neglect client individuality; promoting professional apathy. Highly manualized treatment also promotes rigid, authoritarian, rule-bound practice (Addis, 1997; Marshall, 2009) which is associated with poor treatment outcome (e.g., Marshall et al., 2003; Ringler, 1977; Sweet, 1984). Novice therapists, in particular, are those most susceptible to overreliance on manuals since they lack the skills and experience to work more flexibly with clients (Addis, 1997; Beck, Rush, Shaw, & Emery, 1979).

2. Exclusive focus on offending behavior. Current manual-based psychological treatment within corrections focus almost exclusively on offending behavior (Casey et al., 2013; Ward, Gannon, & Birgden, 2007; Harvey & Smedley, 2012) minimizing other aspects of associated need such as trauma, abuse, general mental health, and life quality

(Ward & Maruna, 2007; Ward et al., 2007). As active practitioners ourselves, we have experienced situations in which a highly traumatized client has been unable to fully engage with treatment due to dissociation. Yet, because trauma was not documented within the program manual, we were informed by correctional worker colleagues that the 'trauma' should not be prioritized. This correctional response flies in the face of extensive research evidence supporting the basic psychological principle of flexibility and neglects evolving research literature indicating that trauma may, in fact, severely compromise an individual's ability to benefit from treatment (Clark, Tyler, Gannon, & Kingham, in press; Gray et al., 2003) and should be targeted within correctional programs (Levenson, Willis, & Prescott, 2014). Both flexibility and the evolving research literature are aspects that should inform psychological decision making under the EBP model.

The reality, of course, is that the nomothetic research underlying RNR based programming is unable to account for all existing or emerging therapeutic research evidence nor the inherent variability between clients seen in real practice (see Norcross, 2002). Instead, in line with EBP, possession of skilled clinical judgment and attendance to client preference and values is critical. For example, research is accumulating to suggest that non criminogenic needs are important for improving offenders' motivation and responsivity within offending behavior programs (Flinton & Scholz, 2006; Harkins, Flak, Beech, & Woodhams, 2012; Willis, Yates, Gannon, & Ward, 2013). Yet we have received a variety of multidisciplinary responses regarding our attempts to respond positively to clients' non criminogenic needs which include: slow or inadequate response to our referrals or being requested to prioritize the 'real' task of offence work. It appears, then, that the principles of responsivity and clinical discretion originally espoused within RNR theory are being sidelined in favor of the two principles of risk and need which are arguably easiest to implement across correctional settings. This makes it difficult for even experienced psychologists to engage in flexibility and attend to client individual need; a skill highly espoused within EBP. Most worryingly, however, corrections'

dismissive responses to psychologists' attempts to engage in EBP devalues psychological expertise and erodes the correctional psychologist's identity as a psychologist.

3. Exclusive focus on security and risk. Recently, we read a UK prisoner's own reflection of 'psychology' which caught our attention:

> "[Prison Psychology] does not reflect the attitude of its mainstream counterpart. The essence of psychology is a basic desire to understand the mental experiences and behavior of the self as well as those of others. The difference is that outside it is the individual's/client's interests which are regarded, whereas in prison the system and its politics are of sole concern" (Sanderson, 2009, p. 34).

Ironically, Sanderson—a prisoner himself—is highlighting the disconcerting inability of correctional psychologists to prioritize client need; a principle key to all mainstream ethical codes governing psychology. In other words, the dual relationship problem appears rife. Associated with this, we have noted a particular lack of institutional flexibility in accommodating EBP. For example, it is not uncommon for psychologists to be denied access to a client who has been placed in segregation. At times clients' behavior is so risky that it would be inadvisable for anyone—including their psychologist—to meet with them in segregation. Typically, however, segregation indicates that a client has been engaging in offending, offence paralleling behavior, or actions symptomatic of self regulatory failure or mental health problems (e.g., PTSD) that are causally connected either to offence commission or to the client's ability to respond to risk reducing treatment. Thus, placement in segregation is an important signal for psychologists to prioritize the client and engage in EBP through considering the range of empirically-informed approaches available to work with the client in order to bring about risk reducing and meaningful behavior change. Clearly, however, if psychologists are blocked from seeing their client, or a psychologist is not forthcoming with the reasons why contact within segregation is necessary (i.e., their EBP formulation) then these fundamental opportunities—which lie at the very heart of promoting psychological change—are missed. Some correctional officers may be unable to see

exactly what psychology might offer in such situations. Indeed, when a client's behavior deteriorates and reasons for psychological input are not assertively communicated, a psychologist's attempt to engage with risk might appear soft or even idealistic. It appears that effectiveness of psychological interventions is not fully realized by some correctional workers who have perhaps not had the opportunity to learn about EBP. In such cases, psychologists who walk away from such common correctional confrontations risk overlooking the needs of their client—and also the community—in favor of subjugation to heavily enforced correctional security. This is particularly disconcerting given research shows that the effectiveness of psychological interventions can surpass those of medical interventions (APA Presidential Task Force on Evidence Based Practice, 2006; Lipsey & Wilson, 2001; Marshall & McGuire, 2003).

A whole variety of treatment approaches that inform the research evidence strand of EBP require significant practitioner flexibility and innovation within correctional settings. Examples include the empirically supported treatment approaches of flooding (DeRubeis & Crits-Christoph, 1998), or aversion therapy (Garfield, 2008) as well as key techniques found to be effective in promoting in vivo tests of beliefs and attitudes associated with dysfunctional and offence supportive behavior (i.e., the *Behavioral Experiment*; Bennett-Levy, 2003; Bennett-Levy et al., 2004; Gannon, 2014; Hagen & Nordahl, 2008). Within correctional settings there are aspects of psychological treatment approaches that are impossible to conduct due to clear security contraventions. Thus, using EBP as a guiding framework, the onus falls upon the correctional psychologist to be flexible and innovative in the application of such methods. In our experience, simple and effective methods—based on collaboration and flexibility—are extremely difficult to enact within correctional settings for two main reasons. First, the collaboration and flexibility required to develop and engage in effective psychologically informed treatment is misinterpreted within the risk-focused correctional context as *collusion*. Second, since risk is the paramount consideration within correctional settings, possible indicators of risk are prioritized to the detriment of longer term psychological solutions to that risk. This tension, between correctional

environments and key psychological principles required for effective change, leads to psychologists who are (1) unable to practice grass roots psychology, and (2) espouse security management principles and react to security risk related issues as though they were psychological problems. In other words, there is a tangible reduction in the creativity and diversity that psychology can offer in reducing risk within correctional settings.

Therapeutic Alliance

Empirical research has consistently shown that a key feature required for beneficial treatment outcome is the development of a high quality therapeutic alliance[1] between practitioner and client (Ackerman & Hilsenroth, 2003; Elvins & Green, 2008; Horvath, 2001; Horvath & Luborsky, 1993). In fact, psychologists estimate that the proportion of change accounted for by group cohesion and the therapeutic alliance is sizable with some estimates exceeding 30% (Beech & Fordham, 1997; Beech & Hamilton-Giachritis, 2005; Marshall & Burton, 2010, Norcross, 2002, 2011). Research studies indicate that highly important therapist characteristics for enabling behavior change include flexibility, confidence, expertise, respectfulness and factors related to genuineness (i.e., empathy, warmth, openness, trustworthiness; Ackerman & Hilsenroth, 2003; Couture et al., 2006; Elvins & Green, 2008; Evans, 2013;Horvath, 2000; Marshall et al., 2002, 2003; Norcross & Wampold, 2011). All can be viewed as therapist 'virtues' that converge on the three core features or strands of the EBP model. Important therapeutic styles have been identified as collaboration, exploration, reflection and supportiveness of the client (Ackerman & Hilsenroth, 2003; Horvath, 2000). Not only are these features required for the development of the therapeutic alliance but they also appear to play a key role in the repair of ruptured relationships (Safran, Muran, & Eubacks-Carter, 2011). This is important given that unresolved therapist ruptures are

[1] We adopt Bordin's (1979) accepted conceptualization of the term *therapeutic alliance*— (i.e., "agreement on goals, an assignment of task or a series of tasks, and the development of bonds" p. 253).

associated with general treatment evasion and drop-out (Schottenbauer, Glass, Arnkoff, Tendick, & Hafter-Gray, 2008; Strauss et al., 2006). In a therapy outcome study with depressed outpatients, Castonguay, Goldfried, Wiser, Raue, and Hayes (1996) found evidence to suggest that overly rigid adherence to therapy manuals (i.e., lack of individual focus and flexibility) resulted in therapeutic alliance problems (see also Henry, Strupp, Butler, Schacht, & Binder, 1993; Marshall, 2009).

