CHAPTER 23

Correctional Psychology: Law, Ethics, and Practice

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America's response to crime has traditionally been summarized with one word: *corrections*. The choice of this word, indicating the ability to ameliorate—that is, to change—human behavior, has long suggested a partnership between these sometimes punitive and sometimes rehabilitative institutions we call jails and prisons. In this chapter, we explore the historical, current, and potential interactions between psychology and this aspect of the American criminal justice system. This chapter considers only jails and prisons serving primarily adult offenders and excludes community correctional programs such as probation and parole.

THE DIFFERENCE BETWEEN JAILS AND PRISONS

Though both fall under the rubric of corrections, jails and prisons are distinct institutions, with different functions, auspices, stressors, and roles for psychologists.

Jails in the United States are generally run by municipalities or counties, often under the jurisdiction of an elected sheriff. Their residents consist primarily of two classes of people: (1) pretrial felony or misdemeanor detainees, for whom the jail's primary responsibility is to ensure that they do not escape and that they are safely held until release or trial; and (2) persons who have been convicted and are serving sentences typically for less than 1 year, most often for misdemeanors. Many of the sentences for the latter group are short, and jails generally do not place emphasis on changing how inmates behave following release. There are exceptions, such as special jail-based alcohol treatment programs for those convicted of driving while intoxicated and domestic violence programs that seek to reduce the likelihood of repeated family violence. In general, however, jails spend little time and energy on altering behavior; instead, they focus on safely managing people. They are generally regarded as "people processing institutions." In contrast, prisons generally provide long-term (i.e., more than 1 year) confinement of persons convicted of felonies. At least in theory, prisons have traditionally regarded themselves as "people-changing institutions," with the goal of rehabilitating criminals and reducing crime. There is no consensus that this goal has ever been effectively achieved. We believe that this problem has been due in part to the failure of academic and professional psychologists to provide leadership in the area they have been helping people to change their behavior.

A BRIEF HISTORY OF CORRECTIONAL PSYCHOLOGY

Over time, the roles of psychologists in jails and prisons have evolved, from the relatively narrow role of intake assessment to the many varied roles that exist today. This section discusses the developmental course of psychologists' roles within jails and prisons.

The Testing Psychologist

In one of the earliest reports about prison psychology, Donald Powell Wilson (1951) described his 3 years in the early 1950s working as a U.S. Public Health Service psychologist at Ft. Leavenworth, Kansas. He drew extensively on employing prisoners as clinical and research assistants; thus the title of his book, *My Six Convicts*, with a popular film of the same title following in 1952. Wilson described professional activities in which he conducted light therapy and hypnosis, sometimes with men on the "psychopathic ward"; he also conducted drug research. However, his primary role was supervision of testing by his inmate assistants. Wilson was extremely critical of the utility of paper-and-pencil personality tests with prisoners, observing, "They throw little light on the vast problem of personality" (p. 138). Some 15 years after Wilson's tour of duty, in the late 1940s, Raymond Corsini was employed as a psychologist at Auburn Prison in New York. Corsini (1969) described what he believed "was the most successful and elegant psychotherapy I have ever done" (p. 3). An inmate reported, " 'You told me I had a high IQ.' With one sentence of five words I had (inadvertently) changed this person's life" (p. 6). What is important for our purposes is that Wilson and Corsini alike had been locked into the typical role of the prison psychologist of the early to mid-twentieth century, as the administrators of psychological tests given to entering prisoners for purposes of ascertaining intelligence, vocational skills, and personality patterns.

Psychotherapeutic Treatment of Criminal Behavior

Not all psychologists in the early days of prison psychology were committed to testing. In his books *Rebel without a Cause* (1944) and *The Fifty-Minute Hour* (1954), Robert Lindner sought to apply psychoanalytic principles and methods to understanding and treating offenders. In *Rebel without a Cause*, Lindner published the transcriptions of 46 hour-long hypnotherapy sessions with a single offender, designed to show that criminal psychopathology grew out of repressed, painful experiences. In *The Fifty-Minute Hour*, Lindner described his work at a federal penitentiary with a psychopathic "prison failure" inmate who was having blackout spells. Lindner introduced the latter case study by describing the individual psychoanalytic interviews conducted with all inmates and describing his bulky files on this particular inmate, encompassing psychological tests and complete social, educational, criminal, and personal histories. These full evaluations and extensive utilization of mental health data were more typical of federal prisons than state prisons, as, indeed, they are to the present time.

Early on, prison mental health professionals operated under the assumption that criminal behavior was explicitly determined by psychopathological deficits. The logical and needed remedy was psychotherapeutic treatment to correct these deficits. The treatment of choice at the time was the same as the treatment of choice

in free society, namely, psychoanalytically based approaches. As mental health treatments broadened, so did treatment approaches to prisons.

In his best-selling 1966 book *The Crime of Punishment*, psychiatrist Karl Menninger galvanized attention to the harm caused by prisons and the resultant need for change. He described prisons as obsolete, inhumane systems, and he wrote that psychiatrists were caught up in dependence on empty and meaningless jargon. After identifying the unconscious determinants of criminal behaviors, Menninger stated that virtually no treatment is offered to offenders and that effective treatments should be made available for violent offenders. He went on to assert that the majority of offenders are curable:

> It will surely have to begin with motivating or stimulating or arousing in a corrected and ordered the wish and hope and intention to change his methods of dealing with the realities of life. Can this be done by education, medications, counseling, and training? I would answer yes. It can be done successfully in a majority of cases of misbehavior in time. (p. 257)

Among the efforts that reflected the passion of the Menninger polemic was treatment at the Patuxent Institute in Maryland. A "defective delinquent" law had instituted a treatment regime in which release and improvement in living conditions were contingent on therapeutic and behavior gains in a part-behavioral, part-psychodynamic program (Zonaff & Courdess, 1977). The inmates were confined with indeterminate sentences, with length of confinement decided, in large part, by psychological gains. This therapeutic experiment ran from 1955 to 1977 and was criticized for poor diagnostic judgments and ineffectiveness in reducing recidivism (Sidley, 1974). On the other hand, other observers believed the Patuxent experiment to be effective and useful (Rappeport, 1975). These positions were followed by the assertion of Robert Martinson (1974), who declared that "nothing works." Martinson elicited dismay from some psychologists and righteous indignation from others who claimed that treatment was effective. Of greater significance was the resultant commitment to studying which elements of offender therapies did work, for whom, and under what circumstances.

Toward Ethics and Graduate Preparation

In the early 1970s, three major forces influenced mental health services in prisons. In 1971, a major conference with follow-up meetings was held at Lake Wales, Florida. This conference had the ambitious goal of redefining the practice of psychology in the criminal justice system, particularly in corrections (S. L. Brodsky, 1973). Judge David Bazelon was a speaker and participant at the conference, and he urged psychologists working in corrections to do good for prisoners instead of doing well for themselves. The conference report stated that psychologists needed to sort out their alliances to institutions and clients, to rethink their roles, and to move toward a better synthesis of research and treatment.

The issue of role definition was clarified when Monahan (1980) edited an influential book, *Who Is the Client?* Monahan and the contributors to the book identified the nature of loyalty and legal obligations for psychologists in the criminal justice system, including those employed in corrections. In the labyrinthine muddle of competing responsibilities, Monahan clarified how to think about one's role when

acting as a mental health professional in corrections. To the present day, many books on ethics in psychology include sections devoted to the issue of the psychologist faced with competing responsibilities to institutions and to offender clients (e.g., Bersoff, 2003).

