

# Correctional Mental Health

## *A Best Practices Future*

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### Introduction

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The ideas, facts, and recommendations presented in the preceding chapters form a solid foundation for an empirically grounded, “best practices” future of correctional mental health research and practice. What remains, a task necessarily limited by the complexity of the issue and the available space, is to offer a few final thoughts concerning two related questions:

- What are the social, economic, legal, and political factors—that is, the context—impacting the future of correctional mental health for better or worse?
- Given the real-world context in which mental health professionals must function, how could “best practices” prisons and jails be characterized, and how can “best practices” mental health services be provided there?

### The Context of Correctional Mental Health

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*“That we are in the midst of crisis is now well understood. Our nation is at war, against a far-reaching network of violence and hatred. Our economy is badly weakened, a consequence of greed and irresponsibility on the part of some, but also our collective failure to make hard choices and prepare the nation for a new age. Homes have been lost; jobs shed; businesses shuttered. Our health care is too costly; our schools fail too many; and each day brings further evidence that the ways we use energy strengthen our adversaries and threaten our planet.”*

—From President Barack Obama’s Inaugural Address  
January 20, 2009

The American public expresses concern about inmates, and supports rehabilitation, according to recent survey results (Krisberg & Marchionna, 2006). A tentative consensus has emerged supporting prison reform across the political spectrum. For example, in addition to the liberal interests and groups that have been pressing a variety of reform issues for decades, the National Drug Control Strategy (Office of the White House, 2008), issued under the auspices of President George W. Bush, noted the importance and effectiveness of drug courts in diverting nonviolent offenders from incarceration and into treatment programs. Recent legislation, such as the Second Chance Act of 2007, cosponsored by both Democrats and Republicans, is another example of the bipartisan appeal of prison reform. This law promotes community reentry and rehabilitation and, to a lesser extent, alternatives to incarceration. More generally, this might be seen to augur well for the provision of a range of correctional services, including those characterized as “correctional mental health.”

Yet the American prison population continues to rise. By a considerable margin, the United States has the world’s highest incarceration rate, at 738 per 100,000. Second on the list is the Russian Federation with 607 per 100,000. Other Western nations’ incarceration rates—for example, those of the United Kingdom (145 per 100,000), Australia (126 per 100,000), Canada (107 per 100,000), and France (88 per 100,000)—are considerably lower (Hartney, 2006). (More recent data put the U.S. incarceration rate at 762 per 100,000 at midyear 2008; West & Sabol, 2009.) Although some states have recently experienced small decreases in the numbers of prisoners in their correctional systems, trends in other state systems, as well as the federal prison system, have offset this decrease (West & Sabol, 2009). Why is this? In part, the answer lies in the fact that focusing on the treatment of individuals already in jail or prison does not in and of itself entail broader reforms of the laws and policies that produce these large numbers in the first place. If, for example, laws exist under which large numbers of drug users are charged with crimes that carry lengthy prison sentences, then many of these individuals will go to prison, and there they must depend on whatever drug treatment services are available in a setting where healthcare is necessarily subordinate to safety and security missions. Successful completion of prison programs—“rehabilitation”—may be unrelated to the prospect of earlier release where laws prohibit granting parole. Once such laws are passed, politicians may be reluctant to consider repealing them for fear of being considered “soft on crime.” Where life sentences, particularly those without parole, are handed out, rehabilitation and reentry become irrelevant. As more such punishments are handed out, the prison census is further inflated by individuals who will be incarcerated for decades. In the United States, 1 in every 11 prison inmates is incarcerated on a life sentence. This figure included more than 6,800 juveniles, individuals who, unless granted relief, could spend 50 years or more in prison and contribute to the growth of the geriatric inmate population (Nellis & King, 2009). Notably, in 2010, a Supreme Court decision, *Graham v. Florida*, held that juveniles could not be sentenced to life without the possibility of parole for a crime not involving homicide. This made 129 of these individuals (the total number of individuals in prison with such sentences at the time of the decision) eligible for parole and will prevent future imposition of life-without-parole sentences for nonhomicide crimes for juvenile defendants.

It also seems that the public is ambivalent about prison reform in the sense of considering alternatives to incarceration, notwithstanding recent reform initiatives such as the Second Chance Act and drug and mental health courts (see Chapter 1), which may have more of an impact on the prison population given time. The recent experience of California, which has the nation’s second largest prison system (after the federal prison system and slightly ahead of Texas’s; West & Sabol, 2009), is a noteworthy example. In November 2008, despite a multi-billion-dollar budget shortfall and badly overcrowded

prisons, the state legislature rejected a proposal for a drug court program that would have diverted many nonviolent, mainly younger offenders, from prison. It was estimated that the initial costs for expanded community drug rehabilitation programs would have been more than offset by long-term savings in prison construction and administration costs (Secretary of State, State of California, n.d.; The Real Cost of Prisons Weblog, 2008).

In behavioral terms, the predominant trend in the American criminal justice system over the past three decades can be characterized in terms of the removal of many rewards, such as parole (in many jurisdictions) and Pell Grants for education, and the enhancement of punishments, such as the increased use of life sentences. Perhaps most punitive have been the prison conditions in which many inmates have had to live: increasingly overcrowded and underresourced facilities. Such approaches have limited the options prison administrators have in dealing with inmates, as they have fewer incentives to offer, such as earlier release from prison for good behavior.

Some states have instituted reforms (e.g., increasing the amount of good time inmates can earn) intended to cut prison populations, in light of protracted budget difficulties caused by the downturn in the economy. Even California is considering such initiatives (Steinhauer, 2009b). Whether they will be implemented on a large scale and have an appreciable impact on the numbers incarcerated and, if so, be maintained when the economy recovers, remains to be seen. However, with respect to those prisoners with serious mental illness, to release them earlier than otherwise would have been the case or to divert them from prison altogether, without providing the community services they need to make their transitions successful, would simply replicate the conditions that led to their original incarcerations and thereby parallel the ill-considered deinstitutionalization phenomenon of the late 20th century. At present, it is not at all clear that these services will be provided. Related to this is what appears to be an emerging problem at the front end of the criminal justice system—a critical overload of public defenders' caseloads. This has led to a revolt in several states, with lawyers refusing to take new cases (Eckholm, 2008). Well-intentioned reform initiatives can be undercut by an increase in prison admissions when public sector budget cuts result in inadequate legal services to defendants who have no other options.

## Obstacles to Prison Reform and Rehabilitation

Highly relevant to reforming prisons and providing best practice mental health services are obstacles to reform, some of which are discussed here. Chief among these is ignoring preventive approaches: failing to address the root causes of crime and mental illness that together lead to the incarceration of persons with serious thought and emotional disorders.

Preventing mental illness and incarceration in the first place, insofar as that is possible, is fundamental to real reform within the legal and healthcare systems and, therefore, to prison reform. Failure to do so, and instead incarcerating large numbers of those who do not threaten the public well-being, that is, who have committed nonviolent offenses, is the biggest obstacle to best prison practices, as it does little or nothing to break the cycle of crime, punishment, and recidivism. By default, it makes jails and prisons the main locus of mental health treatment and rehabilitation efforts for its residents, many of whose needs are too great for the available services to accommodate. This is the present state of affairs. As noted in Chapter 1, there are more persons with serious and persistent mental illness in correctional facilities than in psychiatric hospitals (see Figure 16.1). Persons admitted to prisons are also exposed to a range of potentially iatrogenic effects, as noted in Chapters 2, 9, and 12.

