CHAPTER 1

The Forensic Treatment Landscape

Brenda has a master's degree in counseling and has recently completed a clinical internship at a university counseling center, where she mainly works with college students experiencing adjustment, depressive, and anxiety disorders. Eager to broaden her clinical experiences, she begins an internship at a criminal justice day reporting center that provides case management, urine drug testing, individual and group counseling, and psychoeducational programs for clients in various stages of criminal justice involvement (e.g., pretrial, probation, and parole). Her first client is Hank, a 25-year-old male referred by the court for "evaluation/counseling" after an arrest for assaulting a female acquaintance. His case is awaiting trial/plea bargaining.

Before her first appointment with Hank, Brenda reviews the limited available information. The referral document from the court provides few details about the incident, except the list of charges and the bail amount. There is also a dearth of information on Hank's psychosocial history. He is noted to have prior convictions for possession/sale of drugs, larceny, and driving under the influence (DUI). To make matters even murkier, on the standard intake form where clients are asked to write the nature of their presenting problem, Hank has only written: "Court sent me here." When Brenda enters the waiting room to meet Hank, he looks up and makes minimal eye contact, scowling. He nonverbally communicates irritation and a sense of being unfairly put upon by the referral to the day reporting center.

In the face of such an unpromising beginning, Brenda senses that she is in a landscape quite unlike that of her prior clinical experiences. Among the questions she silently asks herself are these:

"What did I get myself into?"
"Are all the clients going to be like this?"
"What will it take to develop a therapeutic relationship?"
"What is effective with these types of clients?"
"Does the fact that Hank is court-involved change the clinical focus of treatment and intervention?"
"What risk does Hank pose to me and the community?"

This treatment planner provides a practical guide for working with justice-involved clients (JICs). It is designed for a diverse range of professionals who work with JICs, including psycholo-

gists, social workers, counselors, case managers, community program practitioners, probation officers, and parole officers. The plans and interventions discussed in this book are generally applicable to a wide array of JICs who may be seen in various forensic environments, such as prisons, jails, detention centers, probation and parole departments, day reporting centers, halfway houses, sober houses, and court-mandated community programs. The plans and interventions can also be integrated into different types of activities relevant to behavior change, such as treatment, case management, and supervision.

The initial chapters of this treatment planner address some of the questions raised by Brenda. They highlight key issues for working with JICs that are different from working with individuals in traditional counseling and psychotherapy. Subsequent chapters focus on matters of engagement, as well as assessment and case formulation; describe specific interventions to modify harmful thinking/orientation and lifestyle patterns; and offer templates for documentation and report writing. The present chapter provides an overview of the forensic treatment landscape and offers recommendations for getting the most out of this treatment planner.

WHAT IS WORKING WITH JICs LIKE?

If you have worked in traditional counseling or psychotherapy settings, it was probably quite natural for you to have sympathy, empathy, and a desire to help those seeking services. This may not be initially the case in conducting forensic treatment. By definition, a JIC has been arrested for some type of criminal act that may have caused harm and suffering to someone else, which makes forensic work a perpetrator-based enterprise. For example, JICs may readily acknowledge engaging in physical assault, sexual abuse, drug selling, conning, and theft. They may justify their actions, express no remorse for their behavior, minimize its consequences to others, or even blame those who have been victimized. It is not uncommon—indeed, it is quite typical—to experience automatic, and negative, emotional responses to such individuals. Displaying compassion toward some JICs may not feel natural. Compassion, generally defined as "sensitivity to the suffering of others and a desire to alleviate suffering" (Kolts & Chodron, 2013, p. 7), is foundational in most helping relationships. As with traditional mental health clients, genuine caring about JICs' lives is an essential ingredient for establishing productive working relationships, and thus a prerequisite for overall effectiveness. Burnout is a particular concern in settings where high-volume contact with JICs is the norm, and in some environments practitioners must continually monitor their capacity to approach treatment with a level of empathy and compassion for those with whom they work.

