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AN EXAMINATION OF MINDFULNESS-BASED THERAPY AND PRISON INMATE REHABILITATION

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TAMEKA SAMUELS-JONES

Over the past several decades, an increasing number of empirical studies have offered strong evidence that mindfulness-based practices have a significant and positive effect on mental health as well as improving well-being in general. This article reviews this literature with special emphasis on the benefits of these practices in correctional settings and explores the benefits of mindful practices as they apply to restorative justice. Some of the key benefits noted in this article are an enhanced sense of well-being, increased self-esteem, greater anger management skills, significant reduction in aggressive behavior, fewer prison rule infractions, and an overall positive change in behavior. Also, better adaptive responses to the stresses of life in general including those encountered in the correctional system were noted (Dunn, 2010). Additionally, in examining restorative justice as the framework within which this type of rehabilitation may be introduced and developed, it is noted that when mindful practices are employed, so does self-awareness and the inmates' capacity to accept responsibility for their actions. The capacity for responsible participation which is developed through mindfulness-based therapy (MT) is a critical factor in successful restorative justice programs and is also key for learning self-acceptance and compassion.

Introduction

Over the last several decades, there have been several promising developments in approaches to the challenges of addressing crime within the criminal justice process. This article focuses on two of these developments: (a) mindful practices within the prison system and (b) the concept of restorative justice. The very concept of restorative justice makes mindfulness-based therapy particularly effective within the prison system. Most notable are Vipassana meditation, the mindfulness-based stress reduction (MSBR) programs and mindfulness-based cognitive therapies (MBCT) that have emerged from the work begun by Jon Kabat-Zinn 30 years ago. These programs have demonstrated successes in a variety of areas, especially with respect to how these practices can "rewire" or alter the brain in ways that can lead to more prosocial behaviors (Siegal, 2007, 2010), thereby offering the possibility of a truly rehabilitative corrections program.

Why MT?

Himelstein (2010) notes that approxi-

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mately 70% of released prisoners in the United States will be rearrested within 3 years of their release. This suggests that correctional centers may not be providing offenders with the rehabilitative care needed to successfully reenter society without recidivating. Even worse, is the fact that violent crime such as homicide and robbery have increased between 2001 and 2005 (Federal Bureau of Investigation, 2005). Haney (2006) suggests that the atmosphere in correctional institutions contribute as criminogenic factors that facilitate aggressive and hostile behaviors among inmates which could lead to further criminal behavior. Therefore, prisons and other correctional facilities do not inherently support rehabilitation and deter recidivism.

In a comprehensive study, Malik-Kane and Visher (2008) evaluated the mental and physical state of 1,100 prisoners through interviews and self-report surveys. The analyses of their data revealed that many inmates suffered in prisons; there were high numbers of cases with post-traumatic stress disorder (PTSD), depression, and suicide. According to the Bureau of Justice Statistics (2012), more than 50% of inmate population suffered from some form of mental illness. According to their review of the literature, Edwards and Potter (2004) concluded that the high rate of psychological damage among prisoners is a consequence of the prison culture and lack of effective mental health services provided in prison. Steiner (2009) identified overcrowding, solitary confinement, and lack of healthy nutrition in prisons as among the leading causes of mental distress and destructive behavior in inmates. Several factors exacerbate preexisting mental health conditions during the prison stay. The state-of-living conditions, job status, and physical and sexual abuse history are strongly correlated to one's mental health. Loss of consistent contact with loved ones, preexisting substance addiction, and inability to obtain and withdrawal from substances while in prison takes a significant toll on the prisoner psyche and contributes to depression.

A rapidly-growing body of empirical evidence shows the value of meditation in prison, both as a way to improve inmate behavior and well-being while incarcerated, as well as a way to reduce recidivism and relapses back into drug and alcohol addictions (Zgierska, 2009; Marlatt 2002). While unfortunately, studies that directly apply to prison are limited; there has been a wealth of research with respect to behavioral problems often seen in prison populations, including addiction, aggression, depression, PTSD, and health-care issues such as high blood pressure. The introduction of mindful practices increase the potential cost benefits for health-care alone, and are significant, but the real benefit is the possibility of restoring the human potential typically lost within the correctional system. The development in criminal justice, which is most likely to drive the introduction of MT in corrections, is the restorative justice movement, which focuses on dealing with crime and criminal justice by bringing healing and reconciliation both to the victim and into the community.