Neglect of the Therapeutic Alliance within Correctional Settings

Any psychologist walking around their correctional establishment will typically receive a number of enquiries from prisoners as they walk by such as: "Who are you?" and/or "What department do you work for?" For those professionals who take care to respond to such enquiries with "Psychologist" or "Psychology" general distaste for psychology as a discipline is generally received. Sometimes, the enquiring prisoner may even provide additional information outlining exactly how psychology has—in their eyes—broken trust.

We believe that such a generally negative perception of psychology amongst prisoners is highly disconcerting and reflects some failure of psychology as a discipline to attend to the therapeutic alliance within correctional settings. All ethical codes of best psychological practice stress the value and importance of the therapeutic relationship. For example, the British Psychological Society's Code of Ethics and Conduct (2009) stipulates that the psychologist should, "be mindful of the importance of fostering and maintaining good professional relationships with clients and others as a primary element of good practice" (p.4). Yet, within the correctional context, this core principle that converges on all three key features of EBP is becoming sidelined. The key issue appears to stem from the inherent mismatch between psychological and correctional goals (i.e., the dual relationship problem; Ward, 2013). Key performance indicators (KPIs) for corrections revolve around security issues such as serious assaults or number of prison escapes (Mennicken, 2013; New Zealand Department of Corrections, 2013; Towl, 2002).

While rehabilitation KPIs are also apparent, and are reflected in many of the vision statements of correctional services worldwide, in practice only relatively rigid rehabilitative ideals are prioritized. For example, in line with RNR, a good deal of energy is spent by psychologists to ensure that all offenders classified as 'high risk' are channeled towards highly intensive treatment. Yet, at the same time, the therapeutic alliance is often overlooked both in correctional program planning and roll out and in how psychologists respond to dual relationship problems. For example, the engagement of correctional officers as paraprofessionals delivering treatment (see Psychological Expertise) is one key area highlighting the lack of attention paid to the therapeutic alliance within correctional settings. Offender clients are likely to find it difficult to fully trust correctional workers due to the fact that the correctional worker's primary role is one of security management. For psychologists, common correctional challenges to the therapeutic relationship include: being asked to aid, or engage with tasks that are purely security or punishment focused (e.g., to help 'lock down', transport, or count prisoners and to sit on disciplinary panels), the blanket application of no-touching policies, and requests to report information provided within treatment that could aid the prison security regime in general (e.g., clamping down on the brewing of "hooch").

1. Engagement with security or punishment focused tasks. Some events threaten basic security and warrant the assistance of a member of staff regardless of discipline (i.e., being asked to aid in the containment of a prisoner when there are not enough officers in sight and the safety of others is at risk). In such circumstances, the psychologist's involvement in such containment practices is unfortunate yet arguably justified by the immediate risk of harm. More ambiguous situations—not accounted for in existing ethical codes—have the potential to challenge EBP and the key psychological principles relating to the therapeutic alliance (Weinberger & Sreenivasan, 1994). Take, for example, a situation in which a psychologist is requested to aid busy correctional officers through returning a client that they have just interviewed back to their cell and shutting the door so that it is locked. There is no set of psychological ethical standards that will specifically direct the psychologist within this situation. Yet in order to

function within the "highest ideals of psychology" as espoused within the American Psychological Association's Ethical Principles of Psychologists and Code of Conduct (2002; 2010 amendments, p. 2), the psychologist must clearly evaluate how such a seemingly innocuous action might damage the therapeutic relationship. In taking on the role of temporary officer, the client's perception of that psychologist as warm, genuine and empathic—all established therapeutic principles required for effective correctional therapy (Ackerman & Hilsenroth, 2003; Elvins & Green, 2008; Horvath, 2000; Couture et al., 2006)—can be severely compromised. Some professionals feel that assistance in general correctional tasks (e.g., head counts) or with prisoners whom one does not have a therapeutic relationship with are unavoidable and do not constitute any threat to the psychological profession. We invite psychologists to seriously consider how their engagement in such seemingly innocuous tasks might threaten the overall therapeutic image of the psychological profession, and the ability of prisoners to trust psychology as a profession. As Weinberger and Sreenivasan (1994) have so aptly stated, such situations result in psychologists being seen as just another "cop", or from our perspective, as a generalized extension of correctional officers. Similarly, numerous writers (e.g., Haag, 2006; Weinberger & Sreenivasan, 1994) have explicitly cautioned psychologists from engaging in disciplinary focused correctional panels—regardless of whether or not the prisoner in question is their psychological client.

2. No touching policies. No touching policies are enacted to protect both prisoners and staff from engaging in relationships that are abusive, coercive, or ambiguous at best. Yet such policies—when strictly adhered to—can threaten to severely undermine the therapeutic relationship between psychologist and client (Zur, 2005). Take, for example, a first meeting with a client, in which a psychologist refrains from shaking that client's hand. Is it possible for this psychologist to develop a positive trusting relationship with their client when such a fundamental social rule has been quashed? The clear signal being sent by the psychologist appears to be, most fundamentally, that the needs and requirements of corrections trump those of the individual client, and that the client is not *worthy* of the psychologist's effort to step

outside of the correctional policy in order to nurture and promote the therapeutic relationship. Adherence to such a policy, in our view, appears strange and incongruent with the overall ethos of beneficence and nonmaleficence underlying the psychological discipline (i.e., to "benefit (....) and take care to do no harm" to clients; American Psychological Association, 2002, 2010 ammendments). Yet, on occasions, we have witnessed psychologists in training either politely declining to shake the hand of their client, or being informed by correctional staff after having done so that they have contravened correctional policy. Within this context, we view the psychologist in training's decline of the handshake as "a failure to respond in a human way" (Gutheil & Gabbard, 1998). Perhaps the very essence of psychological work (i.e., interpersonal interaction) that makes the handshake necessary, is the very reason why the untrained eye can see no justification for it. It is hard to imagine, for example, a medical doctor in training receiving the same cautionary messages. Their need to touch their client as part of their investigation and profession is fully accepted as necessary for effective treatment. As we have illustrated earlier (see Sanderson, 2009), clients in prison clearly notice when psychologists subjugate to correctional needs too readily. Within mainstream psychology we know that the therapeutic alliance is *critical* for effective behavior change. Yet correctional psychologists appear to swiftly subjugate to correctional priorities to the point that psychologists may no longer even question whether or not adherence to such a policy contravenes the behavior change research informing EBP.