**Figure 16.1**

Photograph of Los Angeles County Jail, Known as the Largest Mental Institution in the United States



In principle, prevention is fairly straightforward. However, in fact, the fundamental causes of crime are deeply interwoven into the fabric of society and, to some extent, into the human condition, as data emerges citing the influence of genetics on criminal behavior (e.g., Vaughn, DeLisi, Beaver, & Wright, 2009).<sup>1</sup> Neither is the prevention of crime a new idea. Nearly 150 years ago, it was suggested, “The first in our series of establishments, looking to the repression of crime, should be institutions of a preventive character. Here, indeed, to our view, is the real field of promise” (Wines & Dwight, 1867, p. 63). Of recent note is the relationship between dropping out of school and both incarceration and pregnancy. For example, in 2006 and 2007, about 1 of every 10 males who dropped out of high school was incarcerated at any given time. The comparable figure for high school graduates was fewer than 1 in 33. Incarceration rates were highest for Black dropouts, more than 3 times that of any other group (Asian, Hispanic, or White). Among females, dropping out of high school was also related to a higher likelihood of being a single mother and living in or near poverty (Sum, Khatiwada, McLaughlin, & Palma, 2009). Although no cause-and-effect relationship can be determined based on these data, it appears that increased levels of education, at least through high school, greatly increase the odds of escaping the cycle of poverty and incarceration.

Clearly, the growth of the American prison systems is mute testimony to a long history of failed prevention and reform efforts, in which category can be included many mental health interventions, of which a recent example is the community mental health movement (see Chapters 1 and 2). The breadth of issues that must be addressed in prevention efforts makes the prospect daunting. It includes child abuse and neglect, poverty, the failure of schools to educate young people, unemployment,

and the ready availability of firearms and illegal drugs.<sup>2</sup> When the social safety net fails, incarceration is the frequent result. However, when it succeeds, the benefits are many and wide-ranging. The weight of evidence suggests that prevention programs, particularly those aimed at earlier phases of development—at children and their parents, as well as juveniles—can be particularly cost-effective (Washington State Institute for Public Policy, 2006).

Certainly, cost issues are a factor in the decision to implement or forgo prevention programs. As noted above, initial costs for drug diversion programs being proposed in the state of California would have been appreciable, even though projected savings would ultimately have outweighed these. Other factors that may constitute obstacles to best practices are related directly or indirectly to economics: cost-shifting (Lamb & Weinberger, 2005; see also the discussion of federalization, below), tax benefits, and/or the profit motive that comes into play when the private sector is involved in prison construction and maintenance. Prison systems provide tangible benefits to the individuals who work in them, the localities whose tax bases they enhance, and, in some cases, corporations (Chen, 2008; Hallinan, 2001; Santos, 2008; Whitley, 2002).

Private vendors may reduce costs per inmate, relative to traditional government-operated facilities. In fact, as of this writing, the state of Arizona is considering privatizing all of its prisons as a cost-savings measure (Steinhauer, 2009a). Privatization may include economizing on staff, particularly, for present purposes, mental health treatment staff. Corporations also have an incentive to house more prisoners to increase profits, and an alliance between state politicians and these corporations may be created to promote this. The Institute on Money in State Politics (2006) reported,

Companies favored states with some of the toughest sentencing laws, particularly those that had enacted legislation to lengthen the sentence given to any offender who was convicted of a felony for the third time. Private-prison interests gave almost \$2.1 million in 22 states that had a so-called “three strikes law,” compared with \$1.2 million in 22 states that did not [between 2000 and 2004]. (p. 5)

In extreme cases, the profit motive may conduce to outright illegal behavior and the corruption of public officials. In Luzerne County, Pennsylvania, two juvenile court judges entered into a scheme where, over a period of 5 years, they sent thousands of adolescents to privately operated detention centers in return for kickbacks from the owner-operators. Many of these defendants appeared before the court without lawyers and were sentenced for minor crimes such as shoplifting; in one case, a young woman was remanded for lampooning the assistant principal of her high school on the Internet. The judges were eventually indicted and pled guilty (Juvenile Law Center, 2009; Urbina, 2009; Urbina & Hamill, 2009). The private prison industry may be necessary, given the current needs for housing the millions of individuals sentenced to confinement, but it requires careful oversight and can easily become an impediment to best practices.

The *federalization* of American corrections has also served to enlarge and maintain the prison population. Much of the overall census increase in American prisons is accounted for by the U.S. Federal Bureau of Prisons (FBOP). It is now the largest prison system in the nation, and between December 31, 2000, and December 31, 2007, it grew at more than twice the mean state incarceration rate (4.6% vs. 1.7%). Notably, during the same period, the number of federal inmates housed in private facilities increased at an average annual rate of 10.5% (West & Sabol, 2009). The expansion of the FBOP has allowed the states to shift much of the costs to the federal government that otherwise would have been involved in processing defendants through their criminal justice systems and then housing them in their prisons.

The federal government's role in corrections has expanded considerably over the past several decades as it has assumed new legal missions, continuing a trend that began early in the 20th century with Prohibition, which made criminals of those who made, sold, and consumed alcohol. Of recent note has been the prosecution of street crime, such as drug offenses, that were largely the province of the various states until the 1980s. The advent of the Internet has also brought with it new forms of computer crime: unauthorized access (hacking), fraud, theft, and child pornography, which often carry a federal sentence (Ax, 2007).

To be clear, this is no criticism of the FBOP *per se*, rather a comment on the policies that shape it. The mission and scale of the federal prison system constitute an obstacle to best practices in two ways. First, the availability of federal incarceration, as noted above, creates a safety valve for states with crowded prisons, allowing a sizeable percentage of those committing crimes in these states to be housed at federal expense instead of in state facilities. The federal budget is not constrained with respect to deficit spending to the extent those of the various states are. Without such an option, states might have been forced to consider alternatives sooner, such as diversion programs.

Second, federal incarceration impedes community reintegration. Individuals placed in federal prisons are commonly housed farther from their homes than they would have been had they been sentenced to state prisons. For example, Mumola (2000) found that 84% of federal inmates with children were housed more than 100 miles from their prior residences, whereas the comparable figure for state inmate-parents was 62%. Greater distance from home reduces the likelihood that inmates will receive regular family and lawyer visits. As a result, community connections may be impaired or destroyed, and legal rights and legitimate grievances may go unaddressed. Those with a direct interest in particular inmates cannot advocate as effectively for their proper treatment, such as prompt medical attention or enrollment in mental health programs in the facilities in which they are housed, if these sites are hundreds or thousands of miles away. Similarly, when caseloads include inmates from all over the United States (and many foreign countries), it becomes nearly impossible for case managers assisting inmates with pre-release planning to develop a working familiarity with the local resources potentially available to those individuals or to establish professional relationships with community corrections staff, such as probation officers and mental health service providers, or with local charities that may help ex-offenders.

Furthermore, there is now an entirely new domestic prison system, administered by another branch of the federal government: the Department of Homeland Security's Immigration and Customs Enforcement (ICE) agency, devoted to housing illegal residents of the United States. As of fiscal year 2007, according to a Government Accountability Office (GAO; 2008) report, there were approximately 300 of these facilities. They had a total average daily population in excess of 30,000, with relatively short stays, about 37 days on average, making them more similar to jails than prisons in that regard. The GAO report found that most ICE facilities were in compliance with standards of medical and mental care. Problems were noted at three of these institutions, including having sick call request forms available only in English and failing to obtain informed consent before providing psychiatric medications. However, there were some exemplars, including one facility at which an inmate was able to receive kidney dialysis. If one facility can provide best practices care, why not all?

