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Dr. Pat Bricklin was one of the giants of professional psychology in Pennsylvania and far beyond our borders. She did more to advance the practice of professional psychology in the Commonwealth than any other person in Pennsylvania.

*– Dr. Joseph French*

# Dr. Patricia M. Bricklin

## A LEGACY OF SERVICE

On December 21, 2010, Dr. Patricia M. (Pat) Bricklin died after a long illness. Dr. Bricklin had been closely associated with professional psychology for more than 40 years. In addition to teaching at Widener University, she had been a member of the Pennsylvania State Board of Psychology, a consultant to the APA Insurance Trust, and had held numerous governance positions within the American Psychological Association and the Pennsylvania Psychological Association. She is survived by her husband, Barry, a distinguished psychologist in his own right, four children, and several grandchildren.

When she received her doctorate in psychology from Temple University in 1964, she was one of the few women to earn a doctorate. Dr. Bricklin was also a certified school psychologist. While raising a family she still found time to co-host with Barry Bricklin one of the first call-in psychology radio shows, "Pinpoint Psychology," on WCAU-FM. For many years she maintained an independent consulting practice with Barry. She also worked as a consultant to Parkway Schools; joined the faculty at Hahnemann University; and later moved with the

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# Ensuring Competence as Psychologists

*Samuel Knapp, Ed.D., Director of Professional Affairs*

Competence, the lynchpin of being an effective professional, has been defined as "the habitual and judicious use of communication, knowledge, technical skills, clinical reasoning, emotions, values, and reflection in daily practice for the benefit of the individual and community being served" (Epstein & Hundert, 2002, p. 226). What is known about competence as a psychologist? First, we know that psychotherapists vary in their outcomes. For example, Okishi et al. (2006) found "super shrinks" and "under performing shrinks." Looking at 71 therapists with at least 30 clients each, they found that the top 7 therapists had lower deterioration rates (5%) than the bottom 7 therapists (11%), and significantly higher treatment gains.

Second, psychologists, like all other persons, may overestimate their competence (called the "Lake Wobegone effect" in that everyone is above average). For example, Davis et al. (2006) found that physicians tend to overrate their competence when compared with observed and impartial measures of competence.

Third, on at least one measure of competence – being disciplined by a licensing board – members of PPA did substantially better than non-members of PPA (Knapp & VandeCreek, 2009). Looking at disciplinary data from the Pennsylvania State Board of Psychology over an 11-year period, the researchers found that only 34 out of 140 disciplinary actions were against PPA members, including only