The ramifications of weak or unsuccessful treatment constitute another key issue. The costs of failing to effect change with JICs can be quite serious, resulting in a loss of their freedom that will negatively affect such individuals (and their families) for years to come. Suboptimal treatment with JICs can also result in unchanged criminal risk profiles, the consequences of which are future criminality and victimization that can ripple out and create suffering for others and the larger community.

The mechanisms through which JICs are referred for services are usually different from those in traditional counseling, where clients willingly seek out services in order to alleviate distressing

symptoms or receive support for dealing with problems. In traditional counseling, even when clients are compelled to get help, the process is typically initiated by concerned others, such as family members (e.g., "I'm really concerned your depression is getting worse"), friends ("Go to counseling; your worrying is driving me crazy"), or employers ("You should attend a stress management program to help you manage the workload"). In contrast, the ubiquity and degree of the coercion that brings JICs into treatment ("Attend a treatment program as a condition of probation, or go to jail") are hallmarks of working in forensic settings.

In many ways, JICs can be strikingly similar to unmotivated psychotherapy clients. However, because of the external factors that usually compel JICs to participate in treatment, you will initially find yourself devoting more time and energy to engaging such clients and identifying appropriate goals. The development of a productive working alliance and agreement on a treatment focus is likely to be more labor-intensive with JICs. Even when JICs appear willing to try treatment, they may exhibit a lack of enthusiasm and eagerness to participate fully in the intervention process.

Understanding two basic assumptions underlying treatment with JICs will help you navigate criminal justice bureaucracies and more effectively focus assessments and interventions.

1. *Reductions in criminal behavior and recidivism are the overarching goals of treatment.* The primary aim of forensic treatment is to prevent future criminality. In contrast, mental health counselors and psychotherapists usually focus on diagnosable disorders, and the symptoms associated with those disorders are viewed as problems to be resolved. JICs are a diverse client group, and many individuals will not meet the diagnostic criteria for any specific disorder. For the benefit of both the clients and the community, success with JICs is best measured in terms of subsequent declines in criminal behavior and criminal justice involvement.

2. *The focus of treatment is on improved functioning in life domains statistically linked with criminal behavior.* It is not uncommon for JICs to attend treatment with minimal symptoms and not much subjective distress. Therefore, their functioning within specific criminal risk domains, and not their symptoms, is what will most often dictate the targets of treatment. These criminal risk domains are introduced later in this chapter and described in detail in Chapter 2. They become the clinical focal points of the interventions presented throughout this treatment planner.

COMMUNITY VERSUS CUSTODY: DIFFERENT SETTINGS AND CHALLENGES

Treatment and intervention with JICs occur in settings that vary in their degree of integration into the larger community—from correctional institutions far from clients' families and friends, to day reporting centers in the same communities where JICs live. You are probably reading this treatment planner because you work (or will be working) in a setting similar to one described below. Keep in mind that the strategies we present are designed to be flexible and easily adapted to the types of environments where JICs are most commonly seen.

Community Settings

The largest proportion of the JIC population is not physically confined in a jail or prison; it comprises the millions of individuals who are living in the community under some form of criminal justice supervision. JICs supervised in the community include *probationers* (who are typically serving their entire sentence in the community), *parolees* (who are released from prison early and serving the remainder of their sentence in the community), and *pretrial defendants* (who are permitted to reside in the community on bail bond while awaiting trial). Community settings that specialize in services for JICs include day reporting centers, drug courts, halfway houses, and transitional housing programs. Some facilities are operated directly by government agencies, while others are run by not-for-profit or private organizations. At day reporting centers, clients are typically mandated to report several days per week for periods as brief as 30 days or as long as several months or more. Day reporting centers often provide treatment, educational, and employment services, as well as drug and alcohol monitoring. Halfway houses and transitional housing programs typically provide similar services as well as housing and meals, and stays can be as long as a year. Some JICs end up in traditional outpatient settings where they pay for services or use insurance to reimburse treatment providers, although this arrangement is less common.