At the same time this conference was held, the University of Alabama and Florida State University developed the first graduate education programs in correctional-clinical psychology (S. L. Brodsky, 1973; Fowler & Brodsky, 1975). Until the initiation of these programs, correctional and legal psychology was an unwelcome and stigmatized stepchild of mainstream clinical psychology graduate studies. Graduate students who were interested in working with offenders were considered odd. These clinical-correctional psychology PhD concentrations helped initiate a research-practitioner model to prepare psychologists for understanding correctional institutions.

Class Action Suits

The third major influence from the 1960s was the success of class action suits addressing the living conditions and medical and mental health needs of prisoners. As described in another section of this chapter, a path opened to legitimate and ready access to the courts to seek redress of deprivation of constitutional rights in areas of 8th Amendment litigation. These efforts were not always successful because of institutional resistance to court orders (S. L. Brodsky, 1988; S. L. Brodsky & Miller, 1982; Yackle, 1989). On the other hand, Metzner (2002a, 2002b) concluded that such class action suits and subsequent court orders greatly improved the quality of prison mental health care.

What had begun with the judiciary expressing the power to intervene in the administration of prisons on behalf of constitutional rights of inmates in the 1960s and 1970s was severely curtailed in the mid-1990s. After 20 years of litigation to improve prison conditions, including the delivery of mental health, the passage of the Prison Litigation Reform Act (PLRA) of 1995 was explicitly intended to shift the playing field to make such suits more difficult. The legal rights and ability of prisoners to file litigation were diminished as these cases were portrayed as "frivolous suits." They were, in fact, often substantive in nature. As Chan (2000) pointed out, it was about the legal ability and resources of prisoners to file meritorious actions for basic aspects of safety and health. Despite the PLRA, such litigation continued, resulting in important cases such as *Coleman v. Wilson* (1995) and *Madrid v. Gomez* (1995), which together resulted in 10s of millions of additional health and mental health care dollars being funneled into California's prison system.

Professional Organizations and Journals

The role of psychologists in corrections is reflected in the history of the organizations formed to support and promote the field. In their comprehensive discussion of the history of the American Association of Correctional Psychology (AACP), Bartol and Freeman (2005) noted the AACP's difficulty in maintaining continuity in the American Psychological Association, the criminal justice section of the Division of Psychologists in Public Service has been a home for correctional psychologists. More recently, the British Psychological Society has established its own

Division of Forensic Psychology. Despite the name "forensic" as the title of the division, members are predominantly psychologists working in prisons, probation services, and secure hospitals. The Division has begun a series of books for correctional psychologists, including *Psychology in Prisons* (Towl, 2003), a book series that identifies roles and responsibilities of psychologists who work with offenders and correctional staff.

The professional or scholarly journal serves as a marker of professional respectability. When the journal *Criminal Justice and Behavior* was established in 1974, it reflected a clear commitment to correctional psychology to attain that respectability. Furthermore, correctional psychology articles have become a routine part of other mainstream clinical psychology journals.

The Human Element

Psychologists working in state correctional systems during the early through mid-1900s were often employed at the discretion of the warden. Many psychologists were expected to report the content of therapy sessions to custodial staff. Some were assigned desks in prison corridors, with minimal privacy. At large institutions in Michigan and other states, a single psychologist was expected to test all newly admitted prisoners and write reports, which sometimes meant evaluating as many as 200 prisoners a week. The quality of such assessments was understandably questionable. When psychologists advocated for treatment of prisoners or responded to outside inquiries or reporters, their position could be terminated immediately. Psychologists working in corrections at that time were often frustrated by the institutional controls and disappointed at how little difference they could make.

Five related events changed the occupational toxicity of prison psychology. First, legal and legislative actions legitimized and sometimes mandated the importance of psychological services. Second, civil service positions protected psychologists from arbitrary actions by administrators. Third, psychologists rose to administrative positions, often as associate wardens for treatment, and thus became invested in maintaining a good environment for other psychologists. Fourth, standards of practice were developed in corrections that encompassed mental health care. Fifth, payoffs from research foundations and graduate education began to filter into the correctional setting. Evidence-based treatments and better trained/prepared psychologists made an impact and were more welcome. Some things have not changed: the variability in enormous in how valued and effective psychologists are in different federal and state institutions; ethical conflicts continue to be demanding and difficult; and the milieu influences practice, with overcrowded, understaffed, and unsafe prisons impeding the delivery of mental health services.

THE LEGAL LANDSCAPE

As noted above, correctional psychology has been massively influenced by preeminently constitutional litigation. This section includes a brief history of these developments and a summary of the current status of inmates' rights in mental health treatment.

Constitutional Law

For centuries, Anglo-American common law has required that the government or agency that incarcerates a person is responsible for provision of that person's "necessaries," or those minimally essential goods and services that prisoners are unable to obtain on their own. This "necessaries doctrine" is applied to food, shelter, clothing, and medical care.

The basic tenets of constitutional correctional mental health law can be traced back to the landmark case of *Estelle v. Gamble* (1976). This case, based on the 8th Amendment's prohibition against cruel and unusual punishment, held that states are prohibited from being "deliberately indifferent to the serious medical needs" (p. 103) of the people they incarcerate. One year later, *Bowring v. Godwin* (1977) explicitly included psychiatric need as subject to the requirements of *Gamble*. Although clearly articulating a constitutional duty to provide some level of medical and mental health care for inmates, these two cases were vague in defining serious medical or psychiatric need and listing the nature of the services that would be required. In declining to define deliberate indifference, the *Gamble* Court made it clear that the standard promised to inmates was a low one. For example, "Medical malpractice does not become a constitutional violation merely because the victim is a prisoner." nor is deliberate indifference created by "poor judgment, inadvertence or failure to follow the acceptable norms for practice in a particular geographic area" (p. 106–106). According to F. Cohen and Dvoskin (1992, p. 342), "Looked at another way, deliberate indifference requires greater culpability than malpractice but need not reach the more demanding [criterion] for intentional conduct, that is, consciously acting to achieve a preconceived result."

In 1983, *Ruiz v. Estelle* helped to delineate a prison's responsibilities by articulating six principles that are mandatory in prison mental health:

1. There must be a systematic program for screening and evaluating inmates to identify those who require mental health treatment.
2. Treatment must entail more than segregation and close supervision of the inmate patients.
3. Treatment requires the participation of trained mental health professionals, who must be employed in sufficient numbers to identify and treat, in an individualized manner, those treatable inmates suffering from serious mental disorders.
4. Accurate, complete, and confidential records of the mental health treatment process must be maintained.
5. Prescription and administration of behavior-altering medications in dangerous amounts, by dangerous methods, or without appropriate supervision and periodic evaluations is an unacceptable method of treatment.
6. A basic program for the identification, treatment, and supervision of inmates with suicidal tendencies is a necessary component of any mental health treatment program.

Any consideration of the duties of the government to provide care within its institutions must also include *Youngberg v. Romeo* (1982), which established the principle that "reasonable professional judgments" are presumptively constitutional. Professional judgment occurs when a person with *appropriate* education, training, experience, and/or licensure:

- Addresses the appropriate question.
- Makes a reasonable effort to seek relevant information.
- Makes a decision that falls within the reasonable choices that persons of similar and appropriate education, training, experience, and/or licensure might make.
- Acts on that decision.