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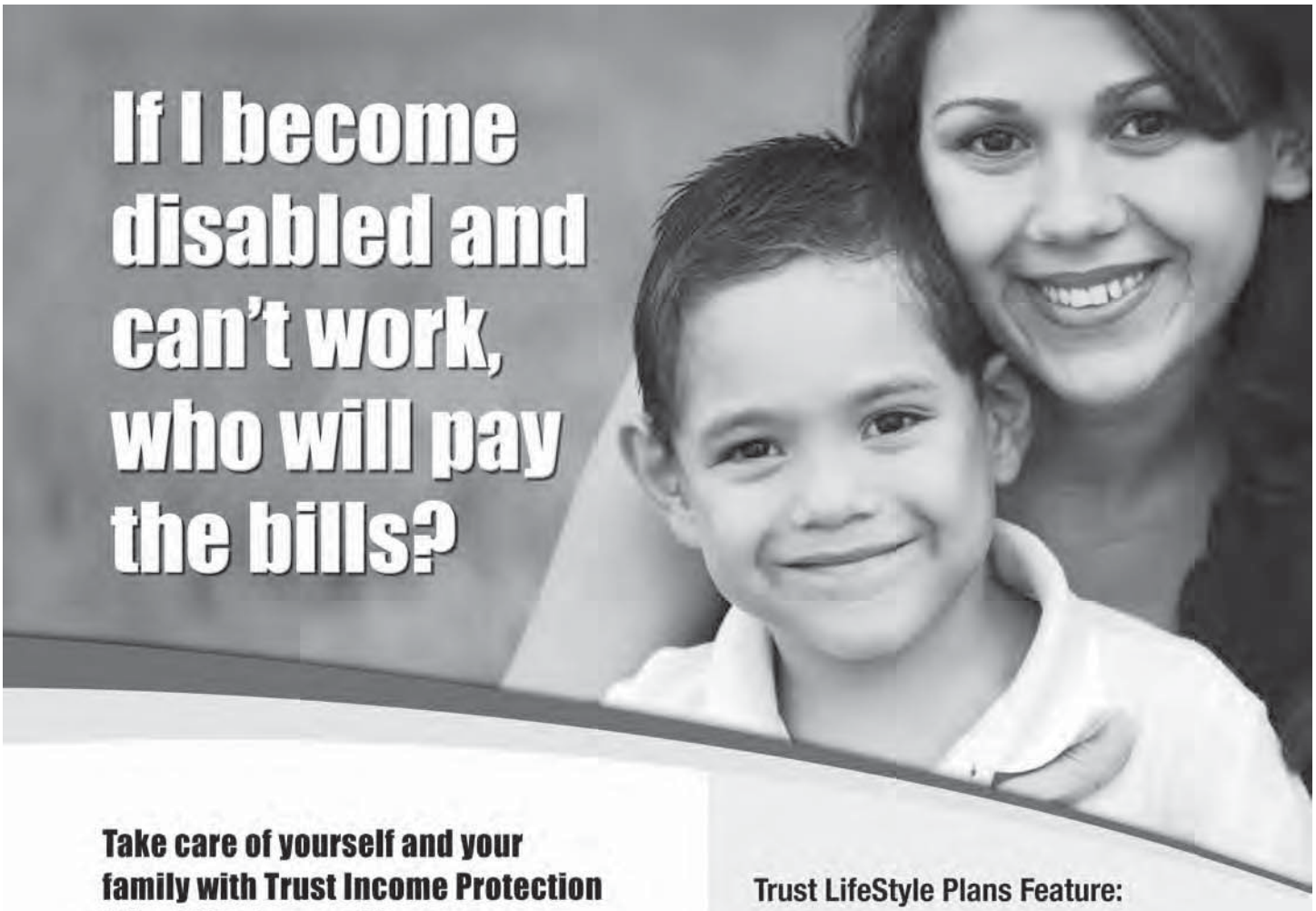

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# The Moral Character of Psychologists: What Standards Are Required for Licensees?

*Samuel Knapp, Ed.D., ABPP*

*Dr. Sam Knapp*

To what extent should licensing boards be concerned with the personal character of psychologists or psychology applicants? On one hand, it could be argued that the licensing boards should not be evaluating personal morality, as long as the licensee is practicing competently or the student is fulfilling other requirements for licensing. On the other hand, it could be argued that licensing boards should be concerned with moral character because personal morality seems closely related to the ability to practice competently and conscientiously.

Pennsylvania's Professional Psychologists Practice Act requires licensing applicants to be of "acceptable moral character" (Section 6 (a) (1)). Unacceptable moral character may be inferred because of actions taken within the field of psychology. For example, the code of ethics of the State Board of Psychology (the board) applies to psychology graduate students and psychology trainees, and a violation of it "may be regarded by the board as evidence of unacceptable moral character" (49 Pa Code §41.61). Also, unacceptable moral character may be inferred because of personal criminal behavior. Pennsylvania's regulations require psychology applicants to submit a criminal history records check and a child abuse history clearance (49 Pa Code §41.30). Also, the Professional Psychologists Practice Act specifically disqualifies applicants who have been convicted of a felony of selling illegal drugs, unless at least 10 years have elapsed since the conviction and the application demonstrates rehabilitation and lack of risk of harm to others. Other licensing laws in Pennsylvania have similar provisions.

Even after a person is licensed, the State Board of Psychology may discipline any psychologist who has been convicted of any felony, or any misdemeanor related to the practice of psychology. By regulation the board requires licensed psychologists to report all misdemeanors to the board within 30 days of the conviction (49 Pa Code §41.91 (a)), and the board determines whether or not the misdemeanor relates to the practice of psychology. Furthermore, psychologists who work with children in agencies funded by Medical Assistance or who work in public schools must have a check for a history of child abuse or crimes against children (called Act 34 and Act 151 background checks).

