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In This Issue:

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HEY, POLITICIANS!

*John Dewar Gleissner, J.D., Attorney-At-Law, Birmingham, Alabama**
johngleisner@charter.net

Your predecessors got our prison systems in a terrible mess. We stacked up many more prisoners than other nations, and at much greater expense, with disastrous consequences. Paying more for prisons and less for education is a sick trend.

Each prisoner costs us about $50,000 per year, and that cost must be multiplied by 2,300,000. You may have heard that it costs less than this to feed, clothe, house and provide medical care to prisoners, but that lower figure does not include the astronomical lost opportunity costs. Locking up that many people and not providing useful work for them means that the value of their labor is lost, too. On the average, each prisoner is able to make about $25,000 per year if put in a regular job. Add this to the direct outlays $25,000 per year, and the cost equals $50,000 per year. This does not count the increased welfare costs outside prison, the social costs of breaking up families and marriages and allowing children to be raised without parents. Nor does this include decreased productivity caused by felons not being able to find employment. Our nation incarcerates more people than any other nation on earth, and a greater percentage of our population is in prison than any other nation on earth. If prisoners were counted as unemployed in unemployment statistics, official unemployment would be 1/2% higher because of our 2.3 million prison population. As you can see, this is a drag on the entire economy at a time we cannot afford it. Yes, we are in a tremendous predicament.

Let's face it; modern prison does not work very well, at least not for its original purpose of rehabilitation, and it does not deter enough crime. It does keep criminals out of circulation for a while, and that's good, but unfortunately prison releases them in worse condition. Prisons are an expensive way to make bad people worse. Many of us have been trying to get your attention. Please help solve the massive prison crisis we have and create more jobs.

John Gleissner

Every enlightened warden and prison reformer in history believed that prisoners should work at useful labor. Hard labor is better for the prisoner, prison administration, and taxpayers. Many offenders are supposedly sentenced to "hard labor," but now only a minority of prisoners work, few of them in private businesses. Restrictive legislation was passed years ago due to the unfair competition created by prisoners working for nothing. But things have changed. Most consumer goods are now made outside the United States. Prison-made goods from China sneak into the U.S. easily, while we throttle our own prison industries.

Our laws should permit private businesses to manufacture goods now made exclusively in foreign countries. You should repeal or amend the Ashurst-Sumners and Hawes-Cooper Acts, because those federal statutes deprive prison-made goods the status of being made in interstate commerce, making

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INTERNATIONAL ASSOCIATION FOR CORRECTIONAL & FORENSIC PSYCHOLOGY

The IACFP Newsletter **is published every January, April, July, and October, and is mailed to all International Association for Correctional & Forensic Psychology (IACFP) members. Comments and information from individual members concerning activities and related matters of general interest to international correctional mental health professionals and others in international criminal and juvenile justice are solicited. The IACFP endorses equal opportunity practices and accepts for inclusion in *The IACFP Newsletter* only advertisements, announcements, or notices that are not discriminatory on the basis of race, color, sex, age, religion, national origin, or sexual orientation. The IACFP is not responsible for any claims made in a newsletter advertisement. All materials accepted for inclusion in *The IACFP Newsletter* are subject to routine editing prior to publication. Opinions or positions expressed in newsletter articles do not necessarily represent opinions or positions of the IACFP. Please send material for publication or comments to Dr. Robert R. Smith: smithr@marshall.edu. Deadlines for submission of all material are:**

January issue—
September 1
April issue—
December 1
July issue—
March 1
October issue—
June 1

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it tough for them to cross state lines or enter the marketplace. Each state should repeal their statutes discouraging or prohibiting prison industries, at least to allow the manufacture of goods now made exclusively overseas. Prisoners don't deserve wage and hour protection or the employment protection that law-abiding Americans enjoy, but their workplaces should be safe. Let's wipe some laws off the books so that employers can freely negotiate with prisoners and not have to worry about most lawsuits. Everybody can win including taxpayers, crime victims, families of prisoners, our economy, organized labor, businesses, prison systems, and prisoners. Prison industries will create jobs outside prisons. If we don't get more Americans working, we will decline in the world, and that's not our destiny.

*John Gleissner, J.D., graduated from Auburn University (B.A. with Honor, 1973) and Vanderbilt University School of Law (1977) where he won the Editor's Award and participated in the Men's Penitentiary Project. After 33 years as a successful trial attorney, he wrote *Prison & Slavery—A Surprising Comparison* in 2010, which proposes sweeping reforms after studying antebellum slavery and our modern form of state slavery or mass incarceration. He has also published 56 articles and he hosts the Incarceration Reform Mega Site: incarcerationreform.blogspot.com/ and Prison Reform You Tube Channel: youtube.com/user/JohnDewarGleissner His article comes from: EzineArticles.com and the article is republished here with his permission.

A Letter of Thanks to Drs. Curt and Anne Bartol

The Executive Board of the International Association for Correctional and Forensic Psychology (IACFP), on behalf or our members and journal readers, wishes to express our sincere appreciation to you, Curt, as Editor, and to Anne, as Managing Editor, for your exemplary service to the journal and to the Association. We are pleased to take this public opportunity to thank you for over 17 years of dedicated service to *Criminal Justice and Behavior* and IACFP. In honor of your excellence over these many years, the Executive Board has authorized the creation of *The Curt and Anne Bartol Honorary Research Award* to be presented annually to qualified and deserving students or professionals in our field as both recognition and reflection of your high standards of professional integrity and superior accomplishments. Thank you, Curt and Anne.

NEW *CRIMINAL JUSTICE AND BEHAVIOR* EDITOR APPOINTED

Congratulations to Emily J. Salisbury, Ph.D., the new Editor of *Criminal Justice and Behavior*. She was appointed by our Executive Board in September 2012, and begins her tenure this month. Doctor Salisbury is Assistant Professor at the Hatfield School of Government, Division of Criminology and Criminal Justice, Portland State University, Portland, Oregon. She has substantial experience working with the journal, as well as a distinguished record of her own with published articles and presentations. We look forward to Dr. Salisbury's tenure as our new journal Editor and wish her every success.

IACFP EXECUTIVE DIRECTOR NEWS

• Doctor John Gannon, IACFP Executive Director, reports that he had the pleasure of introducing Dr. Ida Dickie, an IACFP member and contributor and the scheduled presenter for *The Edwin I. Megargee Honorary Luncheon* (sponsored by IACFP) at the 20th Annual Research Conference on "What Works" for the International Community Corrections Association (ICCA), Orlando, Florida, September 9-13, 2012. Doctor Dickie's presentation was titled: *Ethics in Criminal Justice Settings* and was very well received.

At the conference, Dr. Gannon also received, on our behalf, *The Charlie Flowers Award* given to us by ICCA for our strong support of and collaboration with them. After the awards ceremony, Dr. Gannon convened and conducted IACFP's annual business on September 10, which was promoted in our newsletter and scheduled in advance in conjunction with ICCA's Orlando conference.

• Doctor Gannon, as the IACFP's representative, participated in the International Relations Committee and the International Corrections and Prisons Association-North America Board meetings in Denver at the American Association 141st Congress of Correction, July 20-25, 2012.