The most pervasive problem noted by the GAO (2008) study was that of telephone access. Although this may seem to be a relatively trivial issue, use of the telephone is often the sole means by which inmates can stay in regular and timely contact with family and legal counsel, particularly when they are incarcerated far from their primary residence

within the United States. Costs of using the phone can be prohibitive for an incarcerated population containing a high percentage of indigent persons.

Notably, the findings in a separate report, a joint project of the National Immigration Law Center and the American Civil Liberties Union of Southern California, contrasted sharply with the GAO (2008) report. Based partly on information only made public pursuant to a court order, the report specified violations of detainees' legal rights, for example, to due process, and of failures of oversight and monitoring, even going so far as to accuse ICE of seeking to avoid accountability by keeping the monitoring process and results secret. Specific violations relative to healthcare included some facilities with no medical staff on site and others that completed medical screenings without any medical staff involvement. The report recommended increased transparency by making public several measures of the functioning of the facilities within the system (Tumlin, Joaquin, & Natarajan, 2009).

Problems created by distance are not unique to federal prisons, however. As of July 2005, thousands of prisoners from more than 40 states were on transfer status to another system: a different state department of corrections, the FBO, or a private prison. The most common reason was to relieve overcrowding (LIS, Inc., 2006). Notably, phone access has also been a problem in other prison systems. The American Bar Association has noted the growing and general problem of phone access by prison and jail inmates and has petitioned the Federal Communications Commission to require correctional systems to make telephones available at reasonable rates (Susman, 2009).

All other things being equal, transparency, the openness of prisons to review and scrutiny by outside entities—legislators, family members, nongovernmental organizations (NGOs) that advocate for prisoners' rights, and the media—will be greater when jails and prisons are local than when they are great distances from the communities from which inmates come. With greater geographic distance comes greater social distance for individuals and potentially greater opacity at the institutional level. Certainly, the lack of transparency, including the remoteness of the sites, helped create the climate in which the abuses at the military prisons in Abu Ghraib, Iraq; in Guantánamo Bay, Cuba; and at several secret CIA prisons took place. For example, a report by the International Community of the Red Cross (ICRC; 2007) concerning the treatment of 14 "high-value" detainees in CIA custody noted,

As regards conditions of detention and treatment of the fourteen, the effects of their being in undisclosed detention were severe and multifaceted, as the present report shows. The absence of scrutiny by any independent entity—including the ICRC—inevitably creates conditions conducive to excesses that would not otherwise be permitted. Persons held in undisclosed detention are especially vulnerable to being subjected to ill-treatment. (p. 24)

Such conditions are a fairly extreme case of what may happen, even in a democracy, when opacity combines with a lack of oversight and accountability. In terms of the conditions and practices in prisons and jails located within the United States, these occurrences speak to the importance of oversight by a variety of internal and external (e.g., NGOs, the media) entities.

Further obstacles to broad-scale prison reform and best practice correctional mental health include competing priorities, cultural insularity, fewer options for persons with serious mental illness, and rehabilitation failures. As President Obama noted in his inaugural address, the nation faces a daunting array of challenges. High among these is that of providing healthcare. Forty-seven million Americans, disproportionately poor and ineligible for Medicaid, lacked even basic health insurance (Kaiser Commission on

Medicaid and the Uninsured, 2008), at least until the recent enactment of federal health-care legislation (Patient Protection and Affordable Care Act of 2010), which will cover most, but not all, Americans (Stolberg, 2010). A recent Rand Corporation (2008) report documented that 14% of veterans previously deployed to Iraq and/or Afghanistan screened positive for post-traumatic stress disorder (PTSD). The financial viability of Medicare, the federal government program that provides healthcare for the elderly, is also threatened (Goldstein, 2009; Pear, 2009a).

Hence, the need for resources for best practices treatment of prisoners must compete with other demands. Given that ordinary citizens, and so many veterans who have served our nation heroically in previous and current wars, have compelling healthcare needs, why should the care and treatment of criminals, even those with serious mental illness, be a priority? The extent to which this is a political question cannot be overemphasized. It would be naïve for mental health professionals to underestimate the influence of politics and emotion, as related, for example, to the desire for retribution, or a belief in the need for draconian punishment to ensure that justice prevails, in formulating prison policy. High-profile criminal cases in particular may damage general reform efforts. For instance, the August 2009, arrest of Phillip Garrido, a paroled sex offender, alleged to have kidnapped and repeatedly raped a young girl over an 18-year period, was thought by some California officials to have the potential to derail a bill aimed at reducing the state prison population and the budget deficit through an early parole program (see Chapter 12).

“If we let someone out early, and that man commits a crime, the assembly members are worried that that will come back to haunt them like the old famous Willie Horton ads,” said a prominent state politician, who asked not to be identified because of concerns about undermining legislative negotiations. (Pogash & Moore, 2009, p. A9)

Stated differently, it is vital to consider the *intangible* costs and benefits of incarceration—for example, political advantage to legislators, or among the citizenry an increased sense of safety and security or a sense that justice has prevailed, versus long-term separation of inmates from their families and communities, or perpetuation of cycles of incarceration and poverty—as well as the purely financial aspects. Accordingly, those wishing to advocate effectively on behalf of an increased prioritization of correctional mental health care must marshal arguments that go beyond simple dollar cost-effectiveness to the public’s fears of crime and their reasonable interests in justice and safety.

As noted in Chapter 3, there are competing priorities *within* correctional institutions: security, health, mental health, and so on. Corrections departments must compete at the state and federal levels for limited resources with which to meet their assigned missions. The success of such competition will partly depend on the effectiveness of advocacy both from within those departments and from outside entities: NGOs, the media, and sometimes the courts.

The United States is an increasingly diverse nation, although Whites are still the majority demographic group. However, ethnic and racial minorities are overrepresented among American prison populations. In particular, the incarceration rate for Black males is more than 6 times that of White males (West & Sabol, 2009). More than 14% of those persons housed in the FBOP are foreign-born (West & Sabol, 2009), and all of those in ICE detainee prisons are noncitizens. As noted in Chapter 6, substantial cultural barriers to the provision of even basic mental health services often exist, such as a fundamental distrust of Western medicine and concepts of mental health. Language barriers



will be present to varying extents. Where mental health staff are unable to establish basic communication and trust with these groups of individuals, successfully attending to their mental health needs is unlikely. With minority populations expected to increase, such that Whites will become a minority group by 2050 (Bernstein & Edwards, 2008), this issue will only become more relevant until it is confronted and addressed effectively, or until it breaks the back of the criminal justice system. Such redress ideally emphasizes primary prevention (see below), but it must also include effective interventions for ethnic, racial, and national minorities currently incarcerated in American prisons.

There are presently fewer options for the disposition of those persons with serious mental illness who come into contact with the criminal justice system. As noted in Chapters 1 and 2, deinstitutionalization, beginning in the mid-20th century, was supposed to be accompanied by the resources necessary to treat persons released from psychiatric hospitals in the community. This effort failed on a broad scale, resulting in the “criminalization of mental illness,” an increasing presence of these individuals in the criminal justice system. Yet in the intervening decades, there has been no reversal of this phenomenon. The availability of beds in state facilities has continued to decrease even as the prison system has grown (Lamb & Weinberger, 2005; see also Chapter 2), while community programs for persons with serious mental illness remain underfunded (see Chapter 9).