*Clinical training programs and licensing boards have an obligation to ensure adequate character of those admitted into the profession.*

There is little data on how psychology licensing boards would interpret "acceptable moral character." However, experience with other professions suggests that private behavior that is not illegal is not considered in making a determination. For example, in the 1950s, during the McCarthy era characterized by a heightened concern about Communist influence, the U.S. Supreme Court overturned efforts by the California Bar to deny admission to applicants because of the lack of moral character based only on the fact that they had belonged to the Communist Party (e.g., *Konigsberg v. State Bar of California*, 1957).

Even a serious crime in the past may not necessarily disqualify an individual from sitting for licensing. For example, the California Bar will look at past misconduct on a case-by-case basis and consider factors such as the nature of the crime, age of the applicant at the time of the crime, length of time since the crime, restitution, rehabilitation of the applicant, or behavior of the applicant since the crime, among other factors (California Bar, 2010). The wisdom of taking such a case-by-case approach appears supported by Kelly and Clevette (2005), who found that nurses with previous criminal convictions were no more likely to be disciplined by a State Board of Nursing than nurses who did not have previous criminal convictions, suggesting that the licensing boards were effectively screening nurses with previous criminal convictions. We know of applicants who were permitted to sit for the psychology licensing examination in Pennsylvania even though they had felonies, but these convictions occurred many years ago, the applicants had demonstrated exemplary behavior for years, and the convictions involved unusual and mitigating circumstances. However, more recent felonies or a recent incident of a serious violation of the ethics of psychology could result in the denial of a license on the basis of lack of moral character.

Pennsylvania has some cases concerning denying licenses to individuals who engaged in unacceptable moral behavior, although we found no cases specific to psychology. In *Sellers v. State Board of Nursing* (2008), the Commonwealth of Pennsylvania affirmed the decision of the Pennsylvania State Board of Nursing to deny reinstating the license of

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# Pennsylvania Retains Two APA Representatives

Pennsylvania once again received by far the highest number of votes of all of the state, provincial, and territorial psychological associations (SPTAs) in the APA apportionment voting that ended December 16. We received 4.10% of the total vote. Pennsylvania is the only SPTA that had retained two representatives on APA's Council of Representatives for 2011. The recent vote, which was for the 2012 council, saw three other states join us with two representatives: New York (with 3.40%), California (2.86%), and Illinois (1.99%). New Jersey will retain one representative, having just missed the cutoff for two seats with 1.98%.

Divisions as a group lost three seats and SPTAs as a group gained three seats for 2012. Divisions 12, 15, 39, 43, and 50 each lost a seat, and Divisions 13 and 48 each picked up a seat.

The bylaws amendment, which would guarantee a seat to each division and SPTA on Council, needed to be approved by two-thirds of those voting to pass. It was defeated by the following margin: 56.45% – approve, 43.55% – not approve.

## THE MORAL CHARACTER OF PSYCHOLOGISTS

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a nurse on the grounds of lack of moral character for actions she took related to her practice as a nurse when, among other things, she failed to inform the licensing boards in other states of the disciplinary actions taken against her license in Pennsylvania. This ruling was consistent with the interpretation that behavior that violates standards in the practice of a profession could be evidence of unacceptable moral character.

Clinical training programs and licensing boards have an obligation to ensure adequate character of those admitted into the profession. Papadakis and others have shown that physicians disciplined by a medical board were more likely to have had reports of unprofessional conduct while in medical school (Papadakis et al., 2004; Papadakis et al., 2005); or performed poorly during residency (Papadakis et al., 2008). Of course, many people with problems as students or residents went on to have spotless medical careers. Nonetheless, training programs should intervene and monitor students who engage in unprofessional behavior. Fortunately, most psychology training programs periodically assess their students on conduct and professionalism, which includes classroom behavior, relationships with peers and teachers, and personal conduct (Johnson & Campbell, 2004), and require remedial work and monitoring when indicated.

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## ENSURING COMPETENCE AS PSYCHOLOGISTS

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4 out of 27 disciplinary actions for serious boundary violations.

From these and other studies we conclude that the optimal manner to ensure ongoing competence is to engage in productive self-reflection, which best occurs through contact with others. That is what Knapp and VandeCreek call an "extroverted" attitude toward professional practice. This continual contact with other professionals may occur through meetings, peer consultation groups, listservs, continuing education programs, presentations at conferences, or even by submitting articles for peer review.

This issue of the *Pennsylvania Psychologist* contains three articles that look at issues related to competence, including research on the impact of continuing education on competence, assessment of character as a condition of licensure, and the use of outcome measures as one source of data as part of a self-reflective practice.