3. Security information reporting procedures. Commonly, during security induction, psychologists—like all correctional staff—are requested to complete a report if they receive any information from their client that could aid in the security/intelligence procedures of the prison. The groundbreaking *Tarasoff v Regents of the University of California* case highlights the clear need for psychologists to override the fundamental principles of confidentiality to their client when others' safety is in danger. Competent contemporary psychologists should be aware of the clear limits to confidentiality and of the need to report information associated with their client that

clearly represents a risk to self (i.e., intended self harm or suicide), others (i.e., a planned hostage taking event) or security (i.e., a planned riot, escape, or contraband introduction) as well as clearly specified information regarding unreported offences (Morgan, Winterowd, & Ferrell, 1999). These limits to confidentiality should be clearly specified to clients at the beginning of the therapeutic relationship and reinforced throughout treatment in order to promote and nurture, not only the individual therapeutic relationship, but the image of psychology as a profession more generally. A key problem emerges, however, when correctional establishments request psychology staff to report information that may or may not represent a threat to security (i.e., particular allegiances, changes in routine, brewing of hooch). In such cases, the psychologist must weigh up the relative potential of harm within the therapeutic relationship through reporting potentially irrelevant information against possible threats to security and risk of harm to others. In our view, it is these grey areas which greatly threaten the therapeutic relationship and yet, in the absence of strong identification with EBP and research underpinning the therapeutic relationship, one can easily become dominated by security principles. At the very least, psychologists should be fully transparent with their client regarding the full range of information falling under the remit of limited confidentiality. Yet specifying such a large number of limitations at the onset of treatment is likely to make it difficult or even impossible to ever develop a trusting and genuine therapeutic relationship. In our view, if a situation or piece of information gleaned within treatment is not clearly related to a situation of risk, then psychologists should refuse to share this information. Not only will this protect the individual therapeutic relationship but it also protects and strengthens the overall reputation of psychology as a discipline.

Psychological Expertise

Applied psychological training—generally conducted via clinical placements—aims to instill a level of clinical competency within individuals that enables them to conceptualize and analyze complex clinical information in accordance with the development of extensive and elaborate knowledge structures (i.e., EBP based

translation of psychological knowledge into procedural action; Benner, 2001; Etringer & Hillerbrand, 1995; Lilienfeld et al., 2013; Spruill et al., 2004). Research strongly suggests that competent professionals are more expert in their ability to both detect and adapt to varying client needs; increasing the likelihood of behavior change (Luborsky et al., 1988; Marshall & Burton, 2010). Most importantly, the level of knowledge input, expert feedback, and practical challenges required to develop competency cannot be artificially fast-tracked (Roe, 2002). For example, Roe (2002) argues that psychologists holding "advanced" competencies are characterized by 4 to 5 years of autonomous practice in addition to at least 5 years of academic study and a period of supervised practice. Those who begin the task of unsupervised practice—on the other hand—are likely only to hold a set of 'initial competencies' that they must further develop in order to become truly competent professionals. Clinical expertise and skill are aspects that should underpin psychological decision making under the EBP model. Current theoretical models view professional skills or competencies as paramount in developing a functional therapeutic alliance (Ross et al., 2008). In other words, it is not necessarily knowledge of 'techniques' that is of paramount importance in the transition from novice to expert but instead the way in which the trained psychologist has learnt to interact with, analyze, and respond to key clinical issues played out within the interpersonal context. Ross and colleagues argue that professional skills on the part of the therapist are especially crucial within correctional settings due to the plethora of difficulties associated with presenting clients (e.g., hostility and personality problems). Failure on the part of the therapist to make sense of and respond appropriately to such complex psychological behavior can have detrimental effects on therapy outcome in the form of a ruptured therapeutic relationship (Ross et al., 2008). Put simply, psychological expertise is essential for competent EBP and effective psychological treatment that is able to detect and adapt to varying client needs (Lilienfeld et al., 2013; Luborsky et al., 1988; Marshall & Burton, 2010).

Neglect of Psychological Expertise within Correctional Settings

Surprisingly, psychological expertise is becoming frequently overlooked within correctional services. There are worldwide variations in the qualifications and level of training required of correctional psychologists. Our comments below concerning the use of paraprofessionals in treatment programs will not necessarily be relevant for all countries or states although given the increase in prison numbers we anticipate that this trend will become more evident. Furthermore, the failure of correctional program designers and providers to adopt EBP practices may well accelerate this trend.

1. Growing reliance on paraprofessionals to implement psychology. The extreme economic pressures and accountability faced by corrections has resulted in the proliferation of RNR policy aimed to maximize visible attempts to protect the pubic (i.e., treat as many offenders as possible). Because of the increased focus on economic resources and 'best use' of these resources in corrections (see Towl, 2002), the growth of group interventions has involved extensive delegation of psychological work to paraprofessionals. By paraprofessional, we mean any individual who is not registered as an independent practicing psychologist. There is, of course, nothing wrong with training paraprofessionals to aid in offender rehabilitation. However, in some jurisdictions (e.g., Correctional Services Canada; Her Majesty's Prison Service in England and Wales), it appears that paraprofessionals (i.e., correctional officers, trainee psychologists) provide the majority of treatment implemented in corrections and are supervised, at a distance, by a qualified psychologist. A concern is that the laudable aim of using scarce resources in the most efficient manner may inadvertently result in the devaluation of skilled psychological intervention (see Lilienfeld, 2010).

It appears that many, including those at the heart of psychological corrections, view psychological knowledge as palpable (see Lilienfeld, 2010) and by implication, believe that psychology can be competently and expertly practiced by paraprofessionals. In our view, the value of having consistent qualified psychological input into psychological work with offenders is being overlooked; not only in relation to in vivo supervision opportunities but also in terms of treatment quality itself. Research clearly indicates that effective treatment outcome is related to the skills and competencies of

the treatment provider (APA Presidential Task Force on Evidence Based Practice, 2006; Norcross, 2011). Consequently, it is hard to see how those with little or even no psychological training hold the technical and interpersonal expertise required to engage in the series of complex and dynamic tasks required to implement flexible, cognizant, and reflective EBP treatment that is matched to patient need and grounded in knowledge of the research evidence base pertaining to assessment, formulation, treatment strategies, and ethical decision making. Most notably, the employment of some staff in psychological programing (i.e., correctional officers) may even make one aspect underpinning EBP—that is, the development of a trusting therapeutic relationship—extremely difficult. This is not to say that current approaches are wholly *ineffective*. On the contrary, research evaluations indicate that cognitive skills programs—typically facilitated by paraprofessionals—can lead to tangible reductions in undesirable behavior, negative thinking styles, and reconviction (Friendship, Blud, Erikson, Travers, & Thornton, 2003; Tapp, Fellowes, Wallis, Blud, & Moore, 2009). Yet there is room for significant improvement. For example, Friendship et al.'s (2003) cognitive skills evaluation illustrated significant and positive recidivism effects for medium risk offenders, but not for low and high risk offenders. We believe that a more intense focus on the expertise of professionals delivering such programs could be key.