One common challenge about working in community settings is that services are most often court-mandated. The clients may not want to be there, present as uninterested in treatment, and be resentful of supervision and other mandated conditions such as drug testing. JICs' progress in community programs is typically monitored by the referring courts or criminal justice agencies. You may be required to submit regular written reports documenting clients' attendance, participation, and progress (Chapter 13 provides sample reports). Such documentation is typically more burdensome for practitioners in community settings than for those who work in custody settings (described below). Confidentiality is generally more limited than it is in traditional counseling and psychotherapy. You may be expected to be in regular telephone contact with a probation or parole officer, and provide information on JICs' verbal disclosures, employment status, violations of protective and no-contact orders, and drug test results. For this reason, working in the community with JICs involves a more complex practitioner role—a role that often blends the goals of behavior change, monitoring, and community safety in different proportions, depending on the job and setting.

Custody Settings

Custody settings include state and federal prisons, jails (which are distinct from prisons in that clients are awaiting trial or serving only short sentences), and juvenile detention centers. For JICs who are incarcerated, the treatment environment poses some unique challenges that are not commonly encountered in outpatient settings. In correctional institutions, the clients are, in principle, always available for their appointments. However, in actual practice, the needs of the custody staff—which are focused on the safe and orderly operation of the institution—take precedence over any therapeutic activities. There are periods allotted for "inmate movement," when clients may move from their cells or dormitory to other locations for work, school, or counseling. Within these confines, appointments may be canceled due to lockdowns, staffing shortages, or a host of other administrative concerns that are beyond a client's or practitioner's control.

Similarly, the termination of care may be dictated by reasons other than the successful attainment of treatment goals: No warning may be given about a JIC's transfer from one institution to another, leading to an abrupt and unplanned ending of an intervention protocol. Such premature terminations may exacerbate dysfunctional thinking and behavior patterns. To minimize harm and the potential loss of treatment gains in custody settings, you should occasionally discuss the possibility of unwanted termination and develop a plan to counter potential negative reactions.

Some correctional institutions may not have traditional professional office arrangements. Sessions are sometimes conducted at a JIC's cell door, in the "chow hall," in a visitation/interview area where JIC and practitioner are separated by glass, or in multipurpose rooms within the facility that afford limited privacy. In any of these settings, conversations can be overheard, and a JIC's status as a "mental health patient" is visible to staff and inmates. Even in institutions where professional space exists, practitioners may be surprised to find that offices are equipped with large windows so that staff–inmate interactions can be observed for safety purposes. This can be distracting and limit privacy, as other inmates, as well as custody staff, can see who is in treatment. Another consideration is that JICs who are assigned homework as part of treatment will typically be bringing their assignments back to a small cell shared with one or more other people; or they can be housed in a single large room with as many as 100 bunk beds, affording even less privacy and more distractions. In custody settings, you may need to be sensitive regarding the content of sessions and homework assignments, and to shift topics depending on the degree of privacy afforded to a particular case.

While treatment in correctional institutions is unlikely to be court-mandated, as it is in probation, parole, and some community program settings, it may not be free from other external pressures. JICs in custody may seek treatment to place themselves in a more positive light before the parole board or to obtain a placement in a less restrictive environment. As in working with JICs in the community, you will need to be savvy in understanding the external and internal motivations that go into inmates' decision to participate in treatment.

Finally, for JICs nearing release, the sheer passage of time in a prison environment can make former problems areas seem like historical factors that have been successfully resolved. For example, 3 years of incarceration-induced sobriety may lead a JIC to believe that his or her substance abuse problem has been resolved and treatment is therefore unnecessary, even though such treatment has been imposed as a condition for early release.