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# Outcome Measures: One Tool in a Self-Reflective Outpatient Practice

*Samuel Knapp, Ed.D.*

The traditional manner of ensuring quality services has been to focus on static factors, such as licensing standards or mandatory continuing education, under the assumption that only qualified persons will become licensed and that continuing education programs will ensure the competency of those already licensed. However, considerations are given in other ways to improve the quality of health care services. This article suggests that the use of outcome measures for some patients may help improve outcomes.

I wish to distinguish my recommendation for the informed use of outcome measures from the "pay-for-performance" efforts of some insurers. In recent years some MCOs are offering (or mandating) outcome measures as part of a "pay-for-performance" program. The general idea is that those health care practitioners who show better outcomes as measured by objective benchmarks will be assigned patients with lower copays, receive more referrals, or obtain some other financial incentives. Poorly performing practitioners might even be removed from panels.

Pay-for-performance models have several problems associated with them, especially in mental health care. First, a linear model directly linking one measure of client self-report data to the quality of treatment fails to capture the dynamics and context of treatment or the multiple ways to measure treatment outcome. Also, the ideal assessment instrument should not only report on the progress of the patient, but also suggest reasons for any lack of improvement, such as relationship to the therapist. Furthermore, no program should remove or penalize psychologists on the basis of a small and unrepresentative sample, because it may encourage psychologists to "cherry pick" patients or to avoid those with complex problems or minimal social resources who will likely need long-term treatment and show modest improvements only after a long period of time. (It is interesting that some strong advocates of pay-for-performance often claim to be evidence-based because they cite literature on the benefits of using outcome measures, but then they propose to implement them in punitive ways without any evidence that doing so will actually improve patient care.)

Although I am skeptical of pay-for-performance models, I feel differently about the voluntary use of outcome measures. Psychologists can use data from brief structured assessments for some patients as one source of feedback as part of a self-reflective practice.

One criticism of using outcome measures is that competent psychologists should be able to discern if a patient is doing well or not, obviating the need for a structured outcome measure. There is some truth to this statement, but it does not represent the entire picture because all of us are subject to cognitive biases and blind spots. Clinicians, as a group, tend to be overly optimistic about their ability to help people. Statistical algorithms can predict treatment failure better than psychotherapists using intuition (Lambert, 2007). Another criticism is that outcome measures require time to explain the process to patients and get them to complete the instrument, and they involve other actions that cumulatively drain clinician time and resources. There is merit to this concern. Even in well run and efficient practices, the burdens on the therapist and patient must be considered in determining whether or how to use outcome measures. A third criticism is that since most patients improve when they receive short-term treatment (50% of patients have eight or fewer sessions of therapy), the use of outcome measures is unnecessary. Although most patients do improve with short-term treatment, the question remains as to whether the use of outcome measures would assist those patients who need longer-term treatment, or who are at risk to deteriorate or to fail at treatment.

However, the way in which outcome instruments are used can be as important as whether they are used. For example, the Treatment Outcomes Package (TOPs; Kraus, Wolf, & Castonguay, 2006) goes beyond the general statement as to whether the patient is getting better or not, and looks at signs as to whether the treatment is floundering and provides suggestions as to how to get it on the right track. Of course, the role of these assessment instruments is only to provide information to the treating therapists and not to replace their judgment. When these instruments are integrated into therapy they can form the basis for discussions between patients and psychologists about progress or obstacles in treatment (Lambert & Hawkins, 2004).

*The way in which outcome instruments are used can be as important as whether they are used.*

Systematic self-monitoring may be especially important when moving into new areas of practice. For example, LeVine (2007) presents a good model of self-monitoring where, as one of the first prescribing psychologists in New Mexico, she uses case studies, consultations with primary care physicians, and detailed records to monitor patient progress. However, assessments may also be beneficial in more traditional practices. For example, Gordon (2002) used pre- and post-test data from the MMPI to assess his effectiveness when treating patients with long-term therapy.

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**DR. PATRICIA M. BRICKLIN**

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faculty to Widener University. At Widener the Patricia M. Bricklin Scholarship in School Psychology is awarded annually to a third-year student. She was the author of numerous articles and chapters in peer-reviewed psychology publications.