Perhaps most important, there is no constitutional requirement that such judgments be "right." The language of *Youngberg* is instructive:

> The decision, if made by a professional, is presumptively valid; liability may be imposed only when the decision by the professional is such a substantial departure from accepted professional judgment, practice, or standards as to demonstrate that the person responsible actually did not base the decision on such a judgment. In an action for damages against a professional in his individual capacity, however, the professional will not be liable if he was unable to satisfy his normal professional standards because of budgetary constraints; in such a situation, good-faith immunity would bar liability. (p. 323)

In 1989, *Langley v. Coughlin* combined these principles and explicitly applied the "professional judgment" standard to an analysis of deliberate indifference with regard to prison mental health care. The magistrate explained that although "isolated and inadvertent errors" would not violate the 8th Amendment, "serious failure to provide needed medical attention when the defendants are fully aware of that need could well constitute deliberate indifference, even if they did not act with punitive intent" (p. 537). In addition, *Langley* articulated a list of specific allegations that would, if proven, indicate constitutionally inadequate care of inmates with serious mental illness, including:

- Failure to take and maintain complete and adequate psychiatric records.
- Failure to respond to inmates' prior psychiatric history.
- Failure to at least observe inmates suffering a mental health crisis.
- Failure to properly diagnose mental conditions.
- Failure to properly prescribe medications.
- Failure to provide meaningful treatment other than drugs.
- Failure to explain treatment refusals, diagnosis, and ending of treatment.
- Seemingly cavalier refusals to consider bizarre behavior as mental illness even when a prior diagnosis existed.
- Personnel doing things for which they are not trained.

The 8th Amendment applies only to convicted prisoners and is not applicable to the pretrial detainees who constitute the majority of residents of local jails. However, courts have consistently held that convicted inmates, if anything, are less deserving of rights and privileges than other institutionalized persons (e.g., pretrial detainees and civilly committed psychiatric patients) who are presumed to be innocent. These courts follow the logic of *Bell v. Wolfish* (1979), which guarantees the same rights to pretrial detainees under the 14th Amendment that are afforded to convicted felons under the 8th.

Nonconstitutional Claims

It is likely that the Americans with Disabilities Act (ADA, 1990) will become the subject of correctional mental health litigation. The ADA, which prohibits discrimination against persons with disabilities, also entitles them to "reasonable accommodations" for those disabilities. An individual can be identified as disabled in three ways: (1) The individual has a physical or mental impairment that substantially limits one or more major life activities; (2) the individual has a record of such impairment; or (3) the individual is perceived or regarded as having such impairment.

Jails and prisons are public entities subject to the ADA because they are agencies or instrumentalities of state or local governments (Stone, 1997). Therefore, inmates cannot be denied participation in any program, service, or activity based solely on the fact that they have a disability, and accommodations for inmates with disabilities must be made by the correctional agency and/or its contractors (Morton & Anderson, 1996). After finding that the California Department of Corrections was violating the ADA and the Rehabilitation Act, the 9th Circuit Court of Appeals issued an injunction to improve access to prison programs for prisoners with physical disabilities at all of California's prisons and parole facilities (*Armstrong v. Wilson*, 1997; *Clark v. California*, 1997). To comply with the ADA, policies and practices must be modified to ensure equal access and to ensure that inmates, including those who are mentally disordered, have access to treatment and rehabilitation programs.

Segregated inmates present a particular concern, given that segregation inherently results in lack of access to a variety of programs. Moreover, given the scarcity of resources in many correctional settings, programs are often reserved for those inmates who are thought to be most likely to benefit (Stone, 1997). Administrators and program officials must take care that this practice does not result in the categorical exclusion of inmates with mental disorders. The U.S. Supreme Court held in a unanimous opinion that the ADA applies to state prisoners (*Pennsylvania Dept. of Corrections v. Yeskey*, 1998).[1]

Prisoners' litigation is not, of course, limited to constitutional or federal statutory claims. Like anyone else, a prisoner might file suit under available laws related to intentional or negligent torts. However, most states have low statutory limits on the amount that one can recover from the state. Further, inmates may be

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[1] See also *United States v. Georgia*, 2006 WL 19573, ____ U.S. ____ (January 10, 2006).

suit with a hostile reception from state court juries, where the stigma of incarceration—even against those pretrial detainees who are supposed to be presumed innocent as a matter of law—is strongest. It must also be remembered that tort plaintiffs are often represented by attorneys who have accepted cases based on contingency fees. When the defendant is the state and the plaintiff is an inmate, attorneys may be reticent to accept such fee arrangements. Because many inmates are indigent and cannot hire attorneys, such claims are often presented with the inmate acting *pro se*. For this reason, it is rare to see large, successful inmate claims for simple malpractice, or even serious torts such as wrongful death claims. On the other hand, when there is a colorable claim of deliberate indifference, suits may be filed under section 1983 of the Civil Rights Act (1983), which allows a prevailing plaintiff's attorney, even one who is ostensibly acting *pro bono*, a full recovery of fees billed on an hourly basis. (For an excellent and thorough discussion of the rights of inmates with mental disorders, see E. Cohen's, 1998, *The Mentally Disordered Inmate and the Law*.)

The Costs of Failure

There was a time when states chose to ignore their constitutional obligations to provide mental health care to prisoners, or because of inadequate resources, correctional administrators were forced to choose between mental health treatment and institutional safety. Because institutional civil rights actions were rare, some states chose to wait for litigation and take their chances in court. This shortsighted approach had a number of significant negative consequences. First, losing or settling a systemwide class action, in addition to the actual costs of care, carries with it the impressive costs of monitoring the remedy, whether by a court expert, monitor, special master, or federal receiver. Systemwide litigation also creates a negative public image that can affect the system's ability to garner legislative appropriations, to recruit qualified staff, and to collaborate with universities and medical schools. Even other state agencies, such as those addressing mental health, mental retardation, education, and vocational rehabilitation, may not wish to be associated with the negative publicity that comes with losing a lawsuit. Morale can also be severely compromised when plaintiffs' counsel and court monitors become frequent and judgmental visitors to a prison.

Finally, undertreated or untreated mental illness can endanger the lives of the disordered inmates themselves, other inmates, and the staff who work with them. Mental illness per se may contribute relatively little to the risk of violence in the community (see, e.g., Monahan et al., 2001), but leaving symptoms untreated in a closed, crowded, and hostile environment such as a jail or prison is a quite different situation. A person in the community who is experiencing acute mania but lives alone might not bother his or her neighbors. In prisons, where that same person prevents dozens of inmates with violent histories from sleeping, the likelihood of violence can escalate dramatically. Even when they are not the targets of such violence, staff are put in danger when forced to intervene.

Lawsuits alleging inadequate mental health care are often directed at wardens and other correctional administrators; ironically, however, correctional professionals are often among the most enthusiastic advocates of improved mental health care

for their inmates. They express frustration over the fact that they are forced to provide mental health care under circumstances that are less than therapeutic, in many cases without the assistance of the local mental health authority, for example, a community mental health center. When forced to choose between hiring correctional officers to keep institutions safe and hiring additional mental health staff, correctional administrators make the reasonable decision that without safety, adequate care is impossible. In our view, administrators should not be forced to make such decisions. Security and treatment programs are both essential and constitutional components of any correctional system.

Documentation, Liability, and Risk Management

Documentation is essential in providing mental health care in any setting, including corrections. In underserved settings, clinicians may complain that they are too busy providing care to document it. Some see documentation as an exercise in liability prevention designed only to protect the system from litigation and contributing nothing to the inmates' care. In our opinion, correctional systems frequently require that care be provided by a variety of different mental health practitioners. This requirement makes continuity of care a significantly more difficult challenge. Although treatment plans do not necessarily have to resemble those found in psychiatric hospitals, they are essential to coordinating the efforts of various treatment providers. Equally important, legible progress notes convey important information about each inmate's clinical condition and treatment received, which promotes continuity between providers, between shifts, and between institutions. Documentation also plays an important role in preventing unnecessary liability and in protecting the professional licenses and reputations of the mental health providers who serve in correctional settings. Several years may have passed before lawsuits come to trial, and relying on one's memory about the treatment received by a particular patient is ill advised. Documentation can demonstrate that reasonable professional judgment was exercised.