JUSTICE INVOLVEMENT: THE SCOPE OF THE PROBLEM

The U.S. Bureau of Justice Statistics has estimated the 2014 rate of incarceration for the country at 612 per 100,000 people (Carson, 2015), making it among the highest in the world. Over 1.5 million U.S. residents are incarcerated (Carson, 2015), and almost 5 million are supervised in the country's parole and probation systems (Kaeble, Maruschak, & Bonczar, 2015). In the United States, among the general population, justice involvement occurs at about the same rate as commonly treated psychological problems, such as panic disorder and generalized anxiety disorder (National Institute of Mental Health, n.d.). It is important to keep in mind that 90% of those incarcerated in the United States will be released and returned to the community.

Comparable statistics in other English-speaking nations with similar criminal justice systems are less dramatic but still indicate large numbers of prisoners and probationers. The estimated incarceration rate in England and Wales is 148 per 100,000 people (Walmsley, 2013), and there are about 88,000 people incarcerated and 225,000 on probation (U.K. Ministry of Justice, 2017). In Canada, which has an estimated incarceration rate of 118 per 100,000 people, there are approximately 37,000 federal and provincial inmates and another 102,000 individuals on probation (Correctional Services Program, 2015). The estimated incarceration rate of Australia is 201 per 100,000 people (Walmsley, 2013), with about 37,000 incarcerated and another 62,000 on probation (Australian Bureau of Statistics, 2015).

WHAT WORKS IN REDUCING CRIMINAL BEHAVIOR?

In an oft-cited review of the correctional treatment literature, titled "What Works?: Questions and Answers about Prison Reform," Martinson (1974) commented in the concluding section: "With few and isolated exceptions, the rehabilitation efforts that have been reported so far have had no appreciable effect on recidivism" (p. 25). Building off the title of the report, the phrase "nothing works" came to characterize beliefs about the ineffectiveness of treatment for justice-involved individuals for decades, and paved the way for punitive approaches as the principal means of attempting to reduce criminal behavior. However, with the expansion of cognitive-behavioral interventions to justice-involved populations and the advent of meta-analysis, improving researchers' ability to synthesize treatment outcome studies quantitatively, a body of literature has emerged to challenge the "nothing works" assumption.

Three key conclusions have emerged from this growing meta-analytic literature. First, criminal sanctions without treatment tend to be ineffective in reducing recidivism. In fact, incarceration with no treatment is associated with an increase in reoffending, and community supervision with no intervention is associated with small or no reductions in reoffending (Andrews, Zinger, et al., 1990; Lipsey & Cullen, 2007; Smith, Goggin, & Gendreau, 2002). Second, treatment and intervention focused on risk domains that are commonly intertwined with criminal behavior consistently produce the greatest reductions in recidivism (Andrews & Bonta, 2010a; Lipsey, Landenberger, & Wilson, 2007; Martin, Dorken, Wamboldt, & Wooten, 2012; Morgan et al., 2012; Skeem, Steadman, & Manchak, 2015). Third, across treatment modalities, interventions based on cognitive-behavioral therapy (CBT) have the greatest impact on reducing future criminality (Hoffman, Asnaani, Vonk, Sawyer, & Fang, 2012; Landenberger & Lipsey, 2005; Lipsey, Chapman, & Landenberger, 2001)—even among specialized JIC groups, such as women (Dowden & Andrews, 1999a), youth (Dowden & Andrews, 1999b), those convicted of sexual offenses (Hanson, Bourgon, Helmus, & Hodgson, 2009), and those convicted of domestic violence (Babcock, Green, & Robie, 2004).