Pat was involved with PPA for most of her professional career. As president in 1975-76 she did much to move PPA to a more professionalized organization, including the hiring of PPA's first governmental affairs representative. During her tenure as president, psychologists received recognition as members of multidisciplinary treatment planning teams in the facilities governed by the Department of Public Welfare, and became recognized as persons who can evaluate individuals who want permission to carry lethal weapons. Prior to her presidency she served as chair of the Professional Affairs Board, among other positions. She represented Pennsylvania on the APA Council of Representatives for four terms, where she advocated strongly for the interests of practitioner psychologists. She later received several awards from PPA: the Distinguished Service Award in 1983 and the Distinguished Contributions to School Psychology Award in 2009 for " a life dedicated to education ... providing services with leadership ... contributing to legal and ethical practices ... (and being) an outreach pioneer to the media." Dr. Bricklin also received the first PPA Ethics Educators Award in 1999, and since 2000 the Pennsylvania Psychological Foundation has given the Patricia M. Bricklin Student Award to a graduate student in psychology in Pennsylvania who has written the best manuscript on ethics.

On the national level, Dr. Bricklin served on the Board of Directors of APA and of the APA Insurance Trust, and was a member, sometimes chair, of many APA boards and committees, including the Committee for the Advancement of Professional Practice. Recognizing these many contributions, Dr. Bricklin received the APA State Leadership Award, the 1995 APA Award for Distinguished Contributions to Independent Practice, and the 2007 APF Gold Medal for Life Achievement.

When the first licensing board for psychologists was formed in Pennsylvania, Dr. Bricklin became its vice chair (her license number was PS00002) and was the only woman on that board. She was on the board for most of the next 30 years (often serving as its chair), with brief breaks between appointments. She was widely respected as the chair of the State Board of Psychology and worked effectively in transitioning Pennsylvania into a doctoral level standard for licensing from 1986 to 1995. Many of the first regulations of the licensing board were put into place during her tenure as board chair.

*When the first licensing board for psychologists was formed in Pennsylvania, Dr. Bricklin became its vice chair ... and was the only woman on that board. She was on the board for most of the next 30 years....*

Pat was also very involved in the Association of State and Provincial Psychology Boards (ASPPB), an association composed of members from 64 jurisdictions in Canada and the U.S. including some of its territories. She was president of ASPPB in 1987-88, became an ASPPB fellow in 1990 (the first year fellows were elected), and later received both the Morton Berger Award in 1991 and the Roger C. Smith Award in 1995.

These positions and awards, however impressive, fail to capture the competence and compassion that Dr. Bricklin brought to each of her roles and her dealings with others. Pat Bricklin was intelligent, energetic, happy, creative, and she loved people. In addition to her many professional accomplishments, she was a wonderful teacher, mentor, colleague, and friend. Her warmth and cheerfulness permeated everything she did, and she remained calm even in the most trying situations. When she was with someone, they received her undivided attention, in spite of the many e-mails, calls, and scholarly projects also competing for her attention. Many people throughout the years have commented how grateful they were for her help negotiating the licensure process.

In many of her writings, Pat emphasized that "being ethical is more than following the rules." No one brought this concept to life better than Pat. When someone asked her a question, rather than just answering it, Pat helped the person to find the answer. Her gentle questions guided them through the decision-making process to come to the best resolution of the situation.

One of Pat's most notable characteristics was her humility. She truly cared about others and was very generous with her time and talents. Pat led by example and created a culture of collaboration and collegiality in the many settings in which she worked. She was not only an advocate for the profession of psychology, but for her family, friends, and doing what was right.

Echoing the sentiments of many, her colleague, Dr. Joseph French, stated

> Dr. Pat Bricklin was one of the giants of professional psychology in Pennsylvania and far beyond our borders. She did more to advance the practice of professional psychology in the Commonwealth than any other person in Pennsylvania. Her presence will be greatly missed.

*Note: We thank Drs. Joe French and Linda Knauss for providing much of the background material.*

# 2010 PennPsyPAC Contributors

Many PPA members went above and beyond the call of duty to help ensure the viability and effectiveness of the Pennsylvania Psychological Political Action Committee (PennPsyPAC). We are listing here those who contributed at least $100 during the last calendar year. Many others contributed amounts less than $100; they are not listed here but will be listed in the pamphlet distributed at the annual convention. Thanks to each and every one of you!