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Review of MT in Prison

As noted before, the current research on meditation and mindfulness directly pertaining to the correctional system is relatively small. However, there are several studies which provide evidence of its benefit in a corrections setting. In one important study, a modified MBSR program was offered to over 2,000 inmates in Massachusetts' correctional facilities, including one women's prison, four medium security men's prisons, and one minimum security/pre-release facility between

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1992 and 1996. A reported 1,350 inmates completed the program. Results were measured on three widely-accepted measures of hostility, self-esteem, and mood disturbance. All three measures indicated significant improvements for all participants, although the women and men in the minimum security facility did better. Follow-up, which was conducted 6 to 8 weeks later, demonstrated that gains were still evident (Samuelson et al., 2007). Although these outcomes were very encouraging, it must be noted that there were limitations imposed by prison conditions which required shorter class times and program length. Also, the facilities in which the program was conducted were often less than ideal, and in prison, it is often challenging for inmates to find a quiet place and time to practice.

Another study by Simpson et al. (2007) looked at PTSD symptoms, substance abuse disorder (SUD), and Vipassana meditation in incarcerated individuals. Rates of PTSD and substance abuse are notably higher among incarcerated individuals than in the general population. Incarcerated men with both PTSD and SUD are more likely to re-offend than those with only SUD, and women are more likely to relapse into substance abuse. One of the major issues with both SUD and PTSD is the desire to avoid unpleasant or negative experiences. Mindfulness meditation provides the space for these individuals to look at the painful aspects of their experience by nurturing non-judgmental acceptance of moment-to-moment experience. It is possible that mindfulness practices may, then, be a useful intervention in treating PTSD and SUD while incarcerated. As with many of these studies, the outcomes are encouraging and point to the importance of further research.

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One of the most transformational mindfulness-based practices in prison was held in a maximum security in a North American prison at the Donaldson Correctional Facility in Bessemer, Alabama. It is the subject of the documentary film, The Dhamma Brothers, (2008) and the outcomes have, again, demonstrated the ability of meditation to transform lives. The stories of the men who participated in the 10-day Vipassana retreat are evidence of this transformation. In some cases, this was the first time in their lives that they were able to accept full responsibility for their actions and make peace with themselves. Surprisingly, to date there appears to be no published analysis of the outcomes beyond the favorable testimonials from all parties involved and the decision of the prison to continue the programs.

In a study conducted at the Tidewater Detention Center (TDC) in Chesapeake, Virginia, Sumter offered a seven-week meditation course modeled on Kabat-Zinn's MBSR program. The TDC is a residential detention facility for female detainees. Their program maintained a highly-supervised, highly-structured, paramilitary community environment, which lasted from 20 to 24 weeks. The meditation program was held weekly offering 2 1/2-hour sessions of meditation practice and instruction. Participants were required to maintain silence the rest of the week. The results were overall quite encouraging: there was reported reduction in sleeping difficulties, greater anger management skills, and reduced stress and anxiety. Also, participants showed improvement by experiencing less guilt and feelings of hopelessness about the future (Sumter, 2007).

In an unpublished evaluation of a program sponsored by the Heart Mountain Prison Project at the men's prison in Grants, New Mexico, Wadsworth, Strong, and Brown (2007), found great value to mindful-based therapy. The program evaluated was held in a special "meditation" pod with 16 participants who had chosen to live in the pod and who agreed to more restrictive rules than the prison's general population. These rules included daily silent periods set aside for meditation, no television in the common areas, and a commitment to spiritual practice. As an interfaith program, several traditions were represented, and there was no requirement to adhere to a specific faith. The results showed that most participants did practice and work at utilizing the skills presented. The inmates also reported less stress and frustration, and they appreciated the opportunity to participate. There was a significant reduction in prison infractions and an overall positive change in behavior was noted. The evaluators recommended the program be expanded and otherwise enhanced.