The growing literature on the relative effectiveness of CBT with JICs has not gone unnoticed by criminal justice agencies (Bonta & Andrews, 2007; U.K. Ministry of Justice, 2013; National Institute of Corrections [NIC] & Crime and Justice Institute [CJI], 2004; Scott, 2008). Among the NIC and CJI's (2004) eight principles of effective intervention, CBT is specifically highlighted in Principle 4: "Provide evidence-based programming that emphasizes cognitive behavioral strategies and is delivered by well trained staff" (p. 5). The use of CBT-based interventions has more

recently been extended into the field of probation and parole. Programs training supervision officers to use CBT skills in their sessions with JICs have shown promising results, such as measurable improvements in officers' skills and significant reductions in recidivism (Bonta et al., 2011; Rugge & Bonta, 2014).

IS DIAGNOSIS IMPORTANT?

A customary first step in implementing CBT interventions is to establish an accurate diagnosis. In work with JICs, however, diagnosis may be less important in guiding treatment decisions, because there is no acute clinical syndrome that adequately captures JICs experiences. The most popular diagnostic schemes for this client group are related to personality pathology: antisocial personality disorder (ASPD) as outlined in the *Diagnostic and Statistical Manual of Mental Disorders,* fifth edition (DSM-5; American Psychiatric Association, 2013); dissocial personality disorder (dissocial PD) as defined in the *International Classification of Diseases,* 10th revision (ICD-10; World Health Organization, 1992); and psychopathy as formalized by the Psychopathy Checklist—Revised (PCL-R; Hare, 2003). A conundrum for practitioners is that these conceptualizations are overlapping but not identical, emphasizing different symptom clusters.

ASPD in DSM-5 emphasizes overt conduct through criteria that includes criminal behavior, lying, reckless/impulsive behavior, aggression, and irresponsibility in the areas of work and finances. In contrast, the criteria set for dissocial PD is less focused on conduct; it includes a mixture of cognitive signs (e.g., a tendency to blame others, an attitude of irresponsibility), affective signs (e.g., callousness, inability to feel guilt, low frustration tolerance), and interpersonal signs (e.g., a tendency to form relationships but not maintain them). The signs and symptoms of psychopathy are more complex and blend in almost equal degrees conduct, interpersonal, and affective aspects of functioning. The two higher-order factors of the PCL-R reflect this blend. Factor 1, Interpersonal/Affective, includes signs such as superficial charm, pathological lying, manipulation, grandiosity, lack of remorse and empathy, and shallow affect. Factor 2, Lifestyle/Antisocial, includes thrill seeking, impulsivity, irresponsibility, varied criminal activity, and disinhibited behavior (Hare & Neumann, 2008; White, Olver, & Lilienfeld, 2016). Psychopathy can be regarded as the most severe of the three disorders. Patients with psychopathy would be expected to meet criteria for ASPD or dissocial PD as well, but not everyone diagnosed with ASPD or dissocial PD will meet criteria for psychopathy (Hare, 1996; Ogloff, 2006).

As noted by Ogloff (2006), the distinctions among the three antisocial conceptualizations are such that findings based on one diagnostic group are not necessarily applicable to the others and produce different prevalence rates in justice-involved populations. Adding a further layer of complexity is the fact that practitioners will encounter JICs who possess a mixture of features from all three diagnostic systems, rather than a prototypical presentation of any one disorder. In addition, we recommend caution in using labels such as *antisocial, sociopathic,* or *psychopathic* for JICs, because these labels are likely to trigger defensiveness that can undermine treatment engagement. In discussions with JICs, we sidestep specific personality labels altogether and emphasize the nature of problematic *lifestyle* patterns in areas related to thinking (Chapters 8 and 9) and to routines, relationships, and destructive habits (Chapters 10, 11, and 12). In referring to this family of

diagnoses in this treatment planner, we use the umbrella terms *antisocial orientation* and *antisocial,* rather than any particular diagnostic label.

JICs rarely have just one problem, and their comorbidity patterns are often complex. Some common overlapping conditions are well captured by existing diagnostic categories, while other problems are not. For example, a JIC may meet DSM-5 criteria for a substance use disorder and borderline personality disorder, and may also have significant family dysfunction and vocational instability. We discuss the complexities of conceptualizing individual, social, and contextual factors, as well as mental health problems, in Chapter 6.