2. Neglect of the wider expertise research literature. There is no research evidence available to answer the question as to whether treatment undertaken by paraprofessionals is any less effective than treatment undertaken by trained psychologists (see Mann, Ware, & Fernandez, 2011). However, the general expertise (Chi, 2006) and clinical research literature (Luborsky et al., 1988; Marshall & Burton, 2010) indicates that competent, highly trained professionals are more expert in their ability to both detect and adapt to varying complex issues. In line with EBP, what is fundamental for best practice is the ability of the psychologist to interact with, analyze, and respond to key clinical issues played out within the interpersonal context through both referring to the research evidence base and molding interventions to the preferences and values of the client. Sharpless and Barber (2009) note that, in the

transformation from novice to expert, trainee psychologists proceed through stages characterized by: *rigid rule adherence* (i.e., *novice*), *advanced rule adherence* (i.e., a more flexible repertoire of rule governed behavior), *competence* required for independent practice (i.e., responding to individual client need and synthesizing clinical problems in a sophisticated manner;), and *proficiency* (i.e., a deep and intuitive response to psychological problems that is automatic in nature yet still prone to conscious deliberation). Sharpless and Barber (2009) argue that expert status occurs when the individual views, "clinical problems in an immersed, not detached way, and respond not with rules, but with what experience has taught them" (p. 51). Such competence also manifests through mature reflection regarding competency boundaries (Haag, 2006) and fits readily with research suggesting that experts are faster and more accurate in problem solving (Klein, 1993; Larkin, McDermott, Simon, & Simon, 1980), detect and respond to issues that are unseen by novices (Lesgold et al., 1988), and self monitor performance (Chi, 2006). Yet paraprofessionals—with relatively little, if any, formal psychological training—receive literally days of training to facilitate the most challenging offending behavior groups within corrections (e.g., sexual offender treatment). For example, Mann et al. (2011) note that Prison Officers within Correctional Services of Canada obtain 10 days of training for each treatment program run. In the UK, staff facilitating sexual offender treatment receive 10 days of training for each CORE or rolling SOTP program facilitated and receive additional 10 day training for programs aimed at high risk offenders (e.g., Extended SOTP; Mann et al., 2011). This model is notably one of good practice in training paraprofessionals and is likely to propel trainees to the stage of advanced rule adherence using Sharpless and Barber's (2009) criteria. Yet the stages of competence, proficiency and expertise are likely to take years to establish. Thus, there appears to be a highly concerning increasing lack of appreciation for the expertise and skill provided by the psychological discipline within correctional services.

Putting Psychology Back Into Corrections

In this manuscript, we have critically examined the implementation of psychological services within corrections. Despite espousing commitment to practice

informed by research evidence, we have found that corrections focus predominantly on the provision of RNR-based psychology. Whilst RNR principles can be helpful in guiding program provision, RNR was never intended as an overall model of psychological practice. Yet because this simplistic model has been so heavily relied upon by policy makers, correctional psychologists have become increasingly reliant upon the RNR as their overall guiding model of practice; neglecting the gold standard principles of EBP. We have highlighted three key areas in which correctional psychology is failing to adhere to EBP. We believe that the profession of correctional psychology is facing a mounting and very serious crisis. Correctional psychologists appear to have become increasingly disconnected from commitment to their professional identity as psychologists and more aligned with what looks like security, containment, and risk principles. Thus, it is vital that correctional psychologists themselves, the discipline as a whole, and correctional policy makers work collaboratively to examine the scope of this problem as well as best solutions. In the following sections, we provide a number of recommendations at varying levels (i.e., individual, discipline, and policy-maker) in the hope of injecting the psychology back into corrections and improving rehabilitative success.

Recommendations for Individual Psychologists working in Corrections

First, psychologists themselves must be active in adopting the gold standard EBP as their overarching model of practice. In order to achieve this, psychologists must step outside of the narrow RNR dominated literature to keep their research knowledge broad and current. For example, psychologists should seek to attend scientific conferences and pursue opportunities to interact with non-correctional psychologists implementing EBP. Importantly, lead correctional psychologists should seek to promote and encourage EBP through advocating opportunities for staff to engage in such activities and communicating with correctional management regarding the importance of rewarding and funding such activities.

Second, implementation of EBP within the highly rigid and security focused environment of corrections requires a high level of flexibility and dynamism. Thus,

correctional psychologists must pursue high levels of cognitive flexibility from themselves, colleagues, and trainees. By cognitive flexibility, we are referring to "an individual's ability to structure knowledge in response to changing situational demands" (Adams et al., 2006, p. 58). In other words, becoming 'expert' is critical for enabling independent psychologists to fully implement EBP as was originally intended. Psychologists can foster their own cognitive flexibility through seeking out supervised opportunities to challenge their clinical decision making skills with varying client groups and through being responsive to the full range of solutions available when seemingly impervious problems arise. Supervising psychologists should also seek to foster and reinforce cognitive flexibility in trainee psychologists who are particularly susceptible to the dual relationship problem.

Third, correctional psychologists need to nurture their general identity as a psychologist and take pride in their professional skills and expertise. To achieve this, they must regularly familiarize themselves with ethical codes governing psychological practice, engage in activities likely to foster strong psychological identity (i.e., through attending psychological societies or events), and promote EBP psychology in the face of correctional resistance stemming from genuine misunderstandings, economic pressures, and misperceived psychological parity. Correctional psychologists must also resist pressures to engage in correctional tasks that might compromise their identity as a psychologist and take the time to respectfully communicate the underlying reasons for their refusal to engage in such tasks. In a recent paper, Gaudiano and Miller (2013) stated that psychologists "focus too much on 'getting along' instead of advocating strongly for their interests and perspectives" (p 821). We believe this to be particularly evident within correctional settings. Senior psychologists should pay particular care to model appropriate assertion of professional identity to junior psychologists. Furthermore, lecturers and other professionals who play a key role in training and supervising students should pay more attention to developing the trainee's general identification as a psychologist. This will enable trainees to enter the workforce ready to face significant challenges to their identity.

Recommendations for Correctional Psychology as a Discipline

There are key recommendations that correctional psychology as a discipline need to take on board in order to support correctional workers at the coal face. First, professional forensic organizations need to help correctional policy makers see the benefits of EBP psychology within corrections. Professional organizations must highlight that registered psychologists' expertise and ability to flexibly and dynamically implement psychology within correctional settings is not a skill that can be fast tracked or emulated by paraprofessionals. In fact, they must do more to concretely address the de-professionalism of psychology within corrections through advocating transparent guidelines regarding 'best practice' EBP conditions within correctional settings. If strong guidelines and recommendations are proposed it is likely that the discipline of psychology within corrections can become much more respected and enhanced both by correctional workers and clients themselves. Professional organizations should also focus their attentions on the training of psychologists to work within correctional settings. Much more directive advice is required to make it clear that the dual relationship is problematic and can lead to reductions in best practice EBP psychology. This should then more explicitly inform core curricula for trainee correctional psychologists. Those professional organizations governing correctional psychology practice courses should also ensure that trained psychologists are aware of the 'bigger picture' outside of corrections through providing placements in other related areas (e.g., healthcare) that can promote more generalized clinical-forensic skills.

Recommendations for Correctional Policy Makers

We recognize that correctional policy makers experience significant pressures to implement risk reducing cost effective treatment to large numbers of offenders. Yet we believe that there is room—within these constraints—to inject psychology back into correctional settings so as to further optimize current RNR driven psychological approaches. First, correctional policy makers must increase their efforts to promote a broader EBP model to psychological practice and pay careful attention to ensure that key conditions required to implement EBP are in place. Most correctional policy makers

receive key expert advice from psychologists in order to improve correctional treatment practice. We urge correctional policy makers not only to maintain these links but also to make efforts to broaden their psychological input and advice to ensure that correctional psychology is not overly narrow. As an emerging discipline, correctional psychology has—over the decades— imported models, concepts, and ideas from general clinical psychology. Yet the key EBP model governing clinical psychological practice has been neglected. We urge policy makers to reconnect with experts within general clinical psychology to ensure best practice psychology within corrections.