MT and Restorative Justice

The overall impetus of restorative justice is toward healing and restoring the community to wholeness. Ide-

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ally this also means bringing the offender back into the community as a fully participating member and repairing the harms done to the victim and the community. The role of the offender as a responsible participant is essential for the restorative justice process to be successful. Responsible participation is not always possible because so many offenders either overtly or subtly try to place blame away from themselves. One of the outcomes of meditation and mindfulness practices is an increased self-awareness which may lead to a more willing attitude toward accepting blame. There is also, as has been discussed, an increased ability to accept and face the painful feelings that surface in meditation. It is important to remember that sometimes what the offenders really need to face are their own wounds as well as responsibility for the harms they may have caused others (Dunn, 2010). The accepting, nonjudgmental attitude of mindfulness practice creates a spaciousness, making painful feelings tolerable, thus allowing a sense of personal responsibility to arise. Empathic responses to others have been shown to increase with meditation practice (Davidson et al., 2007). As Siegel (2007, 2010) suggests, mindfulness skills may actually alter the brain circuitry for compassion and empathy. This change can foster a state of self-empathy and create the capacity to enhance our sense of connectedness to ourselves and to others. This can be the beginning of personal healing as well, which is important to the successful implementation of restorative justice.

To date, there are few restorative justice programs in prisons, and the ones that are in place are often only partially restorative (Dhami et al., 2009). However, there are several potential restorative programs that can, with varying degrees of difficulty, be implemented within a prison. Van Ness (2007) offers several possibilities beginning with programs to develop awareness and empathy for victims. Other possibilities include programming that offer opportunities for reconciliation and making amends to the victims. Prisoners are often alienated from their own families, and programs that facilitate reconciliation with family members will have value. Restorative justice can be applied within prison for conflict resolution between prisoners, staff, and between prisoners and staff with the larger goal of creating a culture of peaceful conflict resolution. In all of these potential programs, the transformative effects resulting from mindful-based practices can play an important role. The role that MT can play in restorative justice programs is significant. Offender accountability is an essential part of any restorative justice program, and developing the ability to accept responsibility for one's actions is a natural outcome of MT. This sense of personal responsibility will apply to both acknowledging accountability for the harms caused by the crime and also to taking one's place as a responsible, contributing member of the community after release.

Conclusion

The scientific and anecdotal evidence both suggest that mindful-based practices are beneficial in the criminal justice system. First, the research suggests that mindful-based programs may increase psychological well-being as a result of an increase in positive psychological states, such as hopefulness (Chandiramani et al., 1995), optimism (Bowen et al., 2006), and subjective mood state (Samuelson et al., 2007). Mindful-based programs may also decrease negative psychological states, such as hostility (Chandiramani et al., 1995), and anger (Perkins, 1998). This overall improvement in psychological well-being and reduction in psychological distress could enhance inmates' ability to engage in rehabilitation. Additionally, mindful-based programs have been shown to decrease recidivism (Alexander et al., 2003; Rainforth et al., 2003). Given that one major evaluation of rehabilitation programs in correctional settings is recidivism outcome, mindful-based programs have proven to be valuable treatment alternatives.

The lower rate of inmate frustration and stress would reduce the problems of potential violence and prison rule violations. The inmates who have participated in the programs appreciate them and tend to follow through with the practices and, in fact, in most of these programs, the inmates volunteered to participate. Previously, therapy which involved meditation practices were viewed as exotic Eastern religious practices with little value in the modern world. To the extent that anyone thought of incorporating the ideas behind mindfulness and restorative justice, they were dismissed as being idealistic and out of touch with reality. Now both mindfulness-based practices and restorative justice programs are emerging among the most promising new directions in dealing with the challenges in the criminal justice system.

References available from the author.

CONGRATULATIONS TO TWO OF OUR MEMBERS: DRS. RICHARD ALTHOUSE AND RONALD MELLEN

We received a letter in April 2017 from Willis Harris, Editor of *The Michigan Lifers Report* (founded by Harris). Harris pointed out that articles from Drs. Althouse and Mellen which were republished with our permission in the ...*Lifers Report* were "...generating much discussion in Michigan prisons among prisoners and correctional staff...." We congratulate both Drs. Althouse and Mellen for their continued contributions to the profession. Also, we congratulate Dr. Althouse for being asked by the American Psychological Association to provide a book review for R.C. Smith's *Society and Social Pathology: A Framework For Progress*. A summary of Dr. Althouse's review is found page 12 of this newsletter.

INMATES WONDER....