John Gannon displays *The Charlie Flowers Award.*

• He also participated at the International Corrections and Prisons Association's (ICPA's) Regional Conference, Bucharest, Romania, 14-15 June 2012 titled: *Joint Challenges, Joint Solutions: Developments in Prison and Probation in Europe*. The conference focused on questions of mass incarceration in the United States and how European partnerships and cooperation are important tools to inform, support, and modify our own practices. The sharing of knowledge, experience, and expertise with European colleagues creates a valuable opportunity both to contribute to, and to learn from, broader corrections and criminal justice trends, issues, and developments. The conference was unique in that it was the first to be jointly organized by the main prison and probation organizations: ICPA, EuroPris (The European Organization for Prison and Correctional Organizations), and CEP (The European Organization for Probation). The event was hosted by the Romanian National Administration of Penitentiaries (NAP) and the Romanian Probation Department. While in Bucharest, Dr. Gannon also signed the previously Board-approved protocol between IACFP and the Romanian Prison Service in a separate meeting on June 16, 2012. During his visit, discussions regarding our joint project with the Romanian NAP and their e-learning program directors were held, policies and practices dealing with their offender population were evaluated, and training sessions with correctional psychologists and other Romanian correctional mental health professionals were conducted at various sites.

• In addition to these activities, Dr. Gannon, along with SAGE and the IACFP Executive Board, has been negotiating with Ce-Classes.com to provide all of our IACFP members with opportunities to earn free continuing education credits for licensure maintenance. At this writing, non-IACFP members and student members are also being considered for inclusion in the continuing education package for a small fee and a contract between Ce-Classes.com and IACFP is close to being finalized.

• A significant advance for the IACFP Institute for the Behavioral Sciences, Law, and Public Policy has also been unfolding during this period. Spalding University, in Louisville, Kentucky, has expressed a strong interest in creating a home for the Institute. Doctor Gannon has been negotiating on-site and through telephone and e-mail to integrate the activities of the Institute with ongoing academic programs in psychology and criminology at Spalding. Our expectation is that, together, we can continue to develop our IACFP Forensic Psychology Certification Program for colleges and universities who are training individuals in our field. Our efforts in this regard have already attracted the interest and potential support of correctional authorities in Austria, Belgium, and Trinidad, among others. In addition, we expect to be able to develop an advanced multidisciplinary series of summer workshops, seminars, and roundtable discussions at Spalding to address the most pressing issues in forensic and correctional psychology, as well as "Bridging the Gap" between other disciplines, such as neuroscience, moral philosophy, criminology, and forensic sociology, whose professional interests overlap with our own.

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- Doctor Gannon is also continuing his efforts to work with UN officials and others in the process of qualifying IACFP as a UN non-governmental organization (NGO) with consultative status.

Please remember that we continue to seek member participation in IACFP. We need volunteers to serve on committees, either as members or chairpersons. We are in the process of implementing our Association multi-year plan and your help will be valued. If interested, please contact me (Dr. John Gannon) at: (805) 489-0665 or jg@ia4cfp.org

THE MENTALLY ILL INMATE: MANAGEMENT PERSPECTIVES FROM A CORRECTIONAL OFFICER

*Gary F. Cornelius, B.A., ETC Consultants, LLC, Norfolk, Virginia Area**
adjinstructor@hotmail.com

Introduction

GARY CORNELIUS

To correctional staff managing the inmate who suffers from mental illness is often difficult, dangerous, and stressful. In a facility where supervision of inmates who are not mentally ill is difficult enough, it is worse to have to maintain custody of those who are either not rooted firmly in reality, or know where they are, but due to personality disorders, behave in ways to circumvent the staff. The goals of this article are to help readers understand the importance of properly handling the mentally ill and to provide a concise guide to manage the mentally ill inmate.

The Mentally Ill Offender: Public Misconceptions

In popular media, the seriously mentally ill inmate (SMI) is often shown as a person whose problems can be entertaining. For example, two of the most popular movies in the past several decades showed the mentally ill/disordered as interesting characters in a screenplay. In the 1975 *One Flew Over the Cuckoo's Nest*, audiences laughed at the efforts of the hero (Jack Nicholson, who had faked mental illness to get a lighter sentence for his crime) to rally mentally ill residents against the evil head nurse. In the 1991 *The Silence of the Lambs*, a young FBI agent in training (Jodie Foster) enlists the help of a cannibalistic psychopath (Anthony Hopkins) to catch a brutal serial killer. She introduces herself to him in a specially designed dungeon-like facility where he and other "crazy" inmates are securely confined. To many average citizens, these may be their only views of the mentally ill. To others, exposure to the mentally ill includes news events such as the Virginia Tech shootings in 2007, the 2011 shooting of United States Congresswoman Gabrielle Giffords and several others in Arizona and the 2012 movie theatre shootings in Aurora, Colorado. Some can recall the 1981 assassination attempt of President Ronald Reagan; his assailant was found not guilty by reason of insanity and still is under the supervision of a mental hospital. People may think that many offenders "beat the rap" by pleading insanity.

The English courts have recognized the insanity defense for over 700 years and because American courts derive from English courts, it has been recognized in the United States as well. While many in the general public deride the criminal justice system as letting criminals off because they are "crazy," those who work inside correctional facilities know that the vast majority of offenders face judicial proceedings without a mental illness defense. Statistically, successful insanity defenses are not frequent. Research by Cirinicione and Jacobs in 1999 indicated that in 35 states from 1974-1999, there was a mean of only 33.5 insanity acquittals per year (Bartol & Bartol, 1999). Considering the thousands of criminal court proceedings per year for serious crimes, this success rate is very, very low.

Occasionally, a news story emerges that thrusts the problem of incarcerating mentally ill inmates into the spotlight. In July of 2012, *NBC News* reported that an inmate in New Mexico's Dona Ana County Jail was held in solitary confinement for the length of his 2-year stay, was essentially

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forgotten about and was never taken to trial. When arrested in August of 2005, for driving while intoxicated and alleged auto theft, he was reportedly depressed. Initially he was placed for 3 days in a padded cell, and then was moved to solitary confinement. The inmate's attorney described the jail's policy of managing mentally ill inmates as placing them in solitary confinement. The news report said that the medical, dental, and mental states of the inmate deteriorated; he said that his requests for medical attention and depression medication were ignored. A federal jury awarded him $22 million, one of the largest inmate civil rights monetary awards in United States history (Chuck, 2012).

Now, the other side. Dona Ana County released a statement titled: *Conditions at Detention Center Far From Deplorable*. Concerning the inmate, he had an extensive criminal history (totaling 26 pages) for multiple offenses including robberies, burglaries, and drug offenses. He was afforded an opportunity to be placed in the jail's general population, which he refused. For 5 months, he received medical attention at his request and ordered items from the commissary. After a period, he ceased requesting medical and commissary services and also refused recreation and exercise. The statement also said that the jail had no authority from the local court to release him, and his incarceration was in the hands of the local prosecutor, the district court, and the court appointed attorney. Dona Ana County is appealing the award (*Dona Ana County News,* 2012).

No matter how the appeal turns out, there are some disturbing aspects about this case. First, the conditions described by the plaintiff and his attorney made national news. Second, several agencies "dropped the ball," so there is plenty of blame to go around. Third, if the award is upheld (after all a federal jury sided with the inmate), it is not a good example of how mentally ill, or inmates suspected of being mentally ill, should be treated inside a local jail. No jail administrator wants this kind of publicity. The embarrassment and a punitive damage award on staff are hard to overcome.

"...Inmates who are diagnosed as or suspected of being seriously mentally ill (SMI), if handled improperly, can open up 'cans of worms' for correctional officers. They can harm others by being assaultive or they can harm themselves...."

The "Harm Factor"

One key duty of a correctional officer is to keep inmates from harming themselves. The irrational and often bizarre behavior that is part of mental illness can have tragic results. An example is the 2009 Eighth U.S. Circuit Court case titled: *Vaughn vs. Gray.*

An inmate in a local jail was booked in with a "plethora" of medical and mental health problems which were relayed to the jail staff. Almost immediately after booking, a relative brought to the jail his antidepressant medication which ran out a few days later. After a lapse of 2 days, the prescription was refilled. A few days later the inmate began to act strangely and swallowed some shampoo. At 10 pm, one of the officers observed the inmate vomiting; he asked the inmate if it was due to the shampoo. The inmate did not answer but asked to see a nurse due to stomach discomfort. That request was not honored. Another officer observed the inmate pacing, drinking water, and vomiting the next morning. A half-hour later, he was found unresponsive on his cell floor. He was transported to the hospital where he was pronounced dead from a heart attack. The defendant-officers conceded that they knew the inmate was vomiting, but thought it was from the shampoo. The inmate died of a heart attack (*Correctional Law Reporter,* 2009).