Related to this, as noted earlier, it appears that the expertise and clinical decision making skills of the correctional psychologist have been undervalued. In some countries and jurisdictions, widespread training of paraprofessionals to undertake psychological treatment is common place and highly rigid structured treatment manuals prevail. We believe that the widespread training of paraprofessionals undertaking treatment, without co-facilitation by registered psychologists will lead to facilitators who (1) are not fully aware that the concept of EBP is much broader than RNR and should be their guiding model of practice, (2) do not detect valuable opportunities that they could use in order to bring about change in their clients, (3) remain unaware of or do not sophisticatedly reflect upon issues of clinical complexity, and (4) are at heightened risk of prioritizing relatively minor risk issues at the expense of the fundamental principles of behavior change (i.e., the dual relationship problem). Clinical competence requires maintenance and development of dynamic coal face clinical skills (Barnett, Doll, Younggren, & Rubin, 2007). Thus, corrections must employ qualified psychologists to engage in the complex task of translating and implementing EBP. In cases where paraprofessionals are required to support treatment, registered psychologists should co-facilitate groups in order to provide 'hands on' supervision and assist those in training to develop the competencies required to deliver best practice psychological treatment (e.g., the UK *Firesetting Intervention Program for Prisoners*; Gannon, 2012). Furthermore, policy makers must make efforts to put in place the conditions necessary for such a shift through informing and training correctional staff of the benefits of qualified psychological input.

In the case of manuals provided to guide psychological treatment, policy makers should seek to promote the use of semi-structured manuals or guides (see Marshall, 2009). That is, manuals that guide practice and hold key aims and objectives but also allow for clinical flexibility and do not treat the psychologist as passive 'teacher.' Towards this aim, policy makers should nurture cognitive flexibility on the part of psychological staff through ensuring that opportunities for developing cognitive flexibility are supported through training and CPD experiences. Psychological staff also require support in order to access the latest journal articles and books relating to EBP if they are to keep astride of EBP developments. In short, policy makers must adopt a more productive collaboration between psychology and corrections, examine how EBP can be supported, and find a better way of providing quality psychological treatment to large groups of individuals. In short, policy makers must cease their obsession with the content of manuals and look carefully at training the individuals who provide therapy.

Concluding Comments

We are aware that the title of our manuscript "Where has all the psychology gone" might appear critical of the general psychological skills and competencies of correctional psychologists. Our title is intentionally challenging. We are concerned about the lack of psychology and general support for EBP psychology within corrections. However, our arguments are intended to aid correctional colleagues in their pursuit of best practice psychology. This is not to say that psychologists do not have a role to play in injecting psychology back into corrections. We believe they do, however such efforts are much more likely to be effective if correctional policy makers are able to see the value of psychology as a profession.

We do believe that clinical-forensic psychology is in crisis. Through centralized policy-making, the implementation of concrete RNR principles has become translated in a way that is far removed from what we know about best practice psychology. In other words, RNR principles have become translated into a language which 'works' for correctional settings; that is, prioritize risk detection and management above all other things. Much more attention is needed on the basic psychological principles that we

were trained in and on implementing these in correctional settings. We are not arguing for something unachievable. And, we are not arguing that psychologists should prioritize individual offender client need and disregard the criminal justice system (see Chudzik & Aschieri, 2013). We know that individual therapy is not the key and that there is a need for effective group programming. What we are asking is that correctional psychology takes more of a role rather than quietly acquiescing to political and economic pressures. Risk and security is important within correctional settings but so too is best practice effective rehabilitation. The question is: which road will psychologists and policy makers choose for the future?

References

Adams, K., Hean, S., Sturgis, P., & Clark, J. (2006). Investigating the factors influencing professional identity of first-year health and social care students. *Learning in Health and Social Care, 5*, 55-68. doi: 10.1111/j.1473-6861.2006.00119x

Ackerman, S. J., & Hilsenroth, M. J. (2003). A review of therapist characteristics and techniques positively impacting the therapeutic alliance. *Clinical Psychology Review, 23*, 1-33.

Addis, M. E. (1997). Evaluating the treatment manual as a means of disseinating empirically validated psychotherapies. *Clinical Psychology: Science and Practice, 4* (1), 1-11.

American Psychological Association (2002, 2010 amendments). *Ethical principles of psychologists and code of conduct.* Retrieved March 26, 2014 from www.apa.org/ethics/code/principles.pdf.

American Psychological Association Presidential Task Force on Evidence-Based Practice (2006). Evidence-based practice in psychology. American Psychologist, 61, 271-285. doi: 10.1037/003-066X.61.4.271

Andrews, D. A., & Bonta, J. L. (1994). *The psychology of criminal conduct*. (5th edition). Cincinnati, OH: Anderson.

Andrews, D. A., & Bonta, J. L. (1998). *The psychology of criminal conduct*. (2nd edition). Cincinnati, OH: Anderson.

Andrews, D. A., & Bonta, J. L. (2003). *The psychology of criminal conduct.* (3rd edition). Cincinnati, OH: Anderson.

Andrews, D. A., & Bonta, J. L. (2006). *The psychology of criminal conduct*. (4th edition). Cincinnati, OH: Anderson.

Andrews, D. A., & Bonta, J. L. (2010a). *The psychology of criminal conduct*. (5th edition). Cincinnati, OH: Anderson.

Andrews, D. A., & Bonta, J. L. (2010b).Rehabilitating criminal justice policy and practice. *Psychology, Public Policy, and Law, 16*, 39-55.

Andrews, D. A., Bonta, J. L., & Hoge, R. D. (1990). Classification for effective rehabilitation: Rediscovering psychology. *Criminal Justice and Behavior, 17*, 19-52.

Andrews, D. A., Zinger, I., Hoge, R. D., Bonta, J. L, Gendreau, P., & Cullen, F. T. (1990). Does correctional treatment work? A psychologically informed meta-analysis. *Criminology, 28*, 369-404.

Barlow, D. H. (2011). A prolegomenon to clinical psychology: Two 40-year Odysseys. In D. H. Barlow (Ed), *The oxford handbook of clinical psychology* (pp.3-20). NY: Oxford University Press.

Barnett, J. E., Doll. B., Younggren, J. N., & Rubin, N. J. (2007). Clinical competence for practicing psychologists: Clearly a work in progress. *Professional Psychology: Research and Practice, 38*, 510-517.

Beck, A. T., Rush, A. J., Shaw, B. F., & Emery, G. (1979). Cognitive therapy of depression. New York: Guilford Press.

Beech, A. R., & Fordham, A. S. (1997). Therapeutic climate of sexual offender treatment programs. *Sexual Abuse: A Journal of Research and Treatment, 9*, 219-237.

Beech, A. R., & Hamilton-Giachritis, C. E. (2005). Relationship between therapeutic climate and treatment outcomes in group-based sexual offender treatment program. *Sexual Abuse: A Journal of Research and Treatment, 17,* 127-140.

Benner, P. (2001). *From novice to expert: Excellence and power in clinical nursing practice*. Upper Saddle River, NJ: Prentice Hall.

Bennett-Levy, J. (2003). Mechanisms of change in cognitive therapy: the case of automatic thought records and behavioural experiments. *Behavioural and Cognitive Psychotherapy*, 31, 261-277.

Bennett-Levy, J., Butler, G., Fennell, M., Hackman, A. Mueller, M., & Westbrook, D. (Eds.) (2004). *Oxford guide to behavioural experiments in cognitive therapy*. Oxford: Oxford University Press.

Beutler, L. E., Harwood, T. M., Michelson, A., Song, X., & Holman, J. (2011). Reactance/resistance level. *Journal of Clinical Psychology, 67*, 133-142.

Bonta, J., & Andrews, D. A. (2007). *Risk-need-responsivity model for offender assessment and rehabilitation* (User report 2007-06). Ottawa, Ontario: Public Safety Canada.

Boothby, J. L., & Clements, C. B. (2000). A national survey of correctional psychologists. *Criminal Justice and Behavior, 27*, 716- 732.