A GENERAL TREATMENT PLAN

We recommend that treatment be tailored to meet the unique needs of JICs. Nonetheless, Table 1.1 outlines a general treatment plan, to guide you as you become familiar with this approach to treatment. This outline is considered a template for the broad phases of the treatment process. How much time you will spend in each phase will depend on the characteristics of a particular case and the setting in which you work.

WHAT DO SESSIONS LOOK LIKE?

Effective treatment with JICs involves conducting sessions that are structured, organized, and active. Here we highlight five session characteristics that are emphasized throughout this treatment planner and are consistent with general CBT principles.

1. *Case formulation guides treatment.* Before launching into active change techniques, you will need to spend time assessing and considering the criminal risk domains that are most important in maintaining a JIC's criminal behavior. A common error among forensic practitioners is to adopt a superficial "check-in" style of interacting with JICs (e.g., "Are you staying out of trouble?"). Such check-ins rarely address the long-term patterns that contribute to risky and harmful behavior. Another common error is to become entirely crisis-focused. In this style, each session is about the latest upheaval in a JIC's life. Being flexible and responsive to crises is important; however,

TABLE 1.1. General Plan of Treatment for JICs

- Engaging
- Clarifying values and life priorities
- Assessing criminal risk domains
- Formulating each case and identifying relevant treatment targets
- Establishing collaborative goals and focusing conversations
- Addressing criminogenic thinking and antisocial orientation
- Restructuring routines, relationships, and destructive habits
- Documenting and reporting

there also needs to be *continuity* in terms of attention to risk domains and long-term patterns that are connected to criminality. The third error is to take on a "pass the buck" stance with JICs. In this style, practitioners refer JICs to all sorts of "other" programs and services in hopes that something will work. Such practitioners operate more like brokers, doing very little work themselves to change the patterns of their clients. Even if you typically conduct brief sessions (e.g., as community supervision officers do), your work will be more effective if it focuses on the criminal risk domains (listed in Table 1.2 and described in the next chapter) that are most relevant to a JIC's life. Case formulation means developing an individualized game plan for each JIC and having a clear rationale for which patterns and life areas will become the focal points across sessions.

2. *Sessions are structured and organized*. In addition to having an overall game plan for the course of treatment, you will need to approach sessions in an organized and structured manner, with an identified agenda, beginning, middle, and end. This means thinking ahead about the focus of a particular meeting and the strategy to be used in the session. Of course, not all sessions go according to plan. The ability to be flexible and adjust "on the fly" is often necessary. Table 1.2 provides a general session structure that can be adapted to most forensic settings. In using this structure, you will be providing the focus for the session, while also maintaining the necessary flexibility to address any significant developments that have occurred since the last contact. When homework is applicable, you will review progress on previous assignments. The centerpiece of the session, to which the majority of time is typically devoted, is a focus on a specific risk domain related to a JIC's criminal behavior. Administrative issues are dealt with toward the end of the meeting, and discussions in this area are kept relatively brief. The session ends with a summary highlighting what was most important and reinforcing any next steps to be taken. Finally, documentation related to session content and the JIC's progress is completed.

3. *A skills-building orientation is adopted*. The emphasis in sessions is on improving JICs' functioning (e.g., decision-making capacity, thinking, and behavior) in criminal risk domains. Although listening to and understanding JICs' perspectives are critical skills for successful engagement, discussions that end up as complaining sessions (about others, the system, etc.) will rarely be productive. Similarly, while JICs may develop awareness about how aspects of their personal histories have influenced their present life circumstances, insight in and of itself will not be enough to bring about change. Rather, you will be introducing new skills to alter a JIC's entrenched patterns of thinking and behavior, and thus to reduce criminal potential.