Richard Althouse, Ph.D., At-large Member of the IACFP Executive Board, former IACFP President, and former Chair of the IACFP Executive Board
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RICHARD ALTHOUSE

Occasionally, contributors or the Editor of the newsletter receive correspondence from inmates. Whenever possible and warranted, such correspondence is answered personally. However, once in a while such correspondence raises issues or asks questions of interest not only to individual inmates but to our general readership. Such is the case for this newsletter contribution.

As a result of recent articles in *The IACFP Newsletter,* our Editor received correspondence from Willis Harris, Editor of the *Michigan Lifers Report*. In his correspondence, Harris provided our Editor with a list of four topics Michigan inmates forwarded to him for possible discussion in our newsletter and are as follows:

(a) [What are] the psychological effects on prisoners resulting from excessive incarceration?

(b) Are there different psychological responses between male and female offenders from excessive incarceration?

(c) What is "true" rehabilitation and how is it achieved? Could this failure to reform prisoners be the reason for chronic recidivism?

(d) Statistics nationwide suggest that "lifers" are the best parole risk of any group of prisoners. Why aren't more lifers being paroled or have their "life without parole" sentences commuted, especially after having served 30, 40, or 50 years in prison?

Harris notes that "The above questions are asked by prisoners, correctional officers, college students, and the general public."

These are very good questions, the answers to which are somewhat complex, so complex that over the years many articles, not to mention books, have been written by professionals in criminal justice and other professions about them. So rather than answer each question individually, it might be more useful to provide a rather general overview that might help answer them as a group.

History shows that societies, indeed whole cultures, have viewed criminal behavior in very negative ways. My hypothesis has been that these views are instinctual residuals from the days when individual survival depended not only on an individual's skill, but on tribal protection as well. To insure the survival of both necessitated rules that each member of the tribe needed to follow to ensure the safety of the tribe. Those that didn't follow them were generally killed or banned from the tribe. Why such offenses occurred was not important. Eventually, killing an errant tribal member, and later citizen, was viewed as too extreme for less serious offenses, and other punishments evolved. The point of all these punishments was to reduce the likelihood that the offenders, as well as others, would be less likely to commit such offenses by imposing pain, inconvenience, and social shame as deterrents.

On the one hand, killing an offender guaranteed there would be no recidivism; on the other, killing an offender also deprived the tribe, communities, and society of someone who might provide other services, such as work, while keeping others safe from them. As societies evolved, the evolution of religious views, and later psychological views, of human

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behavior led to various approaches and interventions designed to "rehabilitate" offenders and return them to their communities in which, it was hoped, they would not offend again and become law-abiding citizens, as a percentage do.

But there are two fundamental problems that are generally under-acknowledged: (a) under the surface, most societies and cultures view individuals who commit crimes as in some way mentally defective and therefore untrustworthy, not only at the moment of the offense, but for life; hence, that old adage, "Once a criminal, always a criminal, and (b) the most human responses to crime—as to any perceived threat—are emotional: fear and anger. Therefore, societies' responses to crime have been and still are fundamentally motivated by these emotions, making more logical or humanitarian responses—such as reducing sentences, providing mental health and medical services, and rehabilitation programs--emotionally less appealing, and responses such as longer sentences, long periods in isolation in supermax settings, and cruel and unusual punishment, more appealing. That the old adage claiming that a criminal is a criminal for life is neither logically nor empirically true doesn't matter. Why? Because it is still impossible to predict individual human behavior with certainty, so folks who have demonstrated they are unwilling or unable to follow society's laws and rules remain socially undesirable, despite having been through various forms of treatment programming while incarcerated.