The bottom line? Inmates who are diagnosed as or suspected of being seriously mentally ill (SMI), if handled improperly, can open up "cans of worms" for correctional officers. They can harm others by being assaultive or they can harm themselves. In the New Mexico case, a federal jury believed that the inmate was essentially segregated and forgotten about; in the *Vaughn vs. Gray* case, officers having realized that normal people, including inmates, do not normally ingest shampoo, should have responded to his serious medical need of vomiting much more quickly.

Correctional officers can also be harmed by SMI inmates. Veteran officers all have encountered such inmates in their careers where they had to defend themselves and use such devices as pepper spray and restraint chairs. While some SMI inmates comply with orders, those who are hallucinating or paranoid may resist or physically assault officers.

The Scope of the Problem

Research has indicated the seriousness of housing the mentally ill offender in our nation's correctional facilities. The scope of the problem must be relayed to the front line of corrections, the correctional officers, who both encounter mentally ill inmates and manage them wherever they are housed in

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the institution. The May 2010 joint study conducted by the Treatment Advocacy Center and the National Sheriff's Association found that:

- In the United States, based on 2004-2005 data, there are three times more seriously mentally ill persons incarcerated in correctional facilities than in hospitals, effectively making correctional facilities America's new mental hospitals.
- At least 16% of inmates in correctional facilities are seriously mentally ill; in 1983 the rate was 6.4%. Simply, the rate has almost tripled in the last 3 decades.
- Availability of beds for seriously mentally ill has decreased from one bed in a psychiatric facility bed being available for every 300 Americans, to one bed for every 3,000 Americans in 2005.
- About 40% of persons with a serious mental illness have at one time in their lives been incarcerated in a jail or prison (Treatment Advocacy Center, & National Sheriff's Association, 2010).

These are plain-speaking statistics that should be discussed in the correctional training academies and roll call; officers know that "crazies" come into jails and prisons, and these emphasize the scope of the problem. Officers know that some can be handled; others will behave very irrationally and may pose a danger to all staff and other inmates. No one expects officers to memorize statistics, but these data can be used in training. The training must be presented by mental health professionals who are familiar with institutional operations. Correctional officers are very similar to police officers. They patrol, they deal with law breakers, and every day their health and safety are on the line for the public trust. Imagine a police station roll call. A parole officer is going to brief the officers on serious parole violators in their area. The best parole officer to do it is the one who works cases in that area—he knows the community, he knows many of the people, and he knows the offenders. The same is true for mental health staff who brief correctional officers; the best ones to do so are mental health staff with institutional correctional backgrounds. They are familiar with the dangers and stresses of correctional officers.

Safe Management: Avoiding Liability

The best way for correctional officers to avoid liability is to be familiar with the components of a minimally adequate correctional mental health care system for inmates with mental health issues. These are "common sense" components (Dempsey, Smith, & Blackhurst, 2012). If followed and documented, they can work to defend a correctional agency if sued over the death or mistreatment of a mentally ill inmate.

There are two landmark court cases that address mental health care for inmates. In the 1980 *Ruiz vs. Estelle* case filed in the U.S. District Court for the Southern District of Texas, the court ruled that inmates' access to necessary mental health services is protected by the Eighth Amendment to the U.S. Constitution. In the 1995 *Coleman vs. Wilson* case filed in the U.S. Court of Appeals, Ninth Circuit, the court established the aforementioned components for a correctional mental health care delivery system for incarcerated offenders with mental health issues: screening and evaluation, treatment, adequate staff, records, medication, and a suicide prevention program (cited in Dempsey, Smith, & Blackhurst, 2012). These are minimal; the mental health care delivery system can always be improved as it is an ever-changing field with new data.

Policy into Practice

To successfully defend against litigation alleging mismanagement of mentally ill inmates, correctional trainers and supervisors must look at each component and sell its importance to the officers. So, let's look at each, in no particular order, as they apply to the correctional institution:

- Adequate Staff. Adequate staff means trained, professional staff. Training correctional officers to deal with the mentally ill means more than reading a general order at roll call. Training can include instruction from mental health professionals who are familiar with the facility. Generally, prisons have on-site, full-time mental health staff; local jails may or may not depending on funding. The local community services board may send a psychologist on an as-needed basis to deal with a suicidal inmate, a seriously violently mentally ill inmate, or to make an assessment for detention. That decision may be contrary to the security needs and safety of the staff and inmates. All outside mental health personnel should be very familiar with the institution, its policies and procedures, and the duties of correctional officers. The institution's classification section cannot be overlooked; mental health staff must familiarize themselves concerning under what custody levels and conditions inmates are housed, as well

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as disciplinary and administrative segregation procedures. Correctional officers must also have a mature attitude towards special populations, such as the mentally ill, especially where training is concerned. Training standards, such as those from the American Correctional Association (ACA) are very specific about mental health screening. For example, ACA standards mandate that inmates arriving at a jail receive an intake physical and mental health screenings upon arrival, with screenings including mental health history. Also, all jail correctional officers receive training including suicide prevention before assuming duties (American Correctional Association, 2010). Correctional officer training at the basic levels includes training in special populations. Correctional officers must realize that mentally ill inmates are unpredictable and if one ingests shampoo, staff must respond. Finally, SMI inmates are not to be ignored, ridiculed, harassed, or stereotypically lumped together as a "no good_____".

"...Correctional officers must also have a mature attitude towards special populations, such as the mentally ill, especially where training is concerned. Training standards, such as those from the American Correctional Association (ACA) are very specific about mental health screening...."

• Screening and Evaluation. While medical, mental health, classification, and booking staffs are part of the intake process, all correctional officers must be aware of the symptoms of mental illness. Qualified mental health professionals act upon information passed along to them by booking staff, medical staff, and correctional officers. Basically, the front line in dealing with the seriously mentally ill in correctional facilities is made up of the correctional officer. Intake screening is important; a SMI inmate cannot move past the secure housing of intake until as much information as possible is gathered and a management plan is developed by mental health and treatment staff working with facility staff. Part of screening is the alert correctional officer who has to be aware of three things: (a) types of mental illness; (b) symptoms of mental illness; and (c) the proper initial management techniques.

The correctional officer who is a true professional and keeps up with developments in the field has a general idea of the types of mental illness and disorders: substance abuse disorders (dependency on substances and its effects on behaviors), mood disorders (changes in mood that are abnormal), anxiety disorders (over anxious or repetitive behavior), thought disorders (affects how a person perceive reality), sexual disorders (aberrant behavior concerning sex) and personality disorders (environmental influences and inherited traits influences personality and how the person deals with the world and people in it, for example, antisocial personality). Staff cannot assume that an inmate is just "weird." Having an idea of the types of mental disorders can "spark" a professional curiosity that leads to proper management (Lupton, 1996). Training in corrections has come a long way; mentally ill offenders and other special populations are generally covered in basic officer training. Also important are changes in the field of mental health and how they are translated into practical terms for line staff. The "bible" for mental health professionals has been the *Diagnostic and Statistical Manual of Mental Disorders* or *DSM IV* published by the American Psychiatric Association. It divides mental disorders into 17 different categories (Lupton, 1996). Whatever mental health issues are in the outside population, line officers must realize that they will show up inside. The *DSM V* is scheduled to be released in May of 2013 and will contain new information on such conditions including autism and non-suicidal self- injury disorder (American Psychiatric Association, 2012).