It is important not only to document the decision that was made, but also to briefly document options that were not chosen. For example, in assessing whether or not to place an inmate on suicide watch, a clinician might write the following:

> Despite her earlier threat of suicide, after reviewing her mental health records, consulting with a counselor and several correctional officers, and based on Ms. Jones's improved mood, future orientation, and excitement over a planned visit by her parents, it was my professional judgment that he did not require placement on suicide watch. I approved the inmate for return to the general population and scheduled a follow-up visit in 3 days.
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> —Michael Jordan, PhD, Licensed Psychologist

This note conveys three important components of professional judgment. The clinician clearly states his credentials to make the judgment, he has clearly considered the possibility of a suicide watch, gathered data from several sources, including direct observation of the inmate, and rendered a reasonable opinion; and he has also taken steps to implement the decision. It is important to understand that, as a matter of law, the opinion does not have to be correct to be constitutionally adequate. *Youngberg* (1982) stands for the proposition that clinicians, when exercising

competently and in good faith, have a "right to be wrong." Assuming that clinicians ask the correct questions, consider reasonable alternatives, seek relevant information, render an opinion or judgment, and implement that judgment, even in the face of a negative outcome there is likely to be no finding of constitutional liability. In the absence of adequate documentation, however, there is no way to demonstrate the quality of the clinician's decision-making process, leaving the system and the clinician vulnerable to retrospective criticism.

There is one other important benefit to adequate documentation. Systems of care require organized and routine quality management. Because it is not possible to directly observe all or even most of the care that is delivered, quality improvement teams and managers must rely on assessment of documentation to ensure that care is delivered with adequate quantity, quality, timeliness, appropriateness, and competence. Among the many uses of such quality management data, requests for budget increases are far more likely to be granted when accompanied by reliable data that demonstrate efficient management of the resources that are already in place. The American Psychiatric Association (2000) and the National Commission on Correctional Health Care (2003) have produced the most widely referenced guidelines and standards for correctional health care. Each presents straightforward and user-friendly guidelines, detailing the essential features of mental health care in corrections. The guidelines include definitions of credentials necessary to perform each component of care. These sources can be of particular utility in terms of outlining the mechanism of service delivery and for maximizing the efficient movement of inmates through a given system and toward the level of service best suited to address their needs.

Investigation, Mortality Review, and Psychological Autopsy

Sadly, management of quality in providing mental health care also requires reliable and timely investigation of tragedies. Once again, liability prevention is only one of many reasons for this task, and it is clearly not the most important reason. In the event of a death that is related to mental illness, such as suicide, the most important consideration is to identify any conditions or circumstances that created or increased the risk that the death would occur. This allows the institution to quickly revise practices and to minimize the possibility of a similar occurrence.

Mortality reviews and psychological autopsies are organized efforts to examine all of the known facts that preceded a death, leading to recommendations that will reduce the risk of any further deaths from the same causes. Adequate investigation of a suicide might include mental health providers, chaplains, physicians, nurses, correctional officers, teachers, and anyone else with knowledge about the precursors of the death and/or authority to make changes in policies and practices.

These investigations and incident reviews should result in clear, unambiguous recommendations aimed at reducing risk. They must be documented so that correctional managers can verify whether or not they have been implemented successfully. A failure to document recommendations in order to reduce the likelihood of a successful lawsuit is unacceptable and may suggest that an institution is more interested in protecting itself than the inmates for whom it is responsible.

What does it all mean for correctional psychologists? The rules of engagement for correctional mental health in the United States have become relatively clear,

and protecting oneself from liability has become a straightforward proposition. To that end, we offer the following suggestions:

- Make sure that a system is in place that screens each newly arriving inmate or detainee for the risk of suicide and for the likelihood that he or she will be in need of treatment for serious mental illness or psychiatric crisis.
- Make certain that every inmate who is screened positive receives at least a brief follow-up evaluation by a qualified mental health professional.
- Make sure that each inmate or detainee with a serious mental illness receives at least a simple but useful, individualized treatment plan.
- Any treatment plan should reflect reasonable professional judgment, and its recommendations should be implemented.
- Make certain that the institution has a sensible and comprehensive suicide prevention plan, which includes screening, referral, policies, and procedures. The plan should also include cross training between correctional and mental health staff aimed at identifying the signs and symptoms of depression and suicidality, as well as the policies, procedures, and post orders related to suicide prevention once an inmate is identified as being at risk.
- Make sure that all of the preceding are clearly and legibly documented.

THE ROLES OF PSYCHOLOGISTS IN CORRECTIONAL MENTAL HEALTH

Historically, the practice of correctional psychology was limited to the treatment and management of mentally ill inmates, with an emphasis on containing potentially disruptive behavior in the institution. This narrow view of the role of a correctional psychologist was both unfortunate and inadequate. In fact, there are several mechanisms by which mental health professionals, like correctional staff, can make important and cost-effective contributions (Spiers, Dvoskin, & Pitt, 2003). Assessment and treatment will always be a fundamental part of correctional mental health care, but to be effective and valued, psychologists in corrections must expand the scope of their practice to include a variety of therapeutic, managerial, and consultative interventions (Spiers et al., 2003).

Treatment of Serious Mental Illness

As previously asserted, the U.S. Constitution requires treatment of serious mental health needs of inmates of correctional institutions. Because of this clear mandate, and because an active plaintiff bar has increasingly sought to vindicate this right in correctional systems across the country, the lion's share of mental health resources has gone to meet this need. Unfortunately, one relatively inexpensive way to treat mental illness, at least in the short run, is with psychotropic medication. Just as in the community, the need to provide care at the lowest possible cost has led to a heavy reliance on medication alone as the predominant treatment modality. As is also the case in the community, this focus on medication has often meant that nurses and psychiatrists are viewed as the most essential members of the treatment team.

However, in the community, there has been a dramatic change in the way organized systems of care are learning to treat the most serious mental illnesses. Medication alone is increasingly viewed as inadequate for most patients. Serious mental illness impairs lives in three important ways: (1) the creation of unwanted psychological experiences and behaviors that interfere with the person's functioning (i.e., symptoms), (2) deficits in essential life skills, and (3) social disconnectedness. Generally, medication alone helps with only the first group of problems, and it is not always the treatment of choice even for them. For example, many knowledgeable consumers may choose to engage in cognitive-behavioral psychotherapy for depression or anxiety disorders instead of or in addition to medication. Moreover, many consumers may reject psychotropic medication for psychotic illnesses because they find the side effects intolerable. More important, psychiatric rehabilitation has offered consumers a successful and user-friendly pathway to a more successful life (Anthony, 1982; Anthony, Cohen, & Kennard, 1990; M. Cohen, 1989; M. Cohen & Anthony, 1988). To the extent that psychoeducational and cognitive-behavioral approaches to the treatment of serious mental illness become the standard of care in the free world, they will also become expected treatments for clients in prison. When they do, psychologists will have an opportunity to once again provide leadership in the correctional environment and to create additional jobs for psychologists.