The history of correctional mental health includes repeated and regular efforts at prison reform: ensuring humane treatment and otherwise recognizing inmates’ rights. Advocacy groups, often NGOs such as Amnesty International, Human Rights Watch, and the American Civil Liberties Union, have been instrumental in these ongoing efforts. Yet reforming prisons, such as by relieving harsh living conditions, is not to be confused with the related issue of reforming prisoners, helping them to modify their thoughts and behaviors to support a prosocial and productive lifestyle after their release. The latter is usually called “rehabilitation” now.

Notwithstanding that correctional mental health care includes other services (see especially Chapters 1 and 9), rehabilitation is traditionally the most visible and controversial of these, perhaps because it implies a return to the community and the attendant risk of further harm individuals released from confinement might cause. There is a long history in the United States of disappointing outcomes of rehabilitation efforts, measured in terms of recidivism rates, dating to the creation of the modern penitentiary, which was itself intended as an instrument of reform. This also speaks to the limits of assessment practices, as when individuals judged to be at low risk for future criminal acts reoffend after being given probation or early release from prison (see Chapter 4). (See Ax, 2007, for more about the history of correctional mental health services, including rehabilitation.) When rehabilitation efforts fail, and particularly when they fail visibly (such as when stories of particularly egregious offenses by recidivists are carried in the media), the public may lose faith in the capacity of social science to “fix” criminals and perhaps even become hostile to further efforts.

## **Arguments for Prison Reform and Best Practice Correctional Mental Health**

Several arguments, not mutually exclusive, are commonly advanced for giving greater attention to conditions in prisons and jails and, implicitly or explicitly, to correctional mental health. Two of these are the moral or humanitarian argument and the pragmatic or economic argument.

In general, the moral or humanitarian argument asserts that every human life has value, and everyone deserves to be treated decently, even prisoners (e.g., Whitman, 2003).

To conduct ourselves otherwise debases us as a society, even extending to the treatment of prisoners. When individuals must be confined in jail or prison, the least an enlightened society can do is to treat them humanely and with dignity and, by implication, provide them with good quality mental health care.

A pragmatic or economic argument challenges the utility of mass incarceration: Incarceration does not solve society's problems, including the root causes of crime (e.g., Mauer, 1999). Many crimes, even serious ones, are never reported in the first place (see Chapter 12). In the long run, lengthy periods of incarceration on a large scale (except for violent, dangerous criminals) are a waste of human capital and economic resources that could be better spent elsewhere, such as on public education or healthcare. Such spending is particularly wasteful in an era of budget deficits. Given the fact of incarceration, prisoners' potential as wage-earners, as spouses and parents, and as generally productive citizens must be nurtured through appropriate services, including effective mental health treatment and community reintegration programs.

To these, counterarguments come readily to mind. Rehabilitation is only one of the missions of incarceration (along with punishment, incapacitation, and deterrence), and some would say the least important. Prison inmates are individuals who have victimized others. If they are not appropriately punished, justice is not served, and prospective offenders are less likely to be deterred. They are not productive members of society and are perhaps unlikely ever to be so. High recidivism rates have proven this, it may be asserted, and there is no better place for criminals than prisons and jails. Given the closure of mental hospitals and the failure of community mental health, this includes persons with serious mental illness, who should not be "coddled" with services unavailable to many law-abiding citizens. Longer sentences will assuredly incapacitate these individuals from victimizing others, a safer alternative to the risks attendant upon rehabilitation programs and earlier release policies, and one that will save money as well (for example, in terms of losses to individuals or businesses victimized by criminals who are given alternative dispositions or early release, or medical expenses secondary to violent crimes these persons would commit if released). Furthermore, as already noted, the costs of prisons may be partially defrayed by the direct economic benefits of jails and prisons to local economies (i.e., jobs and taxes). Hence, there are what many would consider sound arguments for keeping prisons and jails open and full.

There are two additional arguments in support of prison programs, including correctional mental health services, which are not so easily countervailed. The first is the public health argument. Prisons and prisoners are part of the larger community, and whether the general public likes it or not, the great majority of people who are arrested are eventually released. As noted in Chapter 1, more than 9 out of 10 prisoners are eventually released, and hundreds of thousands return to the community every year. Those accused of minor crimes may spend only a few hours or days in jail. The potentially iatrogenic, or harmful, effects of incarceration must be taken into account when considering the costs and benefits of large-scale incarceration. If individuals held in correctional facilities are exposed to communicable diseases, cannot get treatment for serious mental disorders, or become angrier and more antisocially oriented as a result of their experiences in the legal system, the community will suffer when they are released. Appropriate health, mental health, and other interventions benefit not only inmates but those living in the community as well. The iatrogenic effects of incarceration can extend to secondary victims. Families and even communities can be devastated (see Chavez, 2007; and Clements et al., 2007, for more information concerning public health and prisons). Yet it may be argued that longer sentences, particularly for those inmates considered most likely to cause harm (based on past behavior), do more to benefit the public in general than programs whose effectiveness cannot be fully assessed while the inmate participants remain incarcerated.

What is ultimately most meaningful is the legal argument. The Eighth Amendment to the United States Constitution states that “cruel and unusual punishments” may not be inflicted. The historic *Estelle v. Gamble* Supreme Court decision in 1976, based on the Eighth Amendment, provided constitutional guarantees of adequate healthcare to prisoners. A series of other decisions, such as *Ruiz v. Estelle* (1980), has since extended those protections to mental health care. As has been made clear during the recent controversy over the treatment of prison detainees in the U.S. military prison at Guantánamo Bay, Cuba, international law also provides protections for some inmates. The Supreme Court held, in *Hamdan v. Rumsfeld* (2006), that the Geneva Convention was relevant to the legal rights of detainees there.

That said, the law provides necessary but not sufficient conditions for best mental health practices in correctional settings. At best, laws are translated into institutional policies and codes of conduct that require high standards of behavior and competence by prison staff on a day-to-day basis. Existing laws cannot dictate what, exactly, constitutes best practices in each subsequent situation, although legal opinions may cite instances of clearly inadequate or abusive treatment. Recourse to “community standards” is of questionable utility; it is a nebulous criterion, varying across jurisdictions, and the access of millions of free-world Americans to health and mental health care, even with the new federal healthcare legislation, remains questionable (see Chapter 2). Furthermore, much of the law is codified morality. If the zeitgeist dictates harsher treatment—longer sentences, capital punishment—then even the legal argument for best mental health practices and programs is weakened. For health and mental health care professionals, however, there is another standard. All recognized healthcare professions have ethical codes, which typically compel a higher standard of conduct than that required by law or institutional policy, as will be discussed below. (See also “Ethical Codes” in the appendix of this book.)

## Best Practice Environments: Policies, Prisons, and Jails

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In this section, an environment is imagined in which best correctional mental health practices take place. These are conceptual benchmarks against which real-world approximations to best practice environments may be measured. A representative, if not comprehensive, list of principles consistent with such a state of affairs would include the following.

1. *Program and treatment resources are adequate.* Budgets are adequate and moneys allocated appropriately to provide needed services. In turn, these resources are utilized to maximum efficiency to minimize waste. This will mean employing innovative practices, for example, telehealth and electronic health records and, likely, expanded scope of practice for some healthcare professionals (see below). Certainly, it will mean adequate funding for community services, to prevent failures similar to those that attended deinstitutionalization.