Concerning symptoms, correctional officers are not expected to do the jobs of qualified mental health personnel. Some officers are enthusiastic and want to help. The best way for them to help is to have a working knowledge of mental illness and disorders and when a behavior is observed, they must recognize that something is wrong. The inmate may not be just "odd" or "weird." Officers must be advised to never ignore the behavior, and get the offender referred to a qualified mental health professional as soon as possible (Lupton, 1996).

"...Training in corrections has come a long way; mentally ill offenders and other special populations are generally covered in basic officer training. Also important are changes in the field of mental health and how they are translated into practical terms for line staff...."

Initial management starts with the offender being closely observed, moved to a high observation area, and is examined by mental health staff. Officers should be trained with examples of court cases that went wrong for an officer where an appar-

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ently mentally ill inmate was mismanaged and died. These are not scare tactics but are a dose of cold reality.

• Records. This is common sense. Without documentation in everything from observation logs to medical/mental health charts, to officer incident reports, adequate care for the mentally ill inmate will not happen and staff will be liable. A correctional officer who assumes a post where a SMI is housed should be able to pick up a log and know that the inmate was seen by the medical and mental health staffs, was fed, showered, and behavior such as agitation, talking to themselves, was observed. Incident reports documenting a SMI inmate's behavior must be written; they serve both to alert staff to any danger issues and can assist in detention proceedings.

• Medication. This is another common sense area. Psychotropic medication cannot be skipped and if a SMI inmate is refusing medication, all staff that deal with that inmate must be alerted. In 2007, Dallas County settled a lawsuit with the families of three inmates for almost $1 million. The three mentally ill inmates had been denied medication while incarcerated in the jail. More than one-half of the settlement went to one inmate due to his psychiatric medications being withheld for 2 months (*Correctional Mental Health Report*, 2009). The best way to manage medication from the line officer standpoint is to be alert when the medical staff gives the inmate the medication and to search cells frequently to make sure that inmates are not secreting and hoarding their medications. Offenders can be mentally ill or have a personality disorder, but that does not mean that they are stupid. They know where they are.

"...They all should have several common threads running through them; a concern that the inmate is a person, not anything less, life (even an inmate's) is precious and the staff has to work together...."

• Treatment. The best chances for long term treatment and therapy for SMI inmates are in federal and state prisons where inmates are serving sentences. Inmates in jails are there for shorter periods of time; they can be transferred to a mental health facility per court order, they can be released on bond, they can be released through court action or be transferred to another facility due to other charges. If convicted, they are sent to departments of correction. While intensive long-term therapy and treatment may not be possible in jails, correctional officers must support mental health staff with whatever methods are being used. Many jails have short-term programs for mentally ill inmates and manage them by medication. There has to be dialogue and cooperation between staff, even officers who are of the opinion (mistakenly) that programs are a waste and mental health staff who conduct individual counseling, group sessions and programs.

• Suicide Prevention. Not all inmates who attempt or commit suicide are mentally ill, but, mentally ill inmates can be unpredictable and suicide can result. The front-line correctional officers must be trained in recognizing the symptoms of suicidal behavior and what to do when suicidal inmates are encountered. Suicide litigation focuses on several aspects: failure to identify the inmate as a potential suicide risk, failure to monitor, and failure to respond (Collins, 2010). They all should have several common threads running through them; a concern that the inmate is a person, not anything less, life (even an inmate's) is precious and the staff has to work together. Officers let mental health staffs know how an inmate is behaving or risks are noted; mental health staff works with correctional officers to put the inmate under the best management possible.

The key to avoiding litigation concerning inmate suicide in correctional intuitions is the prevention of staff deliberate indifference, the actions or lack of actions by staff. The court and jury will want to know if correctional staff had actual, clear knowledge of the suicide threat, attempt, behavior, etc., and if they took reasonable action to prevent or alleviate the problem. Collins (2004) illustrates this point with several cases where institutions were the subject of civil litigation:

• A female inmate who was considered a suicide risk was placed in a detoxification cell that contained loose bedding, tie-off points, and blind spots where she could not be observed by staff.

• An inmate who had a history of mental illness had lost a substantial amount of weight. His mother had contacted the facility and told staff that her son was "paranoid," even though she was not reportedly a mental health professional, parents do know their children. The inmate hid himself from view by placing toilet paper over his cell window; all inferring to a jury that in not taking preventative measures, the staff was deliberately indifferent.

• A correctional officer notified the jail's mental health unit when told by a mentally ill jail inmate that he was thinking of harming himself, but, he forgot or did not care to do some

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common sense things. He did not document the inmate's statement, pass on the information to the oncoming shift, did not notify his supervisor, and did not complete an involuntary commitment form. Three correctional officers discovered the inmate hanging, but made no attempt to cut him down or remove the noose. They said that they could not do so due to other inmate's in the area. There was an agency policy that discussed staff using inmates to cut down a hanging inmate.

Common Sense Approaches

Correctional institutions have to have a common sense approach to managing the mentally ill offender, from booking to release. They have to be screened and if the staff's "gut" tells them that an offender is not dealing with reality or realistically with the situation, the figurative little "red flags" should go up. They must be watched, they should get their medications, and if they refuse or act out, staff should know and be alerted. Staff training should be built around the six minimum requirements necessary for the adequate delivery of mental health services to the mentally ill offender. Training staff must reinforce this to correctional officers: mentally ill offenders will continue to enter the criminal justice system, they will enter incarceration first at the lockup and jail levels, and they must be protected from themselves and other inmates. If they are not, the staff can be held liable. In a perfect world, there would be enough mental health centers to go around. Unfortunately, until the courts devise better ways of handling them, such as drug courts or diversion programs, the mentally ill offender will continue to be incarcerated and the staff will have to deal with the problem. Training must be on going at the in-service level. While correctional officer recruits get training in special populations at the academy level, as time goes on and complacency possibly sets in, this training loses its edge. Trainers must present or make available training for handling the mentally ill, and agency heads and supervisors must support this.

A basic approach would be the use of statistical data. For example, a mental health worker is talking about the latest studies of symptoms of the mentally ill offender. Instead of merely reciting statistics, he should translate the data into a context that correctional officers would relate to. Citing a 2006 United States Bureau of Justice Statistics study, James and Glaze (2006) point out that trainers need to discuss offender symptoms of persistent anger and irritability. These same authors note that these emotions are prevalent in almost 39% of state prison inmates, almost 31% of federal prison inmates, and over 49% of local jail inmates. The bottom line? The rate of anger among inmates ranges at least from one-third to one-half of the inmate population, depending in what type of facility the officer works. Trainers can then discuss how critical to officer safety this statistic is.

If an inmate is mentally ill, that does not necessarily mean that he or she is not subject to disciplinary action or criminal action. If institutional rules are broken, the circumstances may have to be examined on a case-by-case basis. The correctional officers on the front lines have to maintain discipline, control, safety, and order, but, if an order is given to an inmate who is seriously mentally ill and has no concept of rules and regulations, it may be a waste of staff to place charges and try to hold a hearing. In one instance, a SMI female offender refused a jail officer's order. The woman was uncontrollable, screamed for her children constantly, and was frequently placed in restraints. When the hearing officer went to hold a hearing, it was very clear to him that a hearing would be a waste of time. After consultation with the jail mental health staff, the disciplinary charges were dismissed. In such cases, the mental health staff must be consulted. Some SMI inmates can be responsible for their actions and the mental health staff is the best personnel to discuss it with the hearing officers and supervisors. Correctional officers should realize that if charges are dropped, their work is not disrespected in the least. Consultation is necessary in the discussion of criminal charges, in-house charges, and the safest management possible of the SMI. If an officer is seriously or fatally injured, the best course of action is to file criminal charges and the court will decide the matter. The advantage of court action is that the entire case of the individual will be discussed as well as a determination of competency to stand trial.