With that backdrop, there are quick answers to Harris' questions. While "excessive" incarceration is a matter of opinion and individual responses to long periods of incarceration vary by individuals, the criminal justice, psychological, and medical literature includes many discussions related to the negative mental health and physical consequences of long periods of incarceration, including mental disorders, mood regulation disorders, physical illnesses, violence, impairments of social relationships, and suicide, to name but a few. There are indeed differential male and female responses to long periods of incarceration; even short periods of incarceration. "True rehabilitation" is difficult to define, but hypothetically, it would guarantee that someone who is truly rehabilitated (or habilitated) would be motivated and able to lead the life of a law-abiding citizen without any desire to offend, and would not offend. Given the various and complex influences leading to criminal behavior, how such a rehabilitative state is achieved for individuals still remains a mystery. Consequently, there is no single factor that accounts for recidivism rates. However, the emotional difficulties communities may have with returning citizens plays an important role. And last, keep in mind that sentences are levied as punishment for a crime, and long sentences are imposed because the public and legislators believe that some crimes deserve that level of punishment (e.g., murder, kidnapping, repeated sexual assaults, treason, etc.). That aside, remember that the fundamental goal of punishment is deterrence, not only that of the individual offender, but of others who may be inclined to similarly offend. Whether such punishment has been an effective deterrent still remains a topic of professional debate. However, remembering that our responses to crime are more emotional than logical, data that suggests lifers—as a category of offenders—pose less of a public safety threat than those in other categories has not been sufficiently emotionally persuasive to justify lessening many of their sentences. I hope this contribution has been useful, and we continue to encourage our readership to submit responses to our contributions and topics for discussion.

DOCTOR JAVEL JACKSON TO HEAD IACFP

The IACFP Board is pleased to announce the new President Elect of IACFP is Javel Jackson, Psy.D. Upon being informed of the election results, Dr. Jackson stated, "IACFP continues to strive towards making an impact to 'help the helper.' I look forward to continuing that mission in my new leadership role with the Association."

Javel is currently the Chief Psychologist with the Georgia Department of Corrections (GDC). She is also serving as the acting statewide Mental Health Services Director for GDC. Her previous clinical experience is with Old Dominion University, New Life Clinics in Georgia, Metro State Prison in Georgia, and Lee Arrendale State Prison in Georgia. Doctor Jackson received her Psy.D. in psychology from Virginia Consortium for Professional Psychology (included Eastern Virginia Medical School, Norfolk State University, Old Dominion University, and William and Mary). Her undergraduate studies were at Wichita State University, and her graduate studies were at Texas A&M Unversity.

Prior to the election, Javel served on the board and as the IACFP Secretary. She is also a member of the Institutional Review Board for Georgia State University. She was previously appointed by the Secretary of State to serve as a member of the Licensing Board.

As noted by more than one IACFP voting member, the Association was lucky to have two highly-qualified members willing to serve in a leadership role for IACFP. The Board looks forward to increasing interest by members in serving the profession through active IACFP participation. It also looks forward to serving them.

JUDGES USE ACCOUNTABILITY COURTS AS ALTERNATIVE TO JAIL

One by one, drug offenders appear before Judge Frank Jordan Jr. with details about the rocky road to recovery. "How long have you been sober," the judge asks one man struggling with a long-time drug addiction. "8 months now," the man says proudly. "Let's give him a hand," the judge replies. And the courtroom erupts in applause.

At first glance, the encounter seems more like an Alcoholics or a Narcotics Anonymous meeting than a court appearance. But it's the weekly routine at Muscogee County, Georgia's Adult Drug Court, a program designed to help drug offenders overcome their addictions through the criminal justice system.

Within judicial circles, the drug court is considered an "accountability court," established to provide effective alternatives to sentencing for nonviolent offenders struggling with substance abuse, mental illness, and other issues. Accountability courts—with their treatment plans, drug screening, and goal-setting approach—are a growing trend across the United States, expanding court services to case management typically found in the social services arena.

Muscogee County has four accountability courts. In addition to the Adult Drug Court, there's the Juvenile Drug Court, the Mental Health Court and the Veterans Court. Local judges said those programs are so successful that they're planning to add two more accountability courts in the near future—one for parents not paying child support and another for families struggling with addiction.

"Accountability courts have really, really come into vogue," said local Juvenile Drug Court Judge Warner Kennon. "They were the cutting edge when we got started a number of years ago. It's a very hands-on, intensive, court-supervised probation."

Jordan said accountability courts are a more cost-effective way to deal with non-violent offenders than traditional courtrooms. "We spend about $50,000 a year to keep someone in prison," he said. "And by putting them out on the street in the community, they become, hopefully, money-earning citizens who can turn themselves around."

One big proponent of accountability courts is Governor Nathan Deal, whose son, Jason Deal, is a presiding judge of a drug court in Hall County, Georgia, Jordan said. "He had the foresight to take dollars from prisons and put them into state drug court programs," he said. "We've been able to do this because we have funding sources."