2. *Criminal justice policies are preventive, aspirational, and restorative.* In this section, the discussion follows the prevention framework articulated by Eaton (1995), in which *primary* prevention refers to preventing the onset of psychopathology, *secondary* prevention to efforts at impacting its course, and *tertiary* prevention to mitigating its outcome. Here, the terms apply to both the criminal justice process and to psychopathology, broadly speaking. Best correctional mental health practice policies

include appropriate attention to prevention and, where possible, primary prevention; that is, to preventing the development of antisocial attitudes and behaviors, serious mental illnesses, and addictions. Early interventions within the free-world community may focus on the prevention of unwanted pregnancy, child abuse and neglect, complemented with the provision of education and vocational training, as well as health services that help vulnerable persons attain lifelong medical and mental health. Secondary prevention efforts make drug and mental health diversion courts available, allowing defendants, where appropriate, to obtain treatment within the community and avoid incarceration. Psychoeducational programs in community mental health centers could teach persons with serious mental illness about their legal rights, for instance, the right to counsel in the event of arrest and the right not to incriminate themselves, even as adequate funding for public defender services is ensured. Tertiary prevention policies help individuals to avoid or minimize the iatrogenic effects of incarceration; ensure that adequate mental health treatment is available for incarcerated persons; and assist them in remaking their lives in productive, prosocial ways during and after incarceration.

Best practices are aspirational by definition. Accordingly, laws, agency policies and guidelines, and employee codes of conduct are consistent with and supportive of the highest standards and best practices in all departments, given the necessity for interdepartmental collaboration if best mental health practices are to take place (see Chapter 8). They promote fair and humane treatment at the institutional level. For example, for persons with serious mental illness having difficulty functioning in general population, “step-up” general population units and other resources are made available to prevent unnecessary placement in segregation, thereby avoiding the iatrogenic effects of such an experience (Kupers et al., 2009; Magaletta, Ax, Patry, & Dietz, 2005).

Finally, restorative policies foster reintegration of the offender with his or her community upon release: from providing aftercare, including any needed mental health services, to making him or her as nearly “whole” in the eyes of the law and society as possible and appropriate (Ax, 2003). This may involve making restitution, perhaps directly to victims of the offender’s crimes. From a behavioral standpoint, ex-offenders are offered rewards for adopting and maintaining prosocial lifestyles. Persons convicted of felonies forfeit certain rights. Their loss constitutes a barrier to full citizenship, and some or all of these might be restored after specified periods of good behavior in the community. Examples include permitting ex-offenders to be bonded, obtain or regain professional and vocational licenses, get a passport, and vote in elections. Sometimes a fresh start is necessary. For example, individuals who seek to leave gangs may need to relocate to do this successfully, and for their own safety. Funds could be made available for this purpose.

*3. Criminal justice systems are integrated with healthcare systems and the “free world” community.* Two interrelated concepts, the continuity of care and the portability of information, are central to best practices correctional mental health. There is no unitary criminal justice or correctional system in the United States. Prisoners may move between and among local and regional jails, and state and federal prisons, with their incarcerations interspersed with periods of street time. Inmates with healthcare needs may be hospitalized at some point in a local community facility, usually for acute medical needs, and/or within a forensic medical center for long-term mental health care or chronic medical disorder. Similarly, healthcare and mental health care in prison should be continuous with community care, but too often this is not the case. In essence, state prisoners’ healthcare involves three and possibly four disaggregated state systems: criminal justice, health, and mental health, with substance abuse services either autonomous or integrated with, most likely, the mental health system, depending on the state. There

may also be federal systems involved: past incarcerations in the federal prison system and/or treatment in the military, through the Department of Veterans Affairs or Public Health Service.

Best practices would mean having access to all relevant health/mental health care information from each of these systems. Therefore, good communication is essential within and across systems. This must include portability of data: mechanisms for safe and protected electronic storage and transmission of health records. Fortunately, concerns about privacy and security are being raised and addressed by stakeholders, including health and mental health professionals (Lohr, 2009; Nordal, 2009; Pear, 2009b; see also Chapter 1). Continuity of care is not possible without the portability of this information.

There is, however, a further consideration: continuity of care and portability of information *within* correctional facilities. In correctional facilities of any size, a variety of obstacles can interfere with the provision of mental health care. For example, bad weather, a late or inaccurate count, or an institutional disturbance can keep the entire facility locked down, preventing inmates from keeping appointments for psychotherapy or getting to the pharmacy to receive their psychotropic medications. Worse are situations in which inmates are moved from general population to segregation, and this information fails to reach the medical and mental health departments immediately. Providers, perhaps overwhelmed with routine matters, assume for the moment that inmate-patients have simply failed to appear for psychotherapy and/or medication. If follow-up is not undertaken in a timely manner and the inmates' location in the segregation unit identified, treatment may be disrupted or even effectively discontinued. This is another example of how multiple departments must communicate effectively to ensure the continuity of care (see Chapter 7 specifically in regard to medication issues).

*4. Prison and jail treatment outcomes are measured and positive results rewarded, making providers and facilities accountable.* The effectiveness of a prison or jail is often measured in terms of the *absence* of undesirable incidents such as escapes, suicides and other deaths in custody, or documented cases of abuse or denial of rights. To the extent these do not occur, the general public and the legislature are usually satisfied that correctional facilities are functioning adequately. With regard to healthcare in general and mental health care in particular, some assessment mechanisms, including internal agency reviews, are already in place. Many agencies request reviews by independent auditing bodies. The Joint Commission (formerly the Joint Commission on Accreditation of Healthcare Organizations) conducts audits of correctional facilities' healthcare services and accredits (or denies accreditation) as appropriate. The National Commission on Correctional Health Care (NCCHC) publishes health and mental health care standards and accredits facilities based on compliance with these standards. The American Correctional Association (ACA) accreditation criteria also include various aspects of medical and mental health care (see Chapter 5).

However, these reviews commonly take place only once every few years. In a true best practice environment, correctional facility treatment and rehabilitation outcomes would be assessed and made public. Measurable outcomes such as compliance rates with screening requirements of new arrivals and other Level 1 services (see Chapter 2) could be measured and released on a daily, weekly, monthly, or (at most) yearly basis. Recidivism rates for persons released from jails and prisons would be regularly documented and publicly reported. There are foreseeable difficulties with such an arrangement, such as the fact that inmates may be moved among several different facilities during their incarceration, thus complicating the assessment process. Notwithstanding these, if exemplary facilities, programs, and practitioners were recognized and rewarded, it would provide system incentives for best practices by all staff (but particularly mental

health and healthcare providers) and for innovative programming. This state of affairs would promote accountability and thereby improved outcomes.

Information about healthcare is regularly made available to the public by a variety of outlets, formal and informal. A recent PricewaterhouseCoopers Health Research Institute (2008) report documented waste in American healthcare, with more than a trillion dollars lost in three domains: behavioral (e.g., obesity, smoking), clinical (mainly defensive medicine), and operational (with claims processing and ineffective use of information technology the two costliest items). In sum, there is clearly a movement towards measuring healthcare outcomes as a means by which to improve outcomes and reduce waste. The popular periodical *U.S. News and World Report* annually provides a list of the nation's best hospitals (e.g., "America's Best Hospitals," 2009), and consumers can now find online government ratings of nursing homes (U.S. Department of Health and Human Services, n.d.).

Consumers also have an increasing voice in rating healthcare. Patient ratings of physicians are now being made available by the Zagat Survey group in partnership with WellPoint, an insurance company, to the latter's customers (Freudenheim, 2009). On Angie's list (2009), an Internet-based consumer service, "reviews" of physicians, psychiatrists, and other healthcare providers, as well as hospitals, may be obtained. This phenomenon is in some sense the 21st-century version of "word-of-mouth" recommendations. Similarly, the BOPWatch Internet listserv is a forum in which members—lawyers, ex-offenders, family members of prisoners, and others—discuss various aspects of the FBOP, including healthcare. A recent e-mail discussion, for example, involved inquiries and responses about finding good mental health treatment within the federal prison system (e.g., Bussert, 2009; see also Chapter 12 regarding consumer use and marketing of information about sex offenders).