"...Correctional officers should realize that if charges are dropped, their work is not disrespected in the least. Consultation is necessary in the discussion of criminal charges, in-house charges, and the safest management possible of the SMI...."

A new trend is the checklist approach, initiated in 2002 by the New York Department of Corrections (NYDOC) due to a lawsuit filed by inmates at two state institutions, alleging that due process was being violated because of the way staff was holding disciplinary hearings. The NYDOC amended its regulations to include specific criteria to be considered to determine an inmate's mental state or intellectual capacity when conducting due process hearings and adjournment of the hearings. Specific criteria are considered to place the inmate's mental state in issue and testimony is heard from mental health personnel. A nine-point checklist is used that

(Continued on page 11)

THE MENTALLY ILL INMATE *(Continued from page 10)*

includes treatment history, clinical contacts, and medications. This is a fair way; malingering, the degree of mental illness, and seeking a balance between custody staff and mental health staffs are all considered (Knoll, 2008). Jails and prisons would be wise to develop this approach as an objective approach to the problem of managing mentally ill inmates through due process concerning severe behavioral issues.

Summary

Correctional officers must deal with mentally ill offenders incarcerated in our nation's prisons and jails. The public may mistakenly think that getting off in court because "you are crazy" is prevalent, but in reality, is not. Jails and prisons hold seriously mentally ill inmates and have become the community's largest mental hospital. What is crucial is the staff being trained to manage them without incurring liability. The courts have established six guidelines to adequately manage mentally ill offenders: (a) screening and evaluation; (b) treatment; (c) adequate staff; (d) records; (e) medication; and, (f) a suicide prevention program. Each must be examined and operated in a common sense way to avoid liability. When they are mismanaged, the agency runs the risk of being held liable and exposed in the media, resulting in embarrassment to the correctional field. Correctional staff should be trained using data that can translate to their jobs and by mental health staff who are familiar with the dangerous and stressful job of correctional officers. By doing so, good policy can be put into practice. A consultation with mental health personnel is a must when considering in-house or criminal charges; in serious criminal conduct, agencies should file charges. Finally, a checklist approach that considers input from mental health staff and examines the feasibility of holding a hearing for a seriously mentally ill inmate may be the way of the future.

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**Gary F. Cornelius, B.A., is a retired deputy sheriff (lieutenant), corrections author and trainer, and an IACFP member.*

IN BRIEF

Arizona—A psychologist was the court-appointed expert whose testimony led a judge to determine Jared Loughner was competent to plead guilty to killing six people in the rampage that wounded then-Congresswoman Gabrielle Giffords. Christina Pietz, Ph.D., testified for about an hour before the judge ruled Loughner competent, accepted his plea, and sentenced him to life in prison.

Become A Certified Correctional Health Professional in 2013

EDWIN MEGARGEE

Edwin I. Megargee, Ph.D.
Professor Emeritus of Psychology, Florida State University, Tallahassee, Florida*
megargee@aol.com

If one of your New Year's resolutions is to enhance your professional credentials, you should consider becoming a Certified Correctional Health Professional (CCHP). Established by the independent nonprofit National Commission on Correctional Health Care (NCCHC), the CCHP program is now in its 22nd year. Certification offers a unique opportunity for health care professionals to demonstrate they have the specialized knowledge and ability needed to practice their disciplines in correctional settings.

As we all know, correctional psychology poses unique challenges for practitioners. We have to be aware of and abide by strict ethical and legal guidelines with due regard for security regulations, client welfare, and confidentiality while working in complex and often crowded conditions. Certification attests to our specialized knowledge and understanding of the National Commission's *Standards* for practicing in jails, prisons, and juvenile facilities. Approximately 2,600 health care professionals from a broad array of disciplines, including physicians, dentists, nurses, nutritionists, and administrators, as well as mental health workers, are currently certified.

To become a CCHP, you must have the education, training, and licenses appropriate for practicing psychology in your particular setting, be of good character and fitness, and pass the standardized CCHP examination. The examination, a 2-hour, proctored multiple choice examination, tests your knowledge of the NCCHC *Standards*. Because it deals specifically with issues regarding the delivery of health care in correctional settings, it does not include clinical material. The exam is the same for all practitioners regardless of discipline. All the information needed to pass the examination is contained in the NCCHC *Standards*, copies of which are available in many facility's libraries or which can be purchased at a discount from the National Commission. Many applicants find it useful to form study groups and purchase source materials jointly.

Application forms and detailed information about becoming a CCHP, including a free *Candidate's Handbook* to assist you in preparing for the examination, can be found at the National Commission website (ncchc.org/cchp) or by writing the CCHP Program, 1145 West Diversey Parkway, Chicago, IL 60614. Upon receipt of a completed application and the associated $165 application and testing fee, approved applicants are advised of dates and places at which they may take the examination, which is administered at all NCCHC conferences and at regional testing sites around the country. Once you pass the CCHP examination, you will receive the supporting documents and insignia and be able to refer to yourself as a CCHP on letterheads and business cards and in court testimony. You will also be informed of other perquisites such as discounts on membership in the Academy of Correctional Health Professionals and special networking and publishing opportunities. But the chief benefit is the recognition that CCHP status brings you in the eyes of your correctional colleagues.

To maintain your CCHP status, you must apply for continuing certification each year. No further examinations are required, but you must take part in at least 18 hours of continuing education annually, at least 6 of which are specific to correctional health care. An annual recertification fee of $75 is also required.

After 3 years in the certification program, CCHPs in good standing are eligible to apply for advanced certification (CCHP-A). For psychologists, the advanced program recognizes CCHPs who have demonstrated excellence and made an outstanding contribution to the field of correctional psychology. Advanced certification requires a more detailed application, which is reviewed by the CCHP Board of Trustees, and a 4-hour proctored essay examination which is administered three times a year at the three national NCCHC conferences.

Like most New Year's resolutions, vowing to obtain CCHP status involves motivation, time, and effort. However, becoming certified will make you a better correctional psychologist as well as enhancing your professional credentials.

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*Doctor Megargee is a former IACFP President, former Acting Editor of *Criminal Justice and Behavior*, and continues to be a major contributor to the Association representing us on the National Commission on Correctional Health Care (NCCHC) Board, on the Board of Trustees for the NCCHC's Certified Correctional Health Care Professional (CCHP) Program, and in other activities.

THEORIES OF MIND AND CRIMINAL BEHAVIOR: A PERSPECTIVE

Richard Althouse, Ph.D., Immediate IACFP Past President
goldmine123.a@gmail.com

Experts estimate that the human brain, a three pound mass of mostly fat that contains over 400 miles of blood vessels, utilizes about a quarter of the body's energy sources (oxygen and glucose) and generates 25 watts of power, has approximately 100 billion neurons (30,000 neurons will fit on the head of a pin) communicating with each other in milliseconds through about a hundred trillion synapses, each 20-40 nanometers wide (equivalent to speeds between 22 and 223 miles per hour) by over 100 neurotransmitters at the rate of 0.1 quadrillion nerve impulses per second, has the ability to perform between 200 and 100 trillion calculations per second, has the information storage capacity of between 100 to 1000 terabytes (well more than what is needed to store 10 times the information in the entire Library of Congress).

RICHARD ALTHOUSE

The Question: What one thing do all these behaviors have in common?