Doctor Andrew Cox is a licensed addiction counselor who works with the Adult Drug Court as a program and clinical evaluator. He said accountability courts began in 1989 with the first drug court in Miami. Today there are 2,840 drug courts throughout the United States and its territories, serving about 54,777 participants at risk for substance abuse and dependency, according to a recent research paper written by Cox and published by the Forum on Public Policy. The number represents about 10% of the 1.2 million adults arrested in the U.S. each year who are at risk for substance abuse and dependence.

"Basically, it arose really as a means to deal with overcrowding in prisons," Cox said. "A significant amount of prisoners were there because of drug offenses and they weren't getting any treatment. And, of course, it's kind of expensive housing people in prison for nonviolent offenses. So they got the idea of starting these drug courts, combining treatment with the criminal justice system."

Soon, mental health courts were established, and veterans courts followed, providing mental health and substance abuse services to veterans and active duty military personnel facing criminal prosecution. Many participants in the various accountability courts have a combination of mental health and substance abuse problems, Cox said, and it takes a holistic approach to address their needs.

"The people in mental health court also have co-occurring substance abuse disorder," he explained. "And then many of the veterans have co-occurring disorders of mental health coupled with substance abuse. Even with the drug courts, a significant proportion of the people have a co-occurring mental health disorder—depression, anxiety, that kind of thing."

Cox said many individuals in the Adult Drug Court have a long history of substance abuse. In Muscogee County, the average age for participants is early to mid-30s, and the average age that they started using drugs is somewhere around 13 or 14.

"For many of these people, it's the first time they've had a stable situation, where they've worked, had an apartment, rented a house," he said. "Drug courts do not take people who pose a risk to the community. So they don't take violent offenders, people that are convicted of an assault or have a gun charge. They focus solely on those who have some sort of legal charge that involve substance abuse, or they were engaging in some sort of behavior to support their substance abuse history."

Kennon said many of the cases that he sees in the Juvenile Drug Court involve not just youths but also parents suffering from addiction. That's why he's currently seeking funding to launch the family dependency court. "The family treatment court would allow me to wrap my arms around the whole family situation and I think that would help break the cycle," he said.

Chief Superior Court Judge Gil McBride said the parent

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ACCOUNTABILITY COURTS *(Continued from page 8)*

child support court will be another way to help families trapped in the judicial system and also address the foster care crisis in the community. He said the new court, scheduled to start in the Spring, will be the first civil accountability court in the Chattahoochee County, Georgia, Judicial Circuit.

"The legislature and the Governor have come up with funding for a caseworker to help these parents—usually dads but some moms, too—to reconnect with their children, to find employment, to get job training skill, and other things that are part of the problem," he said.

Many of the accountability courts go beyond supervisory services provided in the courtroom. In addition to city Crime Prevention and state funds, Muscogee County's Adult Drug Court recently received a competitive federal grant, amounting to a total of $975,000. The grant, funded by the Substance Abuse and Mental Health Services Administration, provides $325,000 annually, renewable for up to 3 years.

Dayna Solomon, adult drug court coordinator, said the money is being used to add 30 to 40 additional cases, provide 16 transitional housing beds for program participants, and establish the court's own medication assistance program in partnership with New Horizons Behavioral Health. The medication assistance program will focus on treating people with opiate and heroin addictions, primarily using an opioid blocker called Vivitrol, which is injected once-a-month. Solomon said the services are very much needed in the community and the court is developing a sustainability plan to continue with the services after the 3-year grant period.

Even before receiving the grant, the Adult Drug Court had its own drug screening lab at the Government Center, where participants are screened three to five times per week. It's also used by the Mental Health Court.

The Adult Drug Court is held every Wednesday in Jordan's courtroom. Participants go through a five-phase program and are rewarded for their progress at every level. In addition to regular drug screenings and treatment, they're also required to set goals and keep journals, which the judge reads in court.

Each case is managed by a team that consists of court personnel, a caseworker, someone from the District Attorney's Office, and mental health and substance abuse professionals. When all phases are completed, participants graduate out of the program.

Jordan said individuals with a history of gang activity or violent crime aren't allowed in the program. Prospective participants are referred by private attorneys, public defenders, law enforcement officers, relatives, and other sources. To participate, they must be approved by the District Attorney's Office.

The program has