4. *Sessions are active*. JICs are not merely "along for the ride"; they are actively involved in coming up with their own reasons for change, ideas for improving their lives, and participating in repeated practice of new thoughts and behaviors. Your energy and creativity in utilizing activities and assignments to actively engage JICs in sessions will be vital for successful treatment.

5. *Treatment incorporates homework*. In forensic settings, homework is one of the main predictors of treatment success (Morgan et al., 2012), and it is an essential mechanism for transferring skills to JICs' day-to-day lives. The more homework completed, the greater the impact of the intervention (Kroner & Morgan, 2014). Assignments that work best are concrete and specific, easily understood by JICs, easy to implement, and have a real-world emphasis. We have found that when the issue is approached properly, the majority of JICs are willing to complete homework assignments. In fact, many are appreciative for the opportunity to take active steps to improve their lives.

TABLE 1.2. General Session Structure

1. *Set the agenda.* Take the lead in introducing the agenda and focus for the session.
2. *Inquire briefly about new developments.* Inquire about any significant developments since the last meeting (e.g., new police contacts, disciplinary tickets, eviction, a new job, end of a significant relationship).
3. *Review previous assignments.* Conduct a brief review of assignments from the previous meeting (e.g., follow up on referrals, homework, job search efforts).
4. *Focus on a relevant criminal risk domain.* These domains include a history of criminal/antisocial behavior, criminogenic thinking/antisocial orientation, antisocial companions, dysfunctional family/romantic relationships, lack of connection to work/school, maladaptive leisure time, substance abuse/misuse, and anger dysregulation.
5. *Address administrative issues.* Conduct a brief review of practical issues related to supervision or custody conditions that have not yet been addressed during the session (e.g., change of living situation, employment changes, restitution payments).
6. *Provide a summary.* Summarize what was accomplished and what the JIC should be doing (homework) between sessions.
7. *Complete documentation.* Document progress, put notes into record, file, etc.

REALISTIC EXPECTATIONS

Working with JICs has many challenges and rewards. No matter how high your skill level, you will not be successful with every case. Since behavior is determined by multiple influences, you are likely to do exemplary work with some individuals who will nonetheless make poor decisions and continue on the path of creating suffering for themselves and others. The flip side is that you will also have a significant effect in changing the life trajectories of some of the JICs you work with. We have witnessed such successes in our own clinical work, and we have heard many JICs describe caring practitioners whom they credit with influencing them over the longer term. We encourage you to embrace the opportunity to work with JICs, as it presents opportunities to provide services that contribute to the safety of our communities, reduce the human suffering caused by criminal victimization, and afford a chance for a more positive future for some of society's most marginalized members.

We end this chapter where it began. With Brenda's first session under her belt, she is getting ready for her next appointment. Once again, she finds herself with very little information to go on. All she knows is that her next case is a 24-year-old unemployed woman named Jackie, who has been referred to the day reporting center as part of her probation after an arrest for public intoxication, criminal mischief, and trespassing. In the chapters that follow, the cases of Hank and Jackie are used to illustrate the application of the concepts presented in this treatment planner.

KEY POINTS

- Justice involvement is common in the United States: Among the U.S. general population, it occurs at about the same rate as panic disorder and generalized anxiety disorder.
- The primary emphasis of forensic treatment is on the prevention of future criminality. Therefore, criminal behavior and reoffending—not symptom reduction—are the outcomes of most concern.
- Because referrals in forensic environments almost invariably involve some form of external coercion, a significant amount of time and clinical effort must often be devoted to engaging clients and fostering motivation to make changes.
- Compassion is foundational to most helping relationships. Caring and concern for JICs' lives are essential elements of successful treatment.
- The use of diagnostic labels is less helpful in guiding treatment with JICs than treatment with mental health clients, since many targets of intervention are not captured in existing diagnostic schemes.
- Optimism is warranted! Many JICs will benefit from high-quality treatment.

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