It is well for correctional professionals to remember that consumers will seek out information they want if it is not forthcoming from established sources, including the criminal justice system, and perhaps attempt to hold those systems accountable through legal or administrative actions. A best practice would be to embrace this principle, identify as many measurable outcomes in the criminal justice system as possible, and then hold individuals and facilities accountable for those results, with an emphasis on rewarding favorable outcomes rather than punishing failure. Correctional systems are also healthcare systems, and their healthcare—and rehabilitation—outcomes can and should be measured. The National Committee on Vital and Health Statistics (2004) published a report that provided recommendations for assessing the quality of healthcare according to several criteria, all of which in general can be meaningfully applied to corrections: assessing quality of healthcare and outcomes, reducing related racial and ethnic disparities, building the data and information infrastructure (e.g., with respect to patient records) to support quality healthcare, and balancing healthcare consumers' interests in quality care and the confidentiality of their information.

*5. Prisons and jails are more local, smaller, less densely populated, and transparent.* In a best practices environment, one in which prevention programs have met with success, the prison population is smaller. Correctional facilities are more local, thus more readily linked to the community. This makes release planning easier given the proximity to the appropriate resources and personnel in the community to which an inmate will be released. Informal professional relationships can be developed more easily between case managers in jails and prisons and community services providers, such as probation officers and community mental health professionals. Proximity also makes it easier for inmates' family members and lawyers to visit, preserving community ties and helping to ensure that legal rights are respected. This arrangement would especially benefit indigent

inmates, whose family members do not have the funds to travel long distances for visits and who must depend on public defenders for legal representation.

Overcrowding, in terms of square feet allotted per inmate, would not exist. The *Ruiz v. Estelle* (1980) opinion specifically cited “persuasive testimony relating to the incremental negative physical and psychological effects of inmates’ continued close confinement in too-intimate proximity with their fellows” (p. 1282).

6. *Prison populations are representative and accommodate diversity.* The prison population is representative of those who commit crimes, reflecting fair and unbiased treatment within the criminal justice system. Currently, several ethnic minority populations are overrepresented in prisons relative to the degree to which they commit crimes (see Chapter 6).

In particular, it will be necessary for prison systems to be responsive to the needs of Hispanic inmates from foreign countries. In addition to those individuals in state prisons and the FBOP, the United States, as earlier noted, now has a new prison system, run by ICE, which houses foreign individuals who have entered the United States illegally. The majority of these individuals are from countries in which Spanish is the primary language, and many speak little or no English. It will be necessary for these facilities, if they are to function as best practices prison environments, to employ sufficient numbers of mental health and other treatment staff who are fluent in Spanish and other languages and are familiar with the various cultures represented among the prison populations.

7. *Non-mental health care staff conduct and composition also exemplify best practices.* The human component of best practice correctional environments is the most crucial. Staff are well trained; conduct themselves ethically; are present in adequate numbers; and possess the knowledge, skills, and abilities to respond to the globally diverse populations of our prisons and jails. As institutional CEOs, wardens and sheriffs have extremely difficult jobs (see Chapter 3). They hold the highest levels of on-site authority and responsibility and are simultaneously accountable to upper levels of state, federal, or municipal government hierarchies (and, in the case of private prisons, corporate boards) for the safe and orderly running of their respective prisons and jails. They must function under the scrutiny of the media, prisoners’ rights groups, and family members ready to support inmates’ grievances. Their conduct is the key component in determining how these institutions function. “Correctional leadership is the major component to developing a correctional culture that can manage special population prisoners” (Stojkovic, 2005, p. 1-11), a point also underscored in Chapter 3 of this book.

In social learning terms (Bandura, 1977), administrators can *model* best leadership practices. This will set the tone for an institution that is run in a fair and humane manner and in which staff understand that accountability is required at all levels for the quality of care inmates receive. Acting as an advocate (or “champion”) to upper levels of agency management on behalf of well-run programs, such as by making adequate program staffing levels a priority, further promotes a best practices environment. Where leadership fails, drastic consequences can result. One high-profile example of this is the military prison at Abu Ghraib, site of abuses of detainees in 2003, which were later made public. In a subsequent investigation, a failure of leadership was noted on the part of several of the high-ranking officers at the facility, including the facility’s commander, a brigadier general (Taguba, n.d.).

In some facilities, medical and mental health services may be combined in the same department. In others, they are independent. Regardless, cooperation, communication, and collaboration between medical and mental health service providers are crucial.

These services form the core around which other relationships are created to provide comprehensive services to inmates with serious mental illnesses. As noted in Chapter 1 and earlier in the present chapter, continuity of care is critical, particularly where inmate-patients move between correctional facilities and the community and/or from one correctional system to another. Lapses in communication within an institution can result in lost information such as prescriptions for psychotropic medications, referrals for medical or psychological tests and other services, or suicide watch referrals. Perhaps most importantly, from a biopsychosocial perspective, mental health interventions are likely to involve multiple modalities and may have to be coordinated between and among practitioners, particularly medical and mental health practitioners. Avoidance of silos is fundamental to best practices (see Chapter 8).

One practice deserves particular attention in this regard. It is fairly common for general population correctional facilities to employ psychiatrists on a contract, part-time, basis. In practical terms, they become the interface between medical, pharmacy, and mental health staff. If necessary communication, including documentation of appointments, prescriptions, and referrals for medical or psychological tests, is not handled appropriately between and among all staff involved, best practices cannot be provided.

In a best practices correctional environment, custody staff, the “eyes and ears” of mental health staff within the institutions, and often the first responders in the event of a mental health emergency, are well trained in dealing with inmates with serious mental illness (see Chapter 3). They can refer inmates to mental health staff and, through their professional conduct, earn the trust of these individuals, who may be willing to approach such exemplary officers with their concerns, including mental health issues. To be effective, correctional officers must be present in adequate numbers. In particular, they can protect vulnerable inmates. Notwithstanding the desirability of changing prison culture to prevent sexual and other assaults on vulnerable inmates (Zweig & Blackmore, 2008), it is ultimately the presence of sufficient numbers of concerned, highly professional custody/security staff that discourages and ultimately prevents inmate-on-inmate assaults. Furthermore, even the U.S. Department of Justice concedes, “There is not yet a solid body of evidence as to what strategies and interventions prevent rape” (Zweig & Blackmore, 2008, p. 8). The *Ruiz v. Estelle* (1980) decision noted the increased risk of physical and sexual assaults when there are inadequate numbers of custody staff present in an institution. A best practices environment is not only one that provides high-quality mental health care; it is also one in which the iatrogenic effects of incarceration are prevented as much as possible.

## “Real-World” Best Practices for Correctional Mental Health Practitioners

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In this section, a different perspective is adopted in considering the possibilities for best practices by correctional mental health professionals, given the current obstacles presented by the realities of limited correctional budgets and other resources. Aside from those presented within the criminal justice and political systems, healthcare system issues, such as shortages and geographic maldistribution of providers (resulting in an oversupply in some areas and an undersupply in others), can present impediments to best practices. The needs of patients in correctional settings, and their growth in absolute numbers, threaten to overwhelm the capacity of the various American correctional systems to respond adequately. Under these circumstances, it becomes especially important for providers of these services, as individuals and as members of particular



professions, to maintain the aspirational stance referred to earlier in this chapter with regard to their own competence and practice.