Initial Assessments: Reception and Initial Classification

Especially in prisons, at the front door of the system, psychologists have traditionally been involved in assessment and initial classification. This may have included psychological testing, interviews, and consultation with reception center staff. In many systems, a battery of psychological tests is administered to each newly admitted inmate; however, it is often unclear to what extent these batteries affect the course of the person's incarceration. Especially in light of the staff time devoted to such assessments, and the fact that constitutionally mandated treatment for serious mental illnesses may be inadequate, it is important to limit these batteries to questions or to individuals for whom the data will matter. For example, if the inmate's initial security classification status is based exclusively or primarily on the person's crime or sentence, psychological testing may not have a great deal of utility toward that decision. To take another example, if the decision to refer inmates for psychological assessment is based on prior history of mental illness and a previously administered screening instrument, then it is difficult to understand the logic behind a full battery of psychological testing of *all* inmates. On the other hand, if the test results are relevant, valid, reliable, and *utilized*, psychological testing at the prison's front door may represent sound policy. For example, if prisons take program assignments seriously, they may rely heavily on intelligence and achievement testing in deciding whether an inmate will be steered toward academic (e.g., General Education Diploma or college courses) or vocational programming.

Intake Screening

Because of the well-documented problem of correctional suicide, especially in jails, no correctional institution should fail to provide intake screening for each newly admitted inmate or detainee. Thanks to recent advances, screening that was once

aimed solely at suicide prevention now is equally effective in identifying those inmates who are likely to require psychological or psychiatric services during their incarceration (Steadman, Scott, Osher, Agnese, & Clark Robbins, 2005). In a well-run jail screening system, approximately 25% to 30% of inmates and detainees will screen positive at the front door, and about half of those will require and accept mental health services. These numbers do not include those detainees whose sole or predominant psychological problem is drug abuse or addiction (Peters, Matthews, & Dvoskin, 2003), nor do they include those inmates without serious mental illness but whose habits, personalities, and behaviors suggest the need for help, such as anger management or assertiveness training.

Intelligence tests and personality inventories such as the Minnesota Multiphasic Personality Inventory (MMPI and MMPI-2) have long been used by many state correctional institutions as part of an initial test battery at the time of intake (Gallagher, Simmons, & Ben-Porath, 1999; Megargee, 1994; Megargee, Mercer, & Carbonell, 1999). Generally, these tests are used to assist in assigning inmates to security levels and to educational, vocational, and work programs. They also alert prison systems to special needs or concerns relative to each inmate, including the need for mental health treatment. The psychometric portion of initial classification is typically performed by and/or under the supervision of psychologists. However, the continuation and utility of this practice depends on two factors. First, the test results must matter. That is, the assignments that inmates receive must differ as test results differ, or the tests themselves will be viewed as an expensive waste of resources. Second, academic psychologists must continue to work with their prison counterparts to develop new instruments that keep pace with the ever-changing nature of criminals. This will require attention to reliability and validity of psychometric instruments, which must in turn be normed and concerned as prison populations change.

Assessment of Positive Screens

Inmates and detainees who screen positive are not necessarily mentally ill or in need of services. However, because they have been identified as being at risk, the institution has a responsibility to provide a brief hands-on assessment by a mental health professional. In many cases, this duty will be performed or supervised by a psychiatrist. This is not intended to be a comprehensive psychological evaluation; its sole purpose is to decide whether or not the person is to be referred for mental health services or managed in some specific way, such as being placed on a suicide watch.

Assignment to Service

As a result of these assessments, inmates and detainees will either be cleared for the general population or referred for appropriate services or special management. For those inmates with a history or current evidence of serious mental illness, including those who claim to be on psychotropic medication at the time of their arrest, this will likely result in a referral to a psychiatrist or psychiatric nurse practitioner, who will complete the assessment and draw up an initial treatment plan. All other inmates who appear to be in potential need of services or suicide

needs will likely be evaluated by a mental health professional. This service is often provided or supervised by a psychologist.

Referral Mechanisms

Assignment to service through intake and/or screening is the most obvious mechanism of referral for mental health care. However, screens, by definition, have gaps that may result in some inmates remaining unidentified at the initial screening stage. Other inmates will conceal their psychological problems or treatment histories, and still others will develop mental illnesses or emotional crises only after they have been admitted to the facility. For this reason, in addition to screening, it is necessary to have a well-publicized, timely, responsive, and competent system for referral of inmates who want or appear to need services.

Referrals should be able to originate from a wide variety of sources, including inmates themselves, other inmates, correctional and program staff, volunteers, family, and friends. Although written referrals are always preferred, verbal referrals can signal equally important or emergent situations and must receive a timely response, preferably with subsequent documentation. Regardless of the referral mechanism, mental health professionals working in a correctional setting must ensure that all members of the institutional community feel safe and comfortable conveying information to them. At times, the concerns expressed will be inconsequential. However, the potential for heading off a crisis through simple communication is profound.

Suicide Prevention and Crisis Services

Inmates and detainees who appear to be suffering acute exacerbations of serious mental illness or who are in emotional or psychological crisis, whether identified via screening or subsequent referral, must be evaluated by a mental health professional as soon as possible. Once such an emergency referral has been made, the facility should take reasonable steps to keep the person safe.

Often, the evaluation and the response to the crisis are identical. By providing the inmate with reliable information about what he or she can expect, arranging for emergency medication, or moving the inmate to a physically or psychologically safer housing area, it is often possible to reduce fear, anxiety, and anger. These "outpatient" interventions may successfully resolve the crisis so that the inmate can remain in general population housing. Like any closed community, inmates often rely on rumors for a great deal of their information. In many cases, the simple provision of accurate information can avert a potential crisis. In other cases, especially exacerbation of serious mental illness, the crisis is not so easily resolved, and it may be necessary to house the person in special mental health housing for some period of time. Often, the crisis involves serious suicidal ideation and intent, and the person must be watched closely. These crisis settings are typically intended to be short term, only for the period of time deemed clinically necessary.

There is no more pressing duty for a correctional administrator than to keep inmates and staff alive and safe. Because of the well-known dangers of inmate suicide, especially in jails, suicide prevention is of the utmost importance. A complete discussion of correctional suicide prevention is beyond the scope of this chapter, but

some basic principles are the subject of wide agreement among correctional mental health experts.

First, suicide is the leading cause of death in U.S. jails. The risk of suicide in prisons is considerably lower than in jail but remains elevated significantly above the base rate in the community. As a result, every correctional institution should have a reasonable and comprehensive suicide prevention plan that includes the components found in this section (Hayes, 1995).

Second, every newly admitted inmate should receive a brief screening designed to identify those who are at heightened risk of suicide or likely to require mental health interventions in the near future. There are a number of different screening instruments that have been used, and none has yet clearly emerged as the standard of care. However, there is widespread agreement as to many of the items that should be addressed at the front door. There is virtually unanimous agreement that one or two broad, vague questions about "psychiatric problems" or "suicidality" will not suffice (see, e.g., Bersaly, Cox, & Morschauser, 1997; Nicholls, Roesch, Olley, Ogloff, & Hemphill, 2005; Steadman et al., 2005). These screening instruments should be simple, and the people who administer them (usually nurses or correctional or detention officers) must be trained in how to do so. The results must be documented in clear, legible, and straightforward language, and every positive screen must be referred to a mental health professional for (at least) a brief follow-up assessment.

There are no firm rules about how many people should screen positive, but in jails, our experience suggests that an effective screen will result in about 25% to 33% of inmates screening positive, of which about half will be referred for treatment, special management, or both. (Note that some will competently decline services.) In other words, the screen is designed to have many false positives and relatively few false-negative findings.

Third, it is impossible to completely eliminate false-negative results; that is, some inmates with serious psychological needs will falsely report no need for mental health services and no suicidal intent and deny any history of mental illness. For this reason, the referral system described earlier is a crucial and essential element of every correctional suicide prevention program.