A well-known retired defensive football coach from a highly-regarded university football program is observed showering with and possibly raping a young boy in one of the university's shower rooms; a female senator is shot in the head by a mentally unstable gunman who also shot and killed six other people and wounded 13 others; a young graduate student, sporting dyed red hair fading to shades of pink and orange, sits in a Colorado courtroom charged with barging into a movie theater at midnight shooting and killing 12 people and wounding 58 others; a university professor of African Studies at a highly-respected mid-west university, while walking down the street, is charged with lewd and lascivious behavior for allegedly exposing his genitals to a female student who had taken one of his classes. He later admitted he's done the same thing to five other women. A well-known NFL football player gets into a disagreement with and then head-butts and injures his wife of 47 days; apologizes. She files for divorce. He is released from his NFL team. An Army veteran trained in psychological warfare and known for his beliefs in white supremacy walks into a Sikh temple during a worship service, shoots and kills six worshipers, and then shoots and kills himself after being shot by a policeman. Thirty-eight Army soldiers either committed suicide or were suspected of doing so in July, 2012; the highest 1-month tally since the Army began keeping careful track of this statistic, and currently the most common form of death in the Army. One Army analyst, exhibiting a firm grasp of the obvious, believed many of these soldiers were having a difficult time adjusting following their return home. Last, you are sitting across from an offender reincarcerated for the sixth time. You ask if he likes it in prison. He says, "No." You ask if he knew what he did ran the risk of being reincarcerated. He says, "Yes." You ask him to explain how he made his criminal behavior okay to do. He is not able to.

The Answer: All these behaviors were generated by each individual's brain.

The 10-year period between 1990 and 1999 was termed the "decade of the brain," and many discoveries were made regarding brain functioning. Perhaps the two most important ones were that the brain generates new neurons and new neural networks throughout its lifetime (neuroplasticity), and that the expression of genetic predispositions are likely influenced by environmental factors (epigenesis). Since then, more sophisticated measurement tools have allowed neuroscientists and psychologists to discover that despite the fact that our brain performs most of its functions outside our awareness (in our minds), some of them (e.g., attitudes, beliefs, and cognitions) can now be measured, and the results have practical treatment applications (e.g., the *Handbook of Implicit Cognition and Addiction*, Wiers & Stacy, 2006).

Why are these discoveries important? One of the by-products of our brain's inner workings is our ability to consider others as intentional agents; that is, to interpret others' behaviors as reflecting specific intentional (mind) states, such as the intention to do good or harm, and assume other's intentions are a byproduct of individual and volitional choice. This

(Continued on page 14)

THEORIES OF MIND

(Continued from page 13)

ability varies with age and brain maturation and is referred to as a "theory of mind" (TOM). This process ultimately contributes to our beliefs, generally inferred from our own or others' actions, about what is a morally or ethically acceptable intention and behavior. And one of those beliefs is that we have an inherent ability to choose between what is right and wrong behaviors and control our behaviors accordingly.

This point of view was exhibited in a June 2012 *CNN* interview by Don Lemon with Toronto-based psychologist Dr. James Cantor who, commenting on the Jerry Sandusky case, alleged that while pedophilia may have a genetic basis, pedophiles have a choice whether or not to act on their impulses and can choose not to molest. In short, that "choice" is under their self-control; the "self" being emphasized. So, could Penn State coach Jerry Sandusky have chosen not to molest any of his victims? According to Dr. Cantor, Yes. However, anyone who has read *The New Unconscious* (Hassin, Uleman, & Barch, 2005), the *Handbook of Implicit Social Cognition,* Gawronski & Payne, 2010), or even Chris Mooney's *The Republican Brain* (2012) could arrive at any conclusion other than none of the brains behind the behaviors referenced in the first paragraph, including Mr. Sandusky's, could have done anything else. Neural networks excite or inhibit, but don't volitionally choose their interactions. Since one's behavior is ultimately the outcome of one's neural networks, the neuroscientific answer to our question must be, "No."

"It is well-known that U.S. prisons are the de facto repositories of individuals with mental illnesses. Should the sentences of many of these individuals reflect their brain's dysfunction rather than their criminal behavior?"

Almost needless to say, the conceptual and philosophical differences between behavior choice and non-choice in any theory of mind have profound implications for our criminal justice system as well as the practices of correctional and forensic psychology and raise some challenging moral questions. For example, should the sentences of those who violate the law be based on their brain's biology?

In June, 2012, the United States Supreme Court seemed to think so, and barred mandatory life sentences for juveniles convicted of murder. This ruling was made, in part, because a growing mass of scientific research has indicated that there are significant differences between the functioning of a juvenile's brain and that of an adult's, and that a juvenile's ability to control his/her behavior varies with their brain's rate of maturation. Consequently, their behavior should not to be held to the same criminal justice standards as that of an adult who commits the same crime.

Or take the case of Grady Nelson. In 2005, Mr. Nelson brutally stabbed and murdered his wife and stabbed his two stepchildren, both of whom he had sexually assaulted. The children survived, his wife did not. The typical social and criminal justice presumption is that Mr. Nelson could have chosen not to commit these crimes, but chose to anyway of his own free will. He should therefore be held accountable for his criminal behavior. Ordinarily, such a crime could result in a death sentence. However, a Miami jury instead sentenced him to life in prison. Why? His defense attorneys convincingly argued that Mr. Nelson had major brain defects that could explain his behavior, and his criminal behavior was not the result of mere choice. They submitted the results of Q-EEG scans, perhaps the first time in any U.S. courtroom that such evidence was allowed, and the jury was sufficiently convinced that Mr. Nelson indeed had some sort of "brain problem" that they modified his sentence. In contrast, consider courts who believe that psychopaths are resistant to change because their brains are qualitatively different than offenders who are not, and consequently are less likely to be prematurely released, particularly if they have high PCL-R scores.

It is well-known that U.S. prisons are the de facto repositories of individuals with mental illnesses. Should the sentences of many of these individuals reflect their brain's dysfunction rather than their criminal behavior? The Supreme Court's decision seems to lend support to that point of view, as does the sentencing practices of those believed to pose a severe risk to public safety, such as psychopaths and sex offenders. However, once sentenced, how does one consider interventions that are based more in neuroscience than popular sociopolitical notions of morality, retribution, guilt and shame, or psychiatric diagnoses such as a bipolar, anxiety, PTSD, antisocial, or borderline personality disorders? And how might these contributions reshape TOM? The answers to these and similar questions are likely to be areas ripe for future neuroscientific explorations as we enter into the "third decade of the brain."

Meanwhile, in the interests of a truly safer and hopefully more humane society, I believe those of us who work with offenders need to read and become familiar with advances in neuroscience that contribute to our work. Accordingly, our collective brains may contribute to bridging the significant gap between current sociopolitical "tough on crime" criminal justice practices and smarter rehabilitation interventions based on neuroscience.

ACCOP Asian Conference of Criminal and Operations Psychology

A special meeting of the Society for Police and Criminal Psychology

psychweb.cisat.jmu.edu/spcp/

Psychology in Law Enforcement, Terrorism, and Resilience: Global Perspectives

May 20-23, 2013
Singapore

Jointly organized by the Singapore Home Team Behavioral Sciences Center, Police Psychological Services Division (Singapore Police Force), and the Psychological and Counseling Services Branch (Singapore Prisons Service), Singapore, the second run of Asian Conference of Criminal and Operations Psychology (ACCOP) will be held from May 20-23, 2013, in Singapore.

This is a unique opportunity for you to meet and to exchange information with experts in the fields of law enforcement; correctional, criminal and operations psychology; and behavioral sciences from both Asia and the West. The ACCOP 2013 will see the gathering of officers and practitioners in this arena congregating, communicating, and collaborating with one another.