### **Adding Value: Scope of Practice Issues**

In one fundamental respect, this translates to the necessity for mental health care providers to expand their scope of practice by improving what is known in bureaucratic terms as “knowledge, skills, and abilities” and thereby regularly adding value to their work. This is particularly important in an era where shortages of some healthcare professionals, particularly physicians and nurses, exist.

Recognizing the need for improved access to healthcare (including mental health care) in America, the Pew Health Commissions published a report in which they concluded,

United States health care consumers need a regulatory system that bases authority to practice on the practitioner’s demonstrated initial and continuing competence—acknowledging that differently trained and differently named professions may deliver the same services—so long as they demonstrate competence. Professionals should be allowed and encouraged to provide services to the full extent of their current training, experience and skills. A regulatory system that maintains its priority of quality care, while eliminating irrational monopolies and restrictive scopes of practice would not only allow practitioners to offer the health services they are competent to deliver, but would be more flexible, efficient, and effective. (Finocchio, Dower, McMahon, & Gagnola, 1995, p. 13)

Indeed, it is the norm rather than the exception for healthcare professions to evolve in accordance with scientific advances and with marketplace needs and opportunities. For correctional psychologists, this may mean adopting a primary care model or something closely approximating it, so that care can be better coordinated and provided more effectively (Fagan, Brandt, & Kleiver, 2007).

Given the decline in the numbers of psychiatrists being trained (Rao, 2003) and their shortages in some parts of the country (Fraher, Swartz, & Gaul, 2006; Office of Rural Health & Primary Care, Minnesota Department of Mental Health, 2003; Thomas & Holzer, 2006), it is understandable that organized psychology would seek prescriptive authority for those psychologists receiving specialized training in clinical psychopharmacology. Indeed, this has been at the forefront of the American Psychological Association’s (APA’s) agenda for several years now. However, as of this writing, only two states, New Mexico and Louisiana, have passed enabling legislation, and the future of the initiative seems uncertain (Fox et al., 2009). As noted in Chapter 7, clinical pharmacists can prescribe in some states. Other professionals, nurse practitioners or physician assistants, for example, could “train up,” becoming skilled in mental health assessment, diagnosis, and psychological interventions. Added to their current skills and knowledge of clinical pharmacology, these professionals could provide health/mental health primary care in correctional settings.

Certainly, this is consistent with a biopsychosocial model of practice. In particular, this implies the emerging understanding that mental and somatic health are interrelated and speaks to issues of collaboration and evolution in the scopes of practice of the various healthcare professions. This means potential turf wars but also the possibility to maximize the value of a cadre of staff who are already highly trained and critical to the proper function of correctional facilities. Integration at the theoretical level could parallel the integration of medical and mental health services at administrative and

practice levels, as mental and medical healthcare staff collaborate in support of health promotion/disease prevention efforts, a particularly important initiative in prisons, where dysfunctional lifestyles have left many with or vulnerable to illnesses. In particular, substance abuse has contributed to chronic infectious diseases, organ compromise, and other health problems (Chavez, 2007; Fagan et al., 2007; see also Chapter 11). Such collaborations can act as “competence multipliers” to assist inmates in regaining medical health lost to unhealthy lifestyles common among prison populations, in concert with more stable mental functioning.

“Train up or work down and lose out” might be a useful maxim for health and mental health care professionals. Those who fail to upgrade their skills regularly risk being marginalized, spending more of their time performing lower skilled tasks, or losing jobs altogether, as other professions collectively enhance their knowledge and skill sets and become available to perform similar assessment and treatment services, perhaps doing so at equivalent quality levels and at lower cost. This is likely to be more urgent in prison systems, where healthcare is a subordinate mission, and safety and security concerns reliably rank as higher priorities. Lower priority missions must accordingly be increasingly cost-effective. It is also a matter of advocacy. The ultimate success or failure of psychology’s prescriptive authority initiative, for example, will be largely determined by the degree of political involvement and persistence of its members in promoting legislative initiatives in other states and in making a case for the usefulness of this skill in public agencies on behalf of underserved patient populations, such as prisoners. “Psychologists must understand that our obligations transcend guild concerns and must ultimately address the fundamental concern of expanded patient access to expert mental health services” (Fox et al., 2009, p. 267).

In many state correctional systems, the modal mental health provider is a master’s-level “psychologist” (Boothby & Clements, 2000). However, “best practices” is not to be confused with “doctoral-level provider.” Where doctoral-level mental health practitioners, psychiatrists and psychologists, are unavailable to provide needed services, it is desirable that others, following Finocchio et al. (1995), should be given the training and authority to do so. Best practices cannot be divorced from cost-effectiveness issues, especially in the current, economically challenging environment.

In correctional settings, particularly for mental health professionals, who depend on the quality of their therapeutic relationships with their patients for the success of their work, cultural responsiveness is crucial (see Chapter 6). Although it is not possible for them to be conversant with the entire range of cultures represented in prison populations, a willingness to engage with patients in identifying, addressing, and resolving cultural differences that may affect therapeutic work is crucial. More basically, correctional mental health providers who can speak a foreign language, particularly Spanish, will add considerable effectiveness to their work and value to their agencies.

## Role Issues

By definition, the conduct of best practices involves high ethical standards. In correctional practice, this can be particularly difficult. Role conflict is always a possibility in an environment in which treatment missions are subordinate to those of safety and security. Practitioners must sometimes face complex situations involving unrealistic demands from the administration and other staff, on the one hand, and often hostile inmate-patients, on the other, who may refuse or misuse services, demand inappropriate treatments (e.g., preferred psychoactive medications), or malingering. Providers may need to advocate for improved treatment with administrators or other staff who may be hostile to particular best correctional mental health practices, for example, reduced

reliance on the use of segregation or introducing mitigating or exculpatory information about an inmate's mental status in disciplinary hearing cases. Best practice often involves consulting with colleagues familiar with such situations and the ethical conundrums they present. In keeping with the dictum to "do no harm," practitioners must acknowledge the limits of their own competence. Sometimes practitioners must decline to perform an action if to do so would be unethical and potentially harm a patient, even when such actions are requested by the patient (e.g., denying sleep medication when not indicated). It may also be the best practice to do nothing when the alternative is to exceed the scope of one's competence or to impose treatment on a powerless inmate. Similar to this is the need to refrain from making unrealistic claims for the validity of assessment procedures or the effectiveness of treatments.

Problems with prison practice often result when too much time is spent considering what is permissible under the circumstances, rather than what is best. This contributed to the recent controversy the APA experienced in its attempts to create a policy that permitted psychologists to be involved in the interrogations of detainees at the Guantánamo Bay Naval Base and other facilities housing alleged terrorists. Amid growing concerns about allegations of torture, a grassroots movement among members protested this policy, eventually forcing a vote that banned all such involvement (Martin, 2008). Regarding the revised policy, Dr. Alan E. Kazdin, then-President of the American Psychological Association, wrote, in part, to President George W. Bush,

The emphasis of this new policy is to *prohibit psychologists from any involvement in interrogations or any other operational procedures at detention sites that are in violation of the U.S. Constitution or international law* (e.g., the Geneva Conventions and the U.N. Convention Against Torture) [emphasis in the original]. (Kazdin, 2008b, p. 1)

Even alleged terrorists, perhaps the most devalued persons in any American prison system, are entitled to fair and humane treatment under the law and no less so to ethical treatment by health and mental health care providers.