Fourth, for those inmates who screen positive on the basis of suicide-related issues, and who are deemed to pose a high risk of suicide upon follow-up evaluation by a mental health professional, the plan must include efficient procedures for making it as difficult as possible for the inmate or detainee to take his or her life until the assessed risk has abated. This includes special management procedures such as various levels of suicide watch. Currently, the most common type of suicide watch in U.S. jails requires personal observation of the inmate at least once every 15 minutes. However, in our opinion, 15-minute watches may not be adequate to protect those inmates at the highest risk of suicide. We recommend that watches presumptively occur at least once every five minutes; however, the suicide watch procedure for a particular inmate should be individually determined by a clinician. In some cases, the risk will be so great that the situation requires constant observation of the inmate for a period of time. We also recommend reconsideration of the usual assumption that every suicidal inmate must be housed alone. For some in-

mates, segregated housing can increase the feelings of depression that led to the suicidal ideation in the first place. In New York's prison mental health system, unless they are deemed to be a danger to others, suicidal inmates are housed in a 6 to 12 bed dormitory, where they can be effectively and cost-efficiently observed by one officer.

Managerial, Administrative, and Educational Roles

Until the 1970s, there was only one career path that led to the running of a prison. One started as a correctional officer and eventually sought promotion to sergeant, lieutenant, and so on, one day rising to the level of warden. Many of these wardens continued their education during their careers, achieving college or advanced degrees, although degrees were not a requirement for the position. Jails, though commonly run in many jurisdictions by elected sheriffs, had similar career paths for the leadership positions within the jail itself. The 1970s and 1980s saw a distinct change in this practice, as many systems began to require advanced degrees as a prerequisite for managerial positions within corrections. This professionalization of the field was seen as a way of responding to highly publicized disturbances and riots, which were, in part, thought to have resulted from abuses of power by prison administrators. Early on, this change was a double-edged sword, as highly educated wardens often lacked the experience in corrections that is vital to credibility and good leadership. Over time, however, the two career paths converged, so that today's wardens often have an adult lifetime of experience in corrections and an advanced education that preceded and/or continued during their correctional service.

This preference for leaders with advanced degrees provided another opportunity for psychologists. Increasingly, psychologists became assistant wardens, wardens, and even commissioners and directors of departments of corrections. This new career ladder was especially visible in the federal Bureau of Prisons (BOP). Kathleen Hawk, who began her career as a prison psychologist, became first a warden and ultimately director of the federal BOP, perhaps the most visible leader in U.S. corrections).

In addition to serving as correctional administrators at the highest levels, in their formal role as correctional psychologists, psychologists were often asked to serve on various administrative committees, such as classification and disciplinary boards that are part of the prison's administrative structure. Psychologists can and should play an active role in the totality of the correctional community. Areas including, but not limited to, case management, unit teams, program development and evaluation, and staff screening and selection are all appropriate and important venues for the application of psychological principles (Spiers et al., 2003).

Administratively Oriented Psychological Evaluations

From time to time, jail and prison psychologists are asked to serve as members of administrative boards within the institution, such as classification and disciplinary committees. In addition to membership on these committees, psychologists may be asked to provide consultation and, on occasion, psychological evaluations for them. To such boards, informal consultation can be invaluable. A psychologist or other mental

health professional might offer suggestions as to the kind of setting or ordinance that would better suit an inmate, and steps that correctional staff can take to supervise inmates more effectively. Carefully considering whether a given inmate will be capable of negotiating the demands of a given institution, and how to best intervene, can go a long way toward preventing difficulty down the line (Spiers et al., 2003).

Less clear is the value of formal psychological evaluations, especially for disciplinary boards or committees. Certainly, it seems both fair and sensible that inmates should not be punished for behaviors that are symptomatic of severe mental illness. Dvoskin, Petrila, and Stork Riemer (1995) have argued that formal, quasi-forensic evaluations have a number of downsides and should not be required, a position taken by at least one court (*Powell v. Coughlin*, 1991). Formal evaluations take valuable time away from treatment duties and provide an incentive for inmates to feign mental illness for the purposes of avoiding the consequences of their violations. Formal evaluations also place the prison psychologist squarely and publicly in the crossfire between inmates and staff, whose interests in such hearings may directly conflict. Instead, Dvoskin and his colleagues recommend informal consultation between disciplinary boards and mental health professionals to allow mental illness to be taken into consideration before these committees make decisions about guilt and punishment over allegations of prison rule violations.

In many jurisdictions, psychologists have also served as forensic evaluators for various outside agencies. For many years, parole boards would routinely seek psychological evaluations of prospective parolees, in spite of the fact that there was virtually no evidence at the time of an ability on the part of mental health professionals to predict future crimes. In jails, similar evaluations have been requested by probation agencies, pretrial services, and others.

Sex offender commitment laws have created an additional need for psychological evaluations (*Kansas v. Crane*, 2002; *Kansas v. Hendricks*, 1997). Because the U.S. Supreme Court in *Hendricks* decided to treat these commitments as analogous to civil commitment of persons with serious mental illness, mental health professionals have been drawn into service providing the courts with evaluations, especially in regard to a potential committee's "mental condition."

Consultation, Communication, and Training

Traditionally, consultation between mental health and security staff was predominantly related to the management of inmates and detainees (C. M. Brodsky & Sparacio, 1982). Open lines of communication across disciplines are critical for any system to be successful (Dvoskin & Spiers, 2004). Mutual distrust between mental health and correctional professions has been cited as one of the most significant barriers to effective offender care (Rookey & Feldman, 1999). At first glance, the competing demands of security and mental health appear to be polarized and to foster an undercurrent of competition. In fact, the goals of custody and treatment staff are, and should be, remarkably similar: (a) ensure safety, (b) prevent escape, (c) minimize human suffering (in and out of prison), (d) maximize morale, and (e) help to maintain systemic operations (Dvoskin & Spiers, 2004).

Correctional personnel who learn to trust and respect their mental health staff are far more likely to value their advice and respond accordingly. However, for this to be accomplished, mental health professionals in corrections must take steps to

earn the trust of security staff. In assessing an inmate or a system, mental health staff would be well served to solicit the wisdom of seasoned correctional personnel (Dvoskin, Spiers, & Pitt, 2002). All too often, however, there has been little reason for line staff to believe that their opinions or observations were welcomed and valued. In our experience, far too many mental health professionals discount correctional officers as lacking in expertise and, as a result, treat their inmate patients without critical data from line staff (Dvoskin & Spiers, 2004).

Mentally ill offenders present a unique set of concerns in the correctional setting, and management difficulties may arise when training of correctional staff regarding mental health issues is absent or insufficient (Veysey, Steadman, Morrissey, & Johnson, 1997). Whereas clinicians spend only a brief amount of time with inmates, correctional officers essentially live with the inmates at work, at recreation, and in their housing units. As a result, typically the first person to notice a change in an inmate's routine or mental status is a correctional officer (Appelbaum, Hickey, & Packer, 2001). If the wealth of information held by correctional staff is to be shared with mental health staff, mental health staff must first demonstrate that they are open and interested. However, correctional staff must also be armed with the fundamental information necessary to first recognize mental health problems and then convey their observations. Research indicates that many correctional officers are highly motivated to obtain additional training related to mentally ill offenders (Kropp, Cox, Roesch, & Eaves, 1989). Correctional mental health staff should be proactive participants in the training of new staff and providing in-services for veteran staff. Recognizing the signs and symptoms of mental illness, suicide risk, and intervention/referral are obviously some of the most critical content areas in which security personnel must be trained. Mental health professionals can also be helpful in developing curricula in diverse training areas, such as communications, interpersonal skills, conflict resolution, crisis/hostage negotiation, hostage survival skills, sexual assault prevention, and intervention (Hanowski, 2003). In addition to the obvious benefit of teaching critical information, training programs increase service delivery across disciplines and allow a forum for mental health professionals to demonstrate sensitivity to security concerns (Dvoskin & Spiers, 2004).