MINDWARE FOR OPERATIONAL SUCCESS

Further details will be available on the ACCOP website:
accopsingapore.com

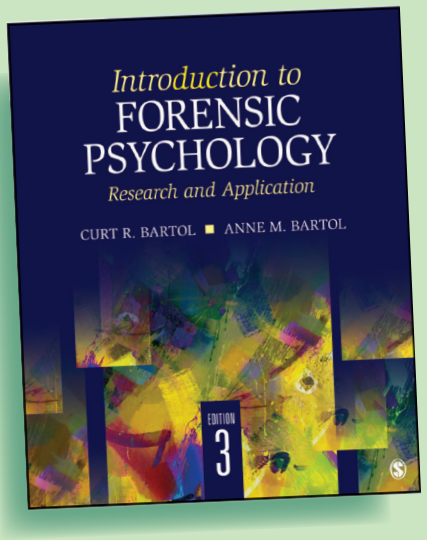
USEFUL CONTACTS

You may wish to visit the HTBSC Facebook page for more updates on ACCOP 2013 at
facebook.com/HTBSC

Alternatively, you can contact us at the following for queries:
Chai_Xiau_Ting@mha.gov.sg
or Toh_Shi_Min@spf.gov.sg

The theme for the conference is: *Mindware for Operational Success*, emphasizing the influence of psychology and behavioral sciences to help inform and shape operational work in the fields of law enforcement, correctional work, and terrorism. The conference tracks for ACCOP 2013 (which will be streamlined further as the program is developed) are:

- Criminal & Forensic Psychology (e.g., organized crime, gambling-related crimes/behaviors)
- Psychology of Terrorism, Counter-Terrorism & De-Radicalization
- Operations Psychology & Criminal Hostage Negotiations
- Correctional Psychology
- Critical Incident & Disaster Psychology
- Resilience & Counseling in Law Enforcement & Corrections Settings
- Leadership & Command Psychology
- Personnel Assessment/Occupational Psychology in Law Enforcement & Corrections Settings
- Cybercrime & New Media Psychology
- Traffic Psychology & Safety Behaviors
- International & Cross-Cultural Psychology



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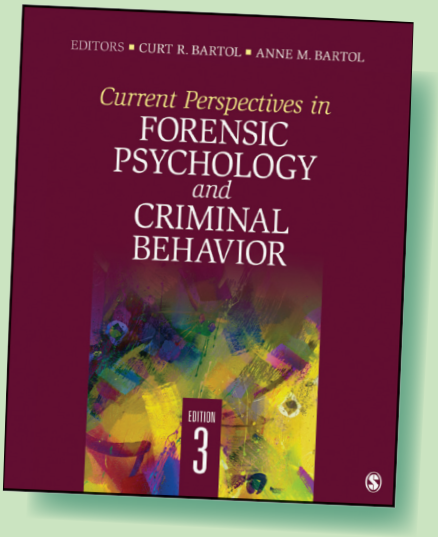

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A BRIEF COMPARATIVE REVIEW OF THE UNITED STATES CRIMINAL JUSTICE SYSTEM AND JUVENILE JUSTICE SYSTEM*

CRIMINAL JUSTICE SYSTEM HIGHLIGHTS

• Based on European and early American influences. Punishment should be defined by the laws. Should apply equally to all members of society, regardless of status based on the 18th Century Classical School of Criminology and Cesare Beccaria (1738-1794). Beccaria argued that the severity of punishment must be related to its usefulness for crime prevention. Punishment is not to torment, but to prevent offenders and others from committing crime. Punishment, he believed, must be swift, certain, and applied equally to all for similar crimes.

• Deterrence works and is based on Beccaria's philosophy. Jeremy Bentham (1748-1832), also from the Classical School of Criminology, reduced human behavior to this simple definition: "The pursuit of pleasure and the concomitant avoidance of pain." Like Beccaria, Bentham claimed that the function of law was to prevent crime, not to achieve vengeance. Bentham introduced his "felicity calculus," a complex mathematical formula providing the exact amount of punishment necessary to deter specific acts which flowed into the concept of "making the punishment fit the crime." The punishment need only be the amount of pain slightly greater than the reward from the criminal behavior.

• Rehabilitation is secondary.

• Prevention is generalized and aimed at deterrence, e.g., Neighborhood Crime Watch, etc.

• Public access to records is mandated.

• Law enforcement uses discretion in diverting offenders out of the criminal justice system.

• Plea bargaining is common.

• Prosecutor builds history for subsequent offenses.

• Prosecutor's decision is based on legal facts.

• Defendants have bond and/or bail rights.

• Defendants have right to a jury trial.

• Guilt must be established on charges being considered.

• All proceedings are open.

• Sentencing is based on severity of offense and criminal history.

• Sentence is often determinate and is based on proportional elements.

• Parole is used for surveillance and reporting to monitor illicit behavior.

JUVENILE JUSTICE SYSTEM HIGHLIGHTS

• The origin of the juvenile justice system in the United States may be traced back to early England and their poorhouses and houses of refuge. Much of today's system in the United States is rooted in the belief of family solidarity with the focus on the father as the central figure. Because early juvenile institutions in the United States were often found to be brutal and lacked appropriate intervention, legal principles, separate from adults, were developed. Our belief today, more than ever, is that youth under 18 can be rehabilitated. Some youth also need to be protected. The legal principle that emerged out of the 1838 Pennsylvania Supreme Court case *Ex parte Crouse* evolved into the *parens patria* doctrine where the state assumed the role of guardian after parents were shown to be unsuitable. The *parens patria* doctrine became the predominant concept in all juvenile courts after the first was established in Cook County, Illinois, in 1899.

• Prevention at reducing risk factors using recreation, schools, churches, and other youth-serving public and private agencies.

• Public access to records and court proceedings is mostly limited.

• Law enforcement and others divert youth to alternative programs.

• Juvenile court, not prosecutor, typically decide what cases to file.

• Decision to file a petition for court action is based on social and legal factors.

• Delinquents may be detained for their own or community's protection.

• Delinquents are not confined with adults unless there is a sight and sound separation.

• Juvenile court proceedings are not criminal.

• If guilt is established, the youth is adjudicated delinquent.

• Right to a jury trial is not provided in all states.

• Disposition is based on social factors, offense severity, and the youth's offense history.

• Disposition has a significant rehabilitation component and may include community-based and residential services. It may also involve parent culpability and is indeterminate, based on the youth's progress.

• Aftercare combines surveillance and integrative activity with family, school, and work.

COMMON IN BOTH SYSTEMS

• Education, e.g., drug and alcohol programs, etc.
• Constitutional and procedural safeguards exist.
• Probable cause needs to be established.
• Accused may be held to ensure court appearance.
• Detention options may include home or use of electronic devices.
• Proof beyond doubt is required.
• Rights to an attorney, to confront witnesses, and to remain silent.
• Appeals to higher courts.
• Decisions influencing current offense include, current offense, offender history, and social factors.
• Decisions hold offender accountable.
• Decisions may not be cruel or unusual.
• Decisions may give victims consideration.
• Behavior of released individuals is monitored.
• Violations may result in reincarceration.

* Excerpted and adapted from several Internet sources including: (a) *Supervisory Training to Enhance Permanency Solutions (STEP)*, (b) *Frontline*, and (c) *LegalMatch Law Library.*

VOTING FOR THE 2012 IACFP ELECTIONS AND RECOMMENDED BYLAWS AMENDMENTS

At press time for the this issue of our newsletter, mailed ballots for our 2012 election and recommended bylaws amendments were still being counted; results will be posted on our website soon after the voting deadline of November 15, 2012. We also plan to publish the complete election and bylaws amendments results in our April 2013 newsletter.

IN BRIEF

Massachusetts—The state has opened a 320-bed mental health facility in Worcester, the first to be built in the state since the 1950s. The Worcester Recovery Center and Hospital will let patients be active in activities and programs on a campus resembling home and neighborhood environments.