However, role flexibility is often vital to best practice in an environment with limited resources. As has been discussed at many points throughout this book, collaboration across disciplines is central to all prison missions, including safety and security, as well as mental health treatment. Mental health practitioners must be willing to assist in preserving the more fundamental correctional missions that involve safety and security, including the prevention of assaults, escapes, contraband trafficking, and so forth. Where these missions are compromised, mental health services suffer. At the same time, innovative practices and new technologies also allow new roles, for example, the collaboration of mental health practitioners with medical personnel, in addressing the behavioral health aspects of health promotion and disease prevention.

Not all correctional mental health professionals work in prisons. They may work in academia, developing new interventions relevant to correctional populations. They may serve as clinicians in the community, providing preventive care for at-risk individuals and families, or care for those who have been released from prison and require ongoing treatment. They also work in the policy arena, as administrators, as legislators, or with NGOs.

## Science and Technology

There is now clear evidence for the effectiveness of mental health interventions. "The challenge of yesteryear about whether psychological treatments are better than no treatment has been put to rest" (Kazdin, 2008a, p. 211). This holds true for many disorders

that are the focus of mental health and rehabilitative intervention in criminal justice systems (Clements & McLearn, 2003). Prominent among the relevant literature is the “What Works” canon of Paul Gendreau and his colleagues (e.g., Gendreau, 1996; Smith, Gendreau, & Goggin, 2007; see Chapter 9). There has been a proliferation of research journals in the corrections and criminal justice fields, including *Criminal Justice and Behavior*, *Journal of Child Sexual Abuse*, *Journal of Correctional Health Care*, *Law & Human Behavior*, *Journal of Interpersonal Violence*, and *Psychology, Crime, and Law* (see the appendix to this volume for a larger list of these journals). A database of empirically supported preventive interventions is emerging (Washington State Institute for Public Policy, 2006). Evidence-based interventions are beginning to gain attention in the probation and parole disciplines (Cadigan, 2008; McGrath, 2008). Ax and Fagan (2007) provided an overview of effective interventions in other nations’ criminal justice systems. As noted in Chapter 7, psychotropic medications have proven effective in treating many of the disorders that contribute to incarceration.

Employing empirically supported treatments is consistent with best practices from both an ethical and an accountability standpoint, which further speaks to the issue of risk management. As health and mental health care outcomes, including those in the criminal justice system, are increasingly measured and scrutinized, patients, providers, and correctional institutions benefit from interventions of proven clinical effectiveness in terms of patient well-being, institutional security, and protection of institutions and staff from litigation. More accurate risk assessment can promote greater credibility and thereby acceptance of mental health providers’ recommendations for treatment, diversion from incarceration, or early release (see Chapter 4).

Technology can leverage the utility of existing staff resources and provide access to specialty care. Telehealth (or telemedicine), as discussed in Chapter 5, has become increasingly popular in criminal justice systems. Prisons are often built in rural areas where healthcare providers may be unavailable for face-to-face consultations (Magaletta, Dennery, & Ax, 2005). Technology can also support continuity of care, which, as previously discussed, can be a particular problem in corrections, both between institutions and in terms of the institutional-community link. The safe and confidential maintenance and transmission of electronic health records will support best practices as inmate-patients move between institutions and return to the community. It also supports the portability, quality, and economy of treatment *within* institutions, particularly when inmates are confined in segregation or are on suicide watch. In these settings, it may be difficult for practitioners to bring paper files, but it is crucial for them to be able to access treatment data during contacts. For example, when mental health practitioners conduct reviews in special housing units, they may see 20 or 30 inmates who have a range of concerns and mental health needs. Portable electronic databases carried by psychologists, psychiatrists, and other mental health providers visiting these restricted access areas would allow them to retrieve treatment records, including diagnoses, recent contacts, and medication histories.

## Summary and Conclusions

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More than two decades ago, the historian Paul Kennedy (1987) wrote about how great nations had declined when their ambitions and international obligations had outstripped their economic, military, and technological resources. He suggested then that the United States was facing a watershed moment similar to that of Imperial Spain in 1600 and the British Empire at the dawn of the 20th century—that our resources were

becoming overtaxed as theirs had been when their declines began. Similarly, a recent report from the National Intelligence Council (2008) projected that in the world of 2025, the United States’s international influence will have diminished. “Shrinking economic and military capabilities may force the U.S. into a difficult set of tradeoffs between domestic and foreign policy priorities” (p. iv). As this is being written, the United States is facing an ongoing series of crises, not the least of which is economic, as President Obama noted in his inaugural address. These may resolve in full or in part with a return of the United States to a position of economic, military, and political preeminence.

In light of these ongoing challenges, however, it remains to be seen whether America has both the capacity and the will to provide adequate mental health services for those under the care, custody, and control of the various American prison systems. In particular, America must confront its willingness to invest in preventive interventions, to take calculated risks on alternatives to incarceration for those marginalized individuals who are clearly not a threat to public safety, and to support other initiatives aimed at reintegrating ex-offenders into their communities. The nation has considerable resources available to it in terms of well-educated health and mental health care providers and new electronic and pharmacological technologies. However, in large part, it will be up to members of the health and mental health care professions to prove the worth of their specialized knowledge, skills, and abilities in the court of public opinion and so create a more favorable, best practice environment.

## Endnotes

1. Readers interested in more information about the biological aspects of antisocial behavior are referred to the November 2009 issue of *Criminal Justice and Behavior*. This is a special issue with the theme “Biosocial Criminology,” in which the Vaughn et al. article appears, along with several others on related topics.

2. Related to the issues of prevention, prison reform, and alternatives to incarceration is that of the reform of drug laws. An extensive discussion of this controversial topic is beyond the scope of this chapter. Suffice it to say at this point that some reconsideration of the often harsh penalties for drug use is occurring as of this writing. Notably, U.S. Attorney General Eric Holder recently announced that the federal government would not prosecute users of medical marijuana who are in compliance with the laws of those states permitting its use (U.S. Department of Justice, 2009). Also, many of the penalties pursuant to the so-called “Rockefeller Drug Laws,” enacted in New York State in 1973 under then-Governor Nelson Rockefeller, have been moderated by more recent legislation, which took effect in April 2009 (Drug Policy Alliance, 2009). These small-scale legal reforms may provide an opportunity to assess the relationship between drug laws, the prison census, and the incidence rates of drug abuse and addiction and thereby have a significant impact on related law and policy in the next decade.

### KEY TERMS

Biopsychosocial model of practice

Ethical codes

Federalization

Private prisons

Public health

Primary prevention

Portability (of treatment and information)

Scope of practice

## DISCUSSION QUESTIONS

1. Should the missions of prisons and jails be confined to punishment, deterrence, and incapacitation? Can prisons rehabilitate criminals, or should rehabilitation be abandoned as a correctional mission?
2. Was deinstitutionalization a good idea, or did it do more harm than good, and on what standards is your answer based? How might the mental health system be re-created so as to respect the civil rights of persons with serious mental illness while providing an effective alternative to incarceration?
3. Are the iatrogenic effects of prison an appropriate part of punishing crimes? Do these effects promote rehabilitation (e.g., by convincing inmates never to return to such a harsh environment)? Are there iatrogenic effects from prison that inmates should not experience, and if so, what can be done to minimize or eliminate them?
4. Should some or all currently illegal drugs be legalized or decriminalized as a means of reducing the prison population? Would this be a more humane, scientific way to treat the problem of drug abuse and addiction, or would it create even greater problems?
5. Imagine that you are a provider of mental health services in a prison and that you are asked to do something you believe to be unethical, such as occasionally to act as a correctional officer—potentially a dual role. What steps would you take in deciding what to do? Would your professional code of ethics be helpful?

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