Boothby, J. L., & Clements, C. B. (2002). Job satisfaction for correctional psychologists: Implications for recruitment and retention. *Professional Psychology: Research and Practice, 33*, 310-315.

Bordin, E. S. (1979). The generalizability of the psychoanalytic concept of the working alliance. *Psychotherapy: Theory, Research and Practice, 16*, 252-260.

Boswell, J. F., Sharpless, B. A., Greenberg, L. S., Heatherington, L., Huppert, J. D., Barber, J. P., Goldfried, M. R., Castonguay, L. G. (2011). Schools of psychology and the beginnings of a scientific approach. In D. H. Barlow (Ed), *The oxford handbook of clinical psychology* (pp.98-127). NY: Oxford University Press.

Brayford, J., Cowe, F., & Deering, J. (2010). *What else works? Creative work with offenders.* Cullompton, UK: Willan.

British Psychological Society (2009). *Code of ethics and conduct. Guidance published by the Ethics Committee of the British Psychological Society*. Retrieved May 01, 2014 from http://www.bps.org.uk/system/files/documents/code_of_ethics_and_conduct.pdf

Cahalan, M. W. (1986). Historical corrections statistics in the United States 1850-1984. *BJS reports. NCJ 102529*. Washington, DC: United States Department of Justice.

Casey, S., Day, A., Vess, J., & Ward, T. (2013). *Foundations of offender rehabilitation*. NY: Routledge.

Castonguay, L. G., Goldfried, M. R., Wiser, S., Raue, P. J., & Hayes, A. M. (1996). Predicting the effect of cognitive therapy for depression: A study of unique and common factors. *Journal of Consulting and Clinical Psychology, 64*, 497-504. doi: 10.1037/0022-006x.64.3.497.

Chi, M. T. H. (2006). Two approaches to the study of experts' characteristics. In K.A. Ericsson, N. Charness, P. Feltovich, & R. Hoffman (Eds.), *Cambridge Handbook of Expertise and Expert Performance.* (pp. 121-30), Cambridge University Press.

Chudzik, L., & Aschieri, F. (2013). Clinical relationships with forensic clients: A three-dimensional model. *Aggression and Violent Behavior, 18*, 722-731. doi: 10.1016/j.avb.2013.07.027.

Clark, L., Tyler, N., Gannon, T. A., & Kingham, M. (in press). Eyemovement desensitisation and reprocessing (EMDR) for offence related trauma in a mentally disordered sexual offender. *Journal of Sexual Aggression.*

Couture, S. M., Roberts, D. L., Penn, D. L., Cather, C., Otto, M. W., & Goff, D. (2006). Do baseline client characteristics predict the therapeutic alliance in the treatment of schizophrenia? *Journal of Nervous and Mental Disease, 194*, 10-14.

Craig, L. A., Dixon, L., & Gannon, T. A. (2013). (Eds), *What works in offender rehabilitation: An evidence based approach to assessment and treatment*. Chichester, UK: Wiley-Blackwell.

Cullen, F. T. (2007). Make rehabilitation corrections' guiding paradigm. *Criminology and Public Policy, 6*, 717-727.

DeRubeis, R. J., & Crits-Christoph, P. (1998). Empirically supported individual and group psychological treatments for adult mental disorders. *Journal of Consulting and Clinical Psychology, 66*, 37-52.

DiLillo, D., & McChargue, D. (2007). Implementing elements of evidence-based practice into scientist-practitioner training at the University of Nebraska-Lincoln. *Journal of Clinical Psychology, 63*, 673-685.

Elvins, R., & Green, J. (2008). The conceptualization and measurement of therapeutic alliance: An empirical review. *Clinical Psychology Review, 28*, 1167-1187.

Etringer, B. D., & Hillerbrand, E. (1995). The transition from novice to expert counselor. *Counselor Education and Supervision, 35*, 4-14.

Evans, I. M. (2013). *How and why people change: Foundations of psychological therapy*. NY: Oxford University Press.

Flinton, C. A., & Scholz, R. (2006). *Engaging resistance: creating partnerships for change in sexual offender treatment.* Brandon, VT: Safer Society Foundation.

Friendship, C., Blud, L., Erikson, M., Travers, R., & Thornton, D. (2003). Cognitive-behavioural treatment for imprisoned offenders: An evaluation of HM Prison Service's cognitive skills programmes. *Legal and Criminological Psychology, 8*, 103-114.

Gannon, T. A. (2012). *The Firesetting Intervention Programme for Prisoners*. CORE-FP, University of Kent.

Gannon, T. A. (2014). *The neglect of the behavioral experiment in forensic psychology*. Manuscript under review.

Gannon, T. A. & Lockerbie, L. (2014). *The Firesetting Intervention Programme for Mentally Disordered Offenders.* Kent Forensic Psychiatry Service and CORE-FP, University of Kent.

Garfield, S. L. (2008). Clinical psychology. *The study of personality and behavior.* NJ: Aldine Transaction.

Gaudiano, B. A., & Miller, I. W. (2013). The evidence-based practice of psychotherapy: Facing the challenges that lie ahead. *Clinical Psychology Review, 33*, 813-824.

Ghaemi, S. N. (2009). The case for, and against, evidence-based psychiatry. Acta Psychiatrica Scandinavica, 119, 249-251. doi: 10.1111/j.1600-0447.2009.01355.x

Gray, N. S., Carmen, N. G., Rogers, P., MacCulloch, M. J., Hayward, P., & Snowden, R. J. (2003). Post traumatic stress disorder caused in mentally disordered offender by the committing of a serious violent or sexual assault. *Journal of Forensic Psychiatry and Psychology, 14*, 27-43.

Greenberg, S. A., & Shuman, D. W. (1997). Irreconcilable conflict between therapeutic and forensic roles. *Professional Psychology: Research and Practice, 28,* 50-57. doi: 0735-7028/97

Greenberg, S. A., & Shuman, D. W. (2007). When worlds collide: Therapeutic and forensic roles. *Professional Psychology: Research and Practice, 38*, 129-132. doi:10.1037/0735-7028.38.2.129

Greil, A. L., & Rudy, D. R. (1983). Conversion to the world view of Alcoholics Anonymous: A refinement of conversion theory. Qualitative Sociology, 6, 5-28.

Gutheil, T. G., & Gabbard, G. O. (1998). Misuses and misunderstandings of boundary theory in clinical and regulatory settings. *American Journal of Psychiatry, 155*, 409-414.

Haag, A. M. (2006). Ethical dilemmas faced by correctional psychologists in *Canada. Criminal Justice and Behavior, 33*, 93-109.

Hagen, R., & Nordahl, H. M. (2008). Behavioral experiments in the treatment of paranoid schizophrenia: A single case study. *Cognitive and Behavioral Practice, 15*, 296-305.

Hanson, R. K., Bourgon, G., Helmus, L., & Hodgson, S. (2009). The Principles of Effective Correctional Treatment Also Apply To Sexual Offenders: A Meta-Analysis. *Criminal Justice and Behavior, 36*, 865-891.

Harkins, L., Flak, V., Beech, A. R., & Woodhams, J. (2012). Evaluation of a community-based sex offender treatment program using a Good Lives model approach. *Sexual Abuse: A Journal of Research and Treatment, 24,* 519-543. doi: 10.1177/1079063211429469

Harvey, J., & Smedley, K. (2012). *Psychological therapy in prisons and other secure settings.* Cullompton, UK: Willan.

Henry, W. P., Strupp, H. H., Butler, S. F., Schacht, T. E., & Binder, J. L. (1993). Effects of training in time-limited dynamic psychotherapy: Changes in therapist behavior. *Journal of Consulting and Clinical Psychology, 61*, 434-440.