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# Mandated Continuing Education: Evidence of Its Effectiveness Is Growing

*Samuel Knapp, Ed.D.*

All health care licensing boards in Pennsylvania require continuing education for licensure renewal. Also, most state boards of psychology require continuing education, and several mandate credit in ethics or law as part of that requirement. Most psychologists support mandated continuing education. On a five-point scale 75% of psychologists agreed or strongly agreed that CE should be mandatory for relicensure and only 10% disagreed or strongly disagreed (Sharkin & Plageman, 2003). In addition, almost 80% of psychologists surveyed reported that their CE experiences were good, and almost 75% reported that they learned a moderate amount or a lot through their CE (Neimeyer et al., 2009). Nonetheless, questions have arisen as to whether continuing education really fulfills its goal of ensuring competence among health care providers.

In 2007, the Agency for Healthcare Research and Quality commissioned Marinopoulos and others to review the evidence for the effectiveness of continuing medical education (CME). Marinopoulos et al. appropriately qualified their conclusions by noting that CE outcomes could vary considerably depending on the material being taught, the media for education being used, the length of the program, the audience, and other factors. Nonetheless, when looking at those studies that had an adequate control group, the authors concluded that "CME activities were effective at improving knowledge with the majority of these studies (68%) demonstrating long-term improvements in knowledge" (p. 3). CME programs also led to a change in attitudes toward certain tests or clinical management options, improved skills, and improved patient outcomes. The more effective programs use multiple means of education, including case presentations or participant interaction and opportunities to practice skills learned; and they have multiple exposures to the same content area (see also Bloom, 2005; Mansouri & Lockyer, 2007).

Despite these promising findings, Swankin et al. (2006) recommend that licensing boards have more flexibility in ways to ensure the continuing competence of its licensees. One suggestion is to require periodic evaluations of the knowledge and performance of licensees through written or oral examinations, peer review of work, consumer satisfaction surveys, records reviews, on-site practice reviews, evaluation of "standardized patients," performance evaluations, or learning portfolios. The College of Psychologists of Ontario (n.d.; the Canadian province's equivalent of a state licensing board) requires psychologists to complete a self-assessment and professional development plan every other year. A percentage of Ontario psychologists are audited every year and must participate in a 3- to 4-hour peer assisted review in which their facilities are toured, and they must respond to a semi-structured interview about their practices. In part, the move toward performance assessment is prompted by studies such as Davis et al. (2006), which found that physicians tend to overrate their competence when compared with observed and impartial measures of competence — suggesting advantages for programs that rely more on external assessment and less on the participant's internal perceptions of their skill level.

> *The more effective programs use multiple means of education, including case presentations or participant interaction and opportunities to practice skills learned....*

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# What Every Psychologist Needs to Know About Corrections, Probation, and Parole

Nationwide, incarcerations have increased over the last 40 years so that now 1 out of every 100 adults in the United States is incarcerated and many more are being supervised in the community as parolees or probationers (Andrew & Bonta, 2010). Most of the increase is due to "tougher" sentencing standards. For example, the prison population in the Pennsylvania correctional system has increased from 9,400 in 1981 (Pennsylvania Bureau of Corrections, 1981) to more than 50,000 today (Pennsylvania Department of Corrections, 2008), even though the state population has increased only 5% during that time, and the number of violent crimes (murder, rape, assault, etc.) has remained steady or actually decreased.

Most psychologists will at some time work with a patient who is in prison, on parole or probation, or will work with a family where one or more of their members are in prison or on parole or probation. This can complicate therapy, because, in addition to the inherent stress of incarceration or community monitoring for the patient or the patient's family member, the criminal justice system has procedures and attitudes that are foreign to most patients, as well as to most psychologists. This article provides basic information that every psychologist in the state needs to know concerning corrections, probation, and parole within Pennsylvania.

Many psychologists already know that offenders may be sent to county jails for immediate pretrial detention or for sentencing of minor crimes. Those convicted of more serious crimes will be sent to state prisons or, if a federal law was violated, to a federal prison. Minor sentences can sometimes be served through probation, which is a diversionary program with monitoring in lieu of incarceration. Released offenders often have a period of parole in which they are similarly monitored. Either probationers or parolees may be sent to prison for failing to adhere to the conditions of their probation or parole. Qualified inmates are eligible to participate in pre-release programs, which may include permission to leave the facility for work or educational or vocational training, or even to live in a group home or community corrections facility.