CORRECTIONAL MENTAL HEALTH PROGRAMS

Mental health care in the community is offered in varying degrees of intensity, depending on the acuity and individual needs of the client. To cost effectively provide all of the services required, but only the services required, correctional mental health programs must also offer a variety of services analogous to those available in the community.

Clinic Services

Even the most mentally healthy inmates may find themselves in need of psychological services from time to time. Often, brief therapeutic contact will be sufficient to address the situational stressors encountered in the correctional setting. This level of service can be readily accomplished by case managers or social workers, who can provide support, information, and assistance managing the daily demands of

incarceration. Often, the type of therapy most helpful to inmates is provided by staff who lack formal training but have an ability to listen to others and to treat them with dignity and respect (Dvoskin, Spiers, Metzner, & Pitt, 2002). For cases in which a more sophisticated level of intervention is necessary, correctional psychologists may engage in a (relatively) long-term treatment relationship with an inmate. Individual therapy will likely mirror free-world treatment, with the caveat that correctional psychologists are mindful of the impact of context on the presenting complaints and selection of intervention strategy.

Group therapy is clearly the most cost-effective treatment modality in corrections (Metzner, Cohen, Grossman, & Wettstein, 1998), as it allows provision of services to a large number of inmates even when resources are limited. Groups can be run by an individual or can be cofacilitated by mental health staff with various credentials. Creative thinking and thoughtful consideration when matching staff expertise with group subject matter can be of great benefit (Dvoskin, Spiers, Metzner, et al., 2002). For example, it may be helpful to include a psychiatric nurse as a facilitator of medication education or life skills groups, whereas a social worker or case manager may be the ideal collaborator for groups focused on discharge planning or managing institutional life, respectively. Group therapy can be particularly effective when the topics are focused, practical, and applied (e.g., stress management, anger management).

Of course, there are potential pitfalls in group therapy that must be addressed. Confidentiality is always a challenge in the group setting. As in the free world, group members must be cautioned from the outset about maintaining the confidentiality of therapeutic communications yet warned that confidentiality cannot be guaranteed. In a correctional setting, security issues and the potential for violence must also be carefully considered.

Residential Treatment

Inmates with serious mental illnesses, and those who are psychologically fragile, often have difficulty coping with the stressful environment of the general inmate population. Fears of bullying, physical and sexual assault, and extortion, both real and imagined, can have a profound and negative effect on psychological well-being, especially of inexperienced prisoners. As such, jails and prisons should also have the ability to place psychologically fragile or mentally ill inmates in residential treatment settings (see, e.g., Cundiff, Dvoskin, & Holmbeck, 1994). These units should maximize the amount of time that the inmate is allowed out of cell, depending of course on the security routines of the institution. Programming is intended to create a reasonably therapeutic environment, which is a constant challenge in a correctional environment. Treatment modalities might include groups or individual supportive counseling.

Typically, there are three different types of inmates housed in such residential treatment units. Some are "halfway in," inmates who require a housing change designed to remove the need for transfer to a crisis bed or inpatient hospital. A second group is those who are "halfway out" of a more intensive placement (i.e., crisis or inpatient bed) and who require a transition period prior to returning to the general population. Finally, some inmates will never be able to survive the stress of the general population, though it is not possible to know this in advance. Typically, in most

mental treatment, efforts are made to teach inmates the skills and resilience needed to successfully live in the general population, even if, in some cases, those efforts never succeed.

Discharge Planning and Provision

Historically, jails and prisons have viewed their responsibilities for inmate health care as beginning and ending at the jailhouse door. *DeShaney v. Winnebago County* (1989) held that the obligation of government actors was based on the taking of custody of the person. Thus, it was reasoned, inmates' release from confinement ended any governmental responsibility for care. However, because systemic malpractice can be grounds for a finding of deliberate indifference (*Estelle v. Gamble*, 1976), it can be argued that abandoning patients, even in the face of known serious dangers in their lives, may have constitutional implications. In *Wakefield v. Thompson* (1998), the court held

> It is a matter of common sense, however, that a prisoner's ability to secure medication "on his own behalf" is not necessarily restored the minute he walks through the prison gates and into the civilian world. Although many patients must take their medication one or more times a day, it may take a number of days, or possibly even weeks, for a recently released prisoner to find a doctor, schedule an examination, obtain a diagnosis, and have a prescription filled (footnote omitted). Accordingly, the period of time during which prisoners are unable to secure medication "on their own behalf" may extend beyond the period of actual incarceration. Under the reasoning of *Estelle* and *DeShaney*, the state's responsibility to provide a temporary supply of medication to prisoners in such cases extends beyond that period as well.
>
> We therefore hold that the state must provide an outgoing prisoner who is receiving and continues to require medication with a supply sufficient to ensure that he has that medication available during the period of time reasonably necessary to permit him to consult a doctor and obtain a new supply. A state's failure to provide medication sufficient to cover this transitional period amounts to an abdication of its responsibility to provide medical care to those who by reason of incarceration are unable to provide for their own medical needs.

Linking recently released inmates or detainees with services in the community should not require a legal mandate; basic professional ethics and human compassion should suffice. Mental health systems have long been aware of the critical need for continuity of care and wraparound service provision. Social support, both prior to and after release from prison, has been consistently, significantly, and positively associated with a wide range of quality of life outcomes (Jacoby & Kozio-Peak, 2007). Case management is perhaps the most important, and unfortunately underutilized, solutions to the problem of ongoing service delivery and support. Shumaker, Ismail, Jacoby, and Huang (1998) found a significant association between quality of postincarceratory case management and a reduction in recidivism. Although findings related to recidivism may be mixed, there is no question about the impact of continued care on quality of life.

SPECIAL PROBLEMS AND ROLES FOR PSYCHOLOGISTS

Providing mental health care in a correctional setting is a daunting task in and of itself, but this challenge can be compounded when working with special populations.

Providing quality care to all inmates is, or should be, the aim of anyone working in a correctional setting.

Women

The prevalence of serious mental illness among female detainees is approximately twice that of males (Teplin, 1994). Interestingly, however, this is not true of disorders such as manic-depressive illness and Schizophrenia, which are increasingly thought of as having genetic or biological etiology. Rather, the entire difference appears attributable to depression, anxiety, and trauma spectrum disorders (Teplin, 1994; Teplin, Abram, & McClelland, 1996).

The effects of trauma can be especially hard on female inmates. For whom the circumstances of their confinement can resurrect images of their maltreatment as children. Even when correctional staff are appropriately and professionally performing their duties, routines such as being controlled by men (i.e., male correctional officers) or physically restrained or segregated can cause relapses of serious trauma spectrum disorders such as Posttraumatic Stress Disorder (PTSD). As Vejvoy (1998) described, the majority of female inmates suffer from problems including, but not limited to, substance abuse/dependence, physical distress, history of childhood and/or adult physical or sexual abuse, and self-esteem issues; they may also have vocational/educational needs and needs associated with pregnancy and/or primary responsibility for minor children. Psychologists can provide valuable aid to such women. Perhaps most important, psychological treatments such as dialectical behavior therapy can help women inmates control and manage their affect, thereby increasing the degree of control they can exert over their circumstances. For example, by learning to avoid losing one's temper, the likelihood of physical restraint by staff can drop dramatically.