Hofmann, S. G., & Asmundson, G. J. G. (2008). Acceptance and mindfulness-based therapy: New wave or old hat? *Clinical Psychology Review, 28*, 1-16.

Horvath, A. O. (2001). The alliance. *Psychotherapy, 38*, 365-372.

Horvath, A. O., & Luborsky, L (1993). The role of the therapeutic alliance in psychotherapy. Journal of Consulting and Clinical Psychology, 61, 561-573. doi: 10.1037/0022-006X.61.4.561.

Johnson, C. L., Cullen, F. T., & Lux, J. L. (2013). Creating ideological space: Why public support for rehabilitation matters. In L. A. Craig, L. Dixon, & T. A. Gannon (Eds), *What works in offender rehabilitation: An evidence based approach to assessment and treatment* (pp. 50-68). Chichester, UK: Wiley-Blackwell.

Johansson, R., Sjöberg, E., Sjöberg, M., Johnsson, E., Carlbring, P., Andersson, T., Rousseau, A., & Andersson, G. (2012).Tailored vs. Standardized internet-based cognitive behavior therapy for depression and comorbid symptoms: A randomised control trial. *PloS ONE, 7* (5). doi:10.1371/journal.pone.0036905

Klein, G. A. (1993). A recognition primed decision (RPD) model of rapid decision making. In G. A. Klein, J. Orasanu, R. Calderwood, & C. E. Zsambok (Eds.), *Decision-making in action: Models and methods* (pp. 138-147). Norwood, NJ: Ablex.

Koerner, N., Hood, H. K., & Antony, M. M. (2011). Interviewing and case formulation. In D. H. Barlow (Ed), *The oxford handbook of clinical psychology* (pp.225-253). NY: Oxford University Press.

Kuyken, W. (2006). Evidence based case formulation: Is the emperor clothed? In N. Tarrier (Ed.), *Case formulation in cognitive behaviour therapy: The treatment of challenging and complex cases* (pp. 12-35). London: Routledge.

Larkin, J., McDermott, J. Simon, D. P., & Simon, H. A. (1980). Expert and novice performance in solving physics problems. *Science, 208*, 13335-1342.

Lesgold, A., Rubinson, H., Feltovich, P., Glaser, R., Klopfer, D., & Wang, Y. (1988). Expertise in a complex skill: Diagnosing x-ray pictures. In M. T. H. Chi, R. Glaser, & M. Farr (Eds.) The nature of expertise (pp. 311-432). Hillsdale, NJ: Lawrence Erlbaum Associates.

Levenson, J., Willis, G., & Prescott, D. (2014). Adverse childhood experiences in the lives of male sex offenders: Implications for trauma-informed care. Sexual Abuse: A Journal of Research and Treatment (Online First). doi: 10.1177/1079063214535819.

Lilienfeld, S. O. (2010).Can psychology become a science? Personality and Individual Differences*, 49*, 281-288.

Lilienfeld, S. O., Ritschel, L. A., Lynn, S. J., Cautin, R. L., & Latzman, R. D. (2013). Why many clinical psychologists are resistant to evidence-based practice: Root causes and constructive remedies. *Clinical Psychology Review, 7*, 883-900.

Lipsey, M. W., & Wilson, , D. B. (2001). The way in which intervention studies have "personality" and why it is important to meta-analysis. *Evaluation and the Health Professions, 24*, 236-254.

Luborsky, L., Crits-Christoph, P., Mintz, J., & Auerbach, A. (1988). *Who will benefit from psychotherapy?* Predicting therapeutic outcome. New York: Basic Books.

Mann, R. E., Ware, J., & Fernandez, Y. M. (2011). Managing sexual offender treatment programs. In Boer, D. P., Eher, R, Craig, L. A., Miner, M. H., & Pfäfflin, F. (Eds.), *International perspectives on the assessment and treatment of sexual offenders: Theory, practice and research* (pp. 331-353). Chichester, UK: Wiley-Blackwell.

Marshall, W. L. (2009). Manualization: A blessing or a curse? *Journal of Sexual Aggression, 15*, 109-120.

Marshall, W. L., & Burton, D. L. (2010). The importance of group processes in offender treatment. *Aggression and Violent Behavior, 15*, 141-149.

Marshall, W. L., & McGuire, J. (2003). Effect sizes in the treatment of sexual offenders. International Journal of Offender Therapy and Comparative Criminology, 47, 653-663. doi: 10.1177/0306624X03256663

Marshall, W. L., & Serran, G. A. (2004). The role of the therapist in offender treatment. *Psychology, Crime & Law, 10*, 309-320.

Marshall, W. L., Serran, G. A., Moulden, H., Mulloy, R., Fernandez, Y. M., Mann, R. E. et al. (2002). Therapist features in sexual offender treatment: Their reliable identification and influence on behavior change. *Clinical Psychology and Psychotherapy, 9*, 395-405.

Marshall, W. L. Serram, G. A., Fernandez, H. M., Mulloy, R., Mann, R. E., & Thornton, D. (2003). Therapist characteristics in the treatment of sexual offenders: Tentative data on their relationship with indices of behavior change. *Journal of Sexual Aggression, 9*, 25-30.

Martinson, R. (1974). What works?—questions and answers about prison reform. *The Public Interest, 35*, 22-54.

Mennicken, A. (2013). Too big to fail and too big to succeed: Account and privatisation in the Prison Service of England and Wales. *Financial Accountability and Management, 29*, 206-226.

Morgan, R. D., Winterowd, C. L., Ferrell, S. W. (1999). A national survey of group psychotherapy services in correctional facilities. *Professional Psychology: Research and Practice, 30*, 6000-606.

Nelson, T. D., Steele, R. G., & Mize, J. A. (2006). Practitioner attitudes toward evidence-based practice: Themes and challenges. *Administration and Policy in Mental Health and Mental Health Services Research, 33*, 398-409.

New Zealand Department of Corrections (2013, March). *Prison performance Table- the model.* New Zealand: Department of Corrections.

Norcross, J. C. (2002). Empirically supported therapy relationships. In J. C. Norcross (Ed.), Psychotherapy relationships that work: Therapist contributions and responsiveness to patients (pp. 3-16). NY: Oxford University Press.

Norcross, J. C. (Ed.), *Psychotherapy relationships that work: Therapist contributions and responsiveness to patients*. NY: Oxford University Press.

Norcross, J. C., & Wampold, B. E. (2011). Evidence-based therapy relationships: Research conclusions and clinical practices. *Psychotherapy, 48*, 98-102.

Persons, J. B. (2006). Case formulation driven psychotherapy. *Clinical Psychology: Science and Practice, 13,* 167-170.

Persons, J. B. (2008). *The case formulation approach to cognitive-behavior therapy*. NY: Guilford Press.

Persons, J. B., & Tomkins, M. A. (2007). Cognitive-behavioral case formulation. In T. D. Eells (Ed.), *Handbook of psychotherapy case formulation* (pp.290-316). NY: Basic Books.

Polaschek, D. L. L. (2012). An appraisal of the risk-need-responsivity (RNR) model of offender rehabilitation and its application in correctional treatment. Legal and Criminological Psychology, 17, 1-17. doi: 10.1111/j.2044-8333.2011.02038.x

Pope, K. S., & Keith-Spiegel, P. (2008). A practical approach to boundaries in psychotherapy: Making decisions, bypassing blunders, and mending fences. *Journal of Clinical Psychology: In Session, 64*, 638-652, doi: 10.1002/jclp.20477

Pratt, M. G., Rockmann, K. W., & Kaufmann, J. B. (2006). Constructing professional identity: The role of work and identity learning cycles in the customization of identity among medical residents. *Academy of Management Journal,* 49, 235-262.