Families sometimes ask, "What can I do to support loved ones who are involved in the criminal justice system?" No one answer suffices for every situation since the needs of the incarcerated person or their families can vary substantially. Some may be sociopathic, in which families need to establish boundaries for their own protection. Others may have special needs that

*Continued on page 10*

## GLOSSARY

**Minimum/Maximum Sentence:** the minimum sentence refers to the time that the offender has to serve in prison before becoming eligible for parole. The maximum sentence refers to the greatest amount of time that the offender might have to serve in prison before release. Pennsylvania law holds that the minimum sentence cannot be less than half the maximum sentence. Some nonviolent offenders may be eligible for release prior to their minimum sentence date.

**Parole:** the system of monitoring inmates released from prison. The conditions of parole may vary from intense to minimal monitoring. Technical violations refer to the failure of the parolee to adhere to the conditions of parole, while convicted violators have been found guilty of new criminal offenses. The degree of monitoring and restrictions given to a parolee vary from intensive to maximum, moderate, and minimum.

**Pre-release Programs:** Programs that allow eligible inmates to leave prison grounds to work or participate in educational or vocational training, or which allow inmates to live in group homes or community corrections centers.

**Probation:** the process of being monitored in lieu of incarceration.

**Reentry:** the movement of a prisoner into the community.

**Unconditional release:** the release of an inmate who has fulfilled the maximum sentence or where the court has reduced or vacated the sentence.

*Continued from page 9*

warrant more active involvement. For example, if the family member has a serious mental illness, then efforts should be made to contact the county jail to ensure mental health treatment. The Pennsylvania Department of Corrections and most county jails have mental health staff or consultants, and psychotropic medications are often available to prisoners. With appropriate releases, family members or psychologists acting on their behalf can call the psychological providers in prisons if any questions or concerns arise; however, they need to appreciate that security concerns, confidentiality issues, and limitations on resources may dictate some of the decisions made by prison staff.

*Inmates who have participated in rehabilitation programs tend to have lower rates of re-incarceration.*

Also, the legal status of the family member will influence some decisions. For example, if the incarcerated family member is awaiting trial, family members should not arrange for an outside mental health professional to visit the inmate; nor should they arrange to release records without checking with the defense attorney ahead of time.

In addition, some counties now have mental health or drug courts, which may divert nonviolent offenders out of prisons and into treatment under supervision. These programs require strict adherence to outpatient programs and regular monitoring (including the possibility of random urine screens). Whether the offender is being monitored by a diversionary court or through parole, it is important for them to comply with monitoring.

Family members may ask, "How can I support my loved one while he is in prison?" Regular visits and contact are very important for morale. Such contacts provide hope for prisoners and motivation for them to make the best of their incarceration. Family members should encourage participation in whatever educational, recreational, vocational, or therapeutic programs the prison has to offer. Inmates who have participated in rehabilitation programs tend to have lower rates of re-incarceration (Bucklen, et al., 2006).

Family members may worry that their loved ones will be terrorized or brutalized while in prison. The experiences of individual prisoners vary considerably. No doubt prisons are unpleasant due to the restriction of activities, regimentation, separation from loved ones, and boredom. Also, fights and assaults do occur in prisons, but the stereotypes of routine and systematic victimization are inconsistent with the realities of state prisons, where sexual assaults do occur but are uncommon (Zortman, 2007). Suicide rates in state and federal prisons are relatively low, but county jails, where persons are first incarcerated, have a higher risk of inmate suicide, especially for first-time offenders (Mumola, 2005).

Family members may ask, "Will prison harden my family member or socialize her into more criminal activity?" Generally, incarcerated persons engage in fewer crimes after their incarceration, but there are exceptions as some data suggests that low-risk offenders may engage in more criminal activity after being exposed to high-risk offenders (Pennsylvania Department of Corrections, 2006). Offenders are at the highest risk to return to prison within 3 years of their release (Beard, 2009), and parole violators represent about 35% of the total prison population (Bucklen, Zajac, & Gnall, 2006). Nonetheless, parolees who have learned basic skills in managing their emotions and impulses and those with ties to the community and family support are less likely to reoffend (Bucklen, et al., 2006).

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