IACFP MEMBER HELP ON COMMITTEES

We continue to seek out volunteers for several Association committees including: Bylaws, Awards, Education, Finance, and others. Important Association work needs to be done and we are eager for a broad range of member input to guide and accomplish that.

Please contact our Executive Director, Dr. John Gannon, at: (805) 489-0665 or jg@ia4cfp.org if you are available. Doctor Gannon will provide you with more information about how you can become more involved.

Letter to Our Executive Director and Executive Board

September 19, 2012

Gentlemen:

I congratulate you all on your patient, hard work in the last few months, and for your informative report in the October 2012 issue of *The IACFP Newsletter.* It was very positive and it reinforced my confidence that IACFP will continue to grow, prosper, and increase its impact on our profession. Thank you all for your diligent, competent perseverance.

Robert J. Powitzky, Ph.D.
Chief Mental Health Officer
Oklahoma Department of Corrections
2901 N. Classen, Suite 200
Oklahoma City, OK 73106

PROCEDURE MODIFICATION FOR IACFP EXECUTIVE BOARD MEETINGS

Business for IACFP's scheduled Executive Board conference-call meeting in July 2012 was conducted though individual telephone and e-mail communications instead of a conference call. Our conference-call meeting for September 28, 2012 was deferred until work on a series of additional recommended bylaws amendments is completed by our Bylaws Committee. At this writing, the Executive Board conference-call meeting on November 30, 2012, is still scheduled for 3 pm ET; an IACFP Executive Board update will be published in the April 2013 newsletter providing members with a report of Board activities.

THE PRICE TO CALL HOME: STATE-SANCTIONED MONOPOLIZATION IN THE PRISON PHONE INDUSTRY

Drew Kukorowski, J.D., M.A., Research Associate, Prison Policy Initiative, Easthampton, Massachusetts
dkukorowski@prisonpolicy.org

DREW KUKOROWSKI

Exorbitant phone rates make the prison phone industry one of the most lucrative businesses in the U.S. today. This industry is so profitable because prison phone companies have state-sanctioned monopolistic control over the state prison markets, and the government agency with authority to rein in these rates across the nation, has been reluctant to offer meaningful relief. Moreover, high phone rates reduce incarcerated persons' ability to communicate with family, and family contact has been consistently shown to lower recidivism. At a time when both sides of the political spectrum are interested in reducing prison populations by exploring new approaches for reducing recidivism, lowering prison phone rates is a simple, straightforward, and evidence-based way to achieve this uncontroversial goal.

Prison phone companies are awarded exclusive contracts through bidding processes in which they submit contract proposals to the state prison systems; in all but eight states, these contracts include promises to pay "commissions"—in effect, kickbacks—to states, in either the form of a percentage of revenue, a fixed up-front payment, or a combination of the two. Thus, state prison systems have no incentive to select the telephone company that offers the lowest rates; rather, states have an incentive to reap the most profit by selecting the telephone company that provides the highest commission.

These high prices make it more difficult for incarcerated persons to stay in touch with family, thereby making it more difficult for them to reintegrate into society when they are released. Typically, incarcerated persons have below average literacy rates that make it less practical for them to communicate in writing. And it is difficult for families of incarcerated persons to pay for phone calls because people in prison tend to come from low-income households. A study of recently released people from Illinois prisons found that the price of phone calls from prison was one of the two most significant barriers to family contact during incarceration.

The link between family contact during incarceration and reduced recidivism is well-documented. The U.S. Federal Bureau of Prisons states that "telephone privileges are a supplemental means of maintaining community and family ties that will contribute to an inmate's personal development." Congress itself has found, in the context of enacting the Second Chance Act of 2007, that "there is evidence to suggest that inmates who are connected to their children and families are more likely to avoid negative incidents and have reduced sentences." And the American Correctional Association, the world's largest professional corrections association and an accreditation agency for correctional facilities, has repeatedly resolved that "sound correctional management" requires that "adult/juvenile offenders should have access to a range of reasonably priced telecommunications services" and that rates for such services should be "commensurate with those charged to the general public for like services." Thus, a variety of stakeholders and policy-making bodies agree that high phone prices are harmful, and yet high prison phone prices persist.

In addition to reducing recidivism, lower telephone prices that lead to increased contact between incarcerated people and their children increase incarcerated persons' involvement with their children after release. As of 2007, 52% of people incarcerated in state prisons and 63% of people incarcerated in the U.S. Federal Bureau of Prisons were parents of minor children, resulting in an alarming 2.7 million children with a parent in prison today. Lowering the cost of communications for these incarcerated persons and their children would potentially improve parent-child relationships by permitting more frequent communication.

The combination of corporate consolidation in the prison phone industry, state-granted monopolies, and inelastic demand for prison telephone service has led to exorbitant rates. In many states, someone behind bars must pay about $15 for a 15-minute phone call. Fortunately, government regulation can help achieve this goal. The Federal Communications Commission is considering a modest regulation to impose price caps on long-distance prison telephone rates. Such regulation would both reduce the price-gouging that incarcerated persons' families suffer and simultaneously contribute to the social good by potentially reducing recidivism.

Vignettes of Glimpses Inside

Ronald R. Mellen, Ph.D., Professor, Department of Criminal Justice, Jacksonville State University, Jacksonville, Alabama, and an IACFP Member
rmellen@jsu.edu

RON MELLEN

After retiring from Saint Mary's University in San Antonio, Texas, and before returning to teach at Jacksonville State University in Jacksonville, Alabama, I worked in the Arkansas Department of Corrections for 6 years. The first 3 years in Arkansas corrections was as Clinical Director of the Special Program Unit (a mental health unit) and the last 3, I was staff psychologist for the maximum (Max) and super maximum (SuperMax) units. Every so often, an offender event would strike me as important and I wrote them down. The events were not earth-shaking, but collectively, they provided insights into the vast array of hidden and emotional experiences that I encountered as a psychologist.

I've used the offender events in my correctional counseling classes for years and the students responded with interest. I started to craft these events into a book, but the thought also came to me that readers of *The IACFP Newsletter* might find the events interesting and possibly also open the door for others to share some of their similar experiences. I'll add one vignette per newsletter issue as long as my supply lasts. My first vignette titled: *Going Out Flat* follows below.

GOING OUT FLAT

Anger Management Group: one member, was an Anglo pedophile with a 60-day release date and a lifetime of torment and fear. He was going out flat, which meant he had served his time day for day. As the inmates said, he was "taking it to the door," no good time. Because he had served all his time, there would be no parole officer and the inmate's greatest fear was of his own appetites.

While he had talked about his strategies for controlling the inner demons, and they numbered more than the cigarette-burned scars on his body, nobody in that group believed he would win those battles. His hopes were high, but, in a deeper part of his soul, he understood the truth behind their disbelief and no one hated this silent knowing more than he did.

It wasn't prison he feared, he had faced that battle and won. No, in the blur of his demented thoughts there lived a genuine wish not to harm more children, as he had been harmed. But a prison isn't a mental health hospital and doesn't always provide adequate treatment. However, offenders do come out with a world of new ways not to get caught.

Twenty- five dollars and a bus ticket on Greyhound is what he will get when the final metal door closes behind him. I guess it seems cheap enough, until I think about the ex-con with all those future young victims. Then the cost seems very heavy indeed.

If you would like to submit a brief article like Dr. Mellen's, the vignette model used by him would be an excellent way to share similar experiences with others in the newsletter.

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JUNE 13-15, 2013

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Further information and links are available online:

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For more detailed information on these regional vacancies, please visit our website at: bop.gov and go to careers, clinical psychologist.

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Robert R. Smith, Ed.D.
Executive Editor
The IACFP Newsletter
625 Richardson Road
Fortson, GA 31808

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