Roe, R. A. (2002). What makes a competent psychologist? European Psychologist, 7, 192-202. doi: 10.1027//1016-9040.7.3.192

Richardson, T. (2009). Challenges for the scientist-practitioner model in contemporary clinical psychology. Psych-Talk [University of Bath], 62, 20-26. http://opus.bath.ac.uk/12672/1/Richardson%2D_Challenges_to_scientist%2Dpractitioner_model.pdf

Ringler, M. (1977). The effect of democratic versus authoritarian therapist behavior on success, success-expectation and self-attribution in desensitization of examination anxiety. *Zeitchrift fur Klinische Psychologie, 6*, 40-58.

Ross E. C., Polaschek D. L. L., Ward T. (2008). The therapeutic alliance: A theoretical revision for offender rehabilitation. *Aggression and Violent Behavior 13*, 462-480.

Safran, J. D., Muran, J. C., & Eubanks-Carter, C. (2011). Repairing alliance ruptures. *Psychotherapy, 48*, 80-87.

Sanderson, L. (December, 2009). *Psychology breaking the rules*. Inside Time. Retrieved 23 May, 2014 from http://www.insidetime.co.uk/backissues/December%202009.pdf

Schottenbauer, M. A., Glass, C. R., Arnkoff, D. B., Tendick, V., Hafter-Gray, S. (2008). Nonresponse and dropout rates in outcome studies on PTSD: Review and methodological considerations. Psychiatry: Interpersonal and Biological Processes, 71, 134-168. doi: 10.1521/psyc.2008.71.2.134.

Serran, G. A., Fernandez, Y. M., Marshall, W. L., & Mann, R. E. (2003). Process issues in treatment: Applications to sexual offender programs. *Professional Psychology: Research and Practice, 34, 368-374.*

Sharpless, B. A., & Barber, J. P. (2009). A conceptual and empirical review of the meaning, measurement, development, and teaching of intervention competence in clinical psychology. *Clinical Psychology Review, 29*, 47-56.

Shirk, S. R., & Karver, M. S. (2011). Alliance in child and adolescent psychotherapy. In J. C. Norcross (Ed.), *Psychotherapy relationships that work* (2nd ed) (pp. 70-91). NY: Oxford University Press.

Smith, D. & Fitzpatrick, M. (1995). Patient-therapist boundary issues: An integrative review of theory and research. *Professional Psychology: Research and Practice, 26*, 499-506.

Strauss, J. L. Hayes, A. M., Johnson, S. L., Newman, C. F., Brown, G. K., Barber, J. P., Laurenceau, J.-P., & Beck, A. T. (2006). Early alliance, alliance ruptures, and symptom change in a nonrandomised trial of cognitive therapy for avoidance and obsessive-compulsive personality disorders. *Journal of Consulting and Clinical Psychology, 74*, 337-345. doi: 10.1037/0022-006x.74.2.337.

Spring, B. (2007). Evidence-based practice in clinical psychology: What is it; why it matters; what you need to know. *Journal of Clinical Psychology, 63*, 611-631.

Spruill, J., Rozensky, R. H., Stigall, T. T., Vasquez, M., Bingham, R. P. De Vaney Olvey, C. (2004). Becoming a competent clinician: Basic competencies in intervention. *Journal of Clinical Psychology, 60*, 741-754.

Sturmey, P. (2009). *Clinical case formulation: Varieties of approaches*. Chichester, UK: Wiley-Blackwell.

Sweet, A. A. (1984). The therapeutic relationship in behavior therapy. *Clinical Psychology Review, 4*, 253-272.

Tapp, J., Fellowes, E., Wallis, N., Blud, L., & Moore, E. (2009). An evaluation of the Enhanced Thinking Skills (ETS) programme with mentally disordered offenders in a high security hospital. *Legal and Criminological Psychology, 14*, 201-212.

Thyer, B., & Pignotti, M. (2011). Evidence-based Practices do not exist. *Clinical Social Work Journal, 39*, 328-333.

Towl, G. (2002). Working with offenders: The ins and outs. *The Psychologist, 15*, 236-239.

Von Hirsch, A. (1976). *Doing justice: The choice of punishments*. NY: Hill and Wang.

United Nations Human Development Program (2007). *Human Development Report 2007/2008. Fighting climate change: Human solidarity in a divided world.* NY: Palgrave.

Ward, T. (2010). Is offender rehabilitation a form of punishment? *British Journal of Forensic Practice, 12*, 4-13.

Ward, T. (2013). Addressing the dual relationship problem in forensic and correctional practice. Aggression and Violent Behavior, 18, 92-100.

Ward, T., Collie, R., & Bourke, P. (2009). Models of offender rehabilitation: The Good Lives Model and Risk Need Responsivity Model. In A. R. Beech, L. A. Craig, & K. D. Browne (Eds.), *Assessment and treatment of sex offenders: A handbook* (pp. 293-310). Chichester: Wiley-Blackwell.

Ward, T., & Gannon, T. A. (2006). Rehabilitation, etiology, and self regulation: The Good Lives Model of sexual offender treatment. *Aggression and Violent Behavior, 11*, 77-94.

Ward, T., Gannon, T. A., & Birgden, A. (2007). Human rights and the treatment of sex offenders. *Sexual Abuse: A Journal of Research and Treatment, 19*, 195-216.

Ward, T., & Maruna, S. (2007). *Rehabilitation. Beyond the risk assessment paradigm.* London, UK: Routledge.

Ward, T., Melser, J., & Yates, P. M. (2007). Reconstructing the Risk-Need-Responsivity model: A theoretical elaboration and evaluation. *Aggression and Violent Behavior, 12*, 208-228.

Ward, T., & Salmon, K. (2009). The ethics of punishment: correctional practice implications. *Aggression and Violent Behavior, 14*, 239-247.

Ward, T., & Stewart, C. A. (2003). Criminogenic needs and human needs: A theoretical model. *Psychological, Crime, & Law, 9,* 125-143.

Ward, T., & Syverson, K. (2009). Vulnerable agency and human dignity: an ethical framework for forensic practice. *Aggression and Violence Behavior, 14*, 94-105.

Ward, T., & Willis, G. (2010). Ethical issues in forensic and correctional research. *Aggression and Violent Behavior, 15*, 399-409.

Weinberger, L. E., & Sreenivasan, S. (1994). Ethical and professional conflicts in correctional psychology. *Professional Psychology: Research and Practice, 25*, 161-167.

Whiston, S. C., & Coker, K. J. (2000). Reconstructing clinical training: Implications from research. *Counselor Education and Supervision, 39*, 228-262.

Willis, G. M., Yates, P. M., Gannon, T. A., & Ward, T. (2012). How to integrate the Good Lives Model into treatment programs for sexual offending: An introduction and overview. *Sexual Abuse: A Journal of Research and Treatment, 25*, 123-142.

Wood, J. L. (2009). Why public opinion of the criminal justice system is important. In J. L. Wood & T. A. Gannon (eds), *Public opinion and criminal justice* (pp. 33-48). Cullompton, UK: Willan.

Zimring, F. E., & Hawkins, G. (1991). *The scale of imprisonment.* Chicago, IL: University of Chicago Publishers.

Zur, O. (2005). The dumbing down of psychology: Faulty beliefs about boundary crossings and dual relationships. In R. H. Wright & N. A. Cummings, (Eds.), *Destructive trends in mental health: The well intentioned road to harm* (pp. 253-282). NY: Brunner-Routledge.