Ethnic and Cultural Minorities

For ethnic minorities and non-English-speaking inmates, jails and prisons can be even more frightening. Anxiety stemming from absent or inaccurate information is one of the most easily rectified and often overlooked origins of crisis in a correctional setting. An inmate is further disadvantaged when he or she is forced to confront the complexities of prison life without a command of the language and/or customs of the majority. Toch, Adams, and Grassa (1987) found a number of ethnic differences in prison infractions and concluded that psychological and educational predispositions may converge to create prison adjustment problems.

Cultural diversity is a significant factor in mental health care, both in custody and in the free world. For example, Blacks and Hispanics have historically been underserved by the mental health system, in and out of prison (Steadman, Holohean, & Dvoskin, 1991). This phenomenon may be secondary to an unwillingness to seek help from predominantly White providers, but may also reflect subtle and/or unintentional racism among these same providers (Dvoskin, Spiers, Metzner, et al., 2002). In the free world, an individual may have the opportunity to exercise some autonomy in terms of selecting his or her care provider(s). In a correctional setting, this is rarely the case. While correctional mental health administrators should

make every effort to recruit a diverse professional staff. It is also imperative that all mental health professionals recognize the potential challenges inherent in working with multicultural inmates. Clearly, no psychologist can aspire to be proficient in treating individuals from every possible background and culture; still, it is incumbent upon those working in a correctional setting to make, at a minimum, a concerted effort to approach each case with an appreciation of cultural context (see, e.g., *Guidelines for Multicultural Education, Training, Research, Practice, and Organizational Change for Psychologists*, American Psychological Association, 2002).

Combat Veterans

Some U.S. combat veterans have reported significant difficulties returning to life at home. There is a great deal of controversy about the percentage of Vietnam veterans who ended up in U.S. prisons. However, whether the number is small or large, at least some combat veterans in prisons and jails suffer from PTSD, in some cases in addition to other serious mental disorders or addictions. Treatment that does not address the symptoms of traumatic stress is likely to fail, and psychologists, especially at Veterans Administration facilities, have provided some of the best research on PTSD and its treatment (Keane & Kaloupek, 1998). As these treatments find their way into prison settings, psychologists have an opportunity to provide a valuable service to the correctional system and its prisoners.

"Manipulative" Inmates

It is common to hear inmates referred to dismissively as "manipulative" or "malingering," as if this insult precludes a finding of mental illness. Such a view is misguided for several reasons. First, how can one be manipulative in a situation in which the people one is allegedly manipulating control virtually all of the circumstances and reinforcers in one's environment? Second, the fact that one exaggerates or feigns symptoms of mental illness does not mean that one does not have other or subtler symptoms of mental illness. If inmates perceive themselves as falling below the threshold of admissibility into treatment yet are suffering, there is an understandable temptation to gild the lily. Third, some of the behaviors that lead to these characterizations, such as self-injurious behavior, existed long before the person was incarcerated.

It is difficult to imagine how a person confined to a 5' by 8' cell, with no property, nothing to do, no television to watch or books to read, could be credibly accused to have selected this circumstance on purpose. There are certainly times when inmates may have viewed a segregated cell as their least negative alternative, for example, when they believe their life to be in danger in the general population. But even in that case, even if there is objectively no credible threat to the inmate, the fear that leads them to such a choice is undoubtedly legitimate. As Dvoskin (1997) wrote, the power to diagnose people can affect their lives for better and for worse. Dismissing an inmate as manipulative or as a management problem should never relieve psychologists of the responsibility to help troubled inmates better adapt to jail or prison and to help correctional officials deal with their most challenging inmates.

The Special Problems of Segregation

Few correctional issues arouse as much controversy as the use of long-term segregation. Proponents argue that the prevalence of illegal and violent gang activity requires strong measures, and that long-term segregation of gang leaders has reduced violence throughout the correctional system. Critics respond that there are long-term negative psychological effects that apply to most or some inmates. Although controlled research is extremely difficult to conduct on this question, it is generally agreed that at least some inmates will demonstrate a psychologically toxic response to long-term segregation, and the most vulnerable inmates in this regard are those with preexisting severe mental disorders.

Advocates argue that the only appropriate response to these circumstances is to ban the use of short- or long-term segregation for any inmate with a mental illness. But this position has some difficult challenges. For example, would mild depression qualify for this exclusion? If so, it is not unreasonable to think that almost any inmate could avoid being housed in segregation by complaining of symptoms for which there is virtually no reliable way to rule out malingering. Even inmates with serious mental illnesses such as Schizophrenia or manic-depressive illness are not necessarily symptomatic at any given time, and some offenses may reflect greed, anger, or sexual desires that have literally nothing to do with the inmate's mental illness. As suggested earlier, formal forensic evaluations in these situations would likely cause more harm than good. Nevertheless, correctional psychologists can be helpful to correctional administrators in resolving this dilemma by providing informal consultation on several questions:

- Is there evidence to suggest that the infraction is largely the result of symptoms of a serious mental illness?
- Is there history or evidence to suggest that the inmate will not be able to safely tolerate segregation due to mental illness?
- If segregation is necessary or appropriate, what mental health services will the inmate require while there?
- Are there alternative sanctions that would provide appropriate consequences for institutional misbehavior without causing an exacerbation of a serious mental illness?

Other Special Needs Groups

Other groups, such as geriatric inmates and those with physical disabilities, present unique challenges for those entrusted with their care. Generally speaking, the offender population is likely to have conducted their lives in a manner less than conducive to good health, thereby lowering the threshold for common illnesses associated with aging (Dvoskin, Spiers, Metzner, et al., 2002). Moreover, inmates are more likely to have histories of poor health care and traumatic injury. With this in mind, it has been suggested that age 50 (as opposed to 65, as in the general population) can be used as a useful criterion for identifying geriatric inmates (American Psychiatric Association, 2006). As the correctional population continues to increase, so, too, will the number of elderly persons behind bars. An elderly

inmate is subjected to all of the routine stressors of aging. However, these stressors are exacerbated by context-specific factors such as physical vulnerability to other inmates, estrangement/isolation, and the prospect of dying in prison (Dvoskin, Spiers, Metzner, et al., 2002).

Regardless of age, inmates enter the criminal justice system with myriad medical and physical disabilities. Even given legally mandated accommodations for disabled inmates, this population can be especially vulnerable in a correctional setting. Mental health providers must approach care bearing in mind that traditional intervention strategies may be ineffective. Here again, the usual stressors of incarceration are compounded. Inmates who are deaf, blind, or physically disabled face, in addition to risk from predatory peers, a greater likelihood of limitations in their ability to engage in traditional coping strategies such as exercise and recreation.

CONCLUSION

The role of psychology in corrections has evolved over many decades, yet psychologists still are often unable to provide valuable services to the people who need them most. The current state of criminal justice and correctional policy in the United States is at a crossroads for psychology. For those inmates with a constitutional right to treatment of serious mental illness, some of the best and most cost-effective treatments are psychological. For society, the wisdom gained from a century of social science about how to help people behave differently has no more appropriate target than those men and women whose behaviors have been so unacceptable that they have been incarcerated. Psychologists have enormous potential value in America's prisons and jails. The criminal justice system needs help to make better decisions about who can return to society and when. Our communities need help so that children can be safer. These activities, in these settings, promise to save the productive lives of prisoners and their otherwise future victims. For psychologists, where most valuable expertise is positive behavior change, there is no more deserving or rewarding area for study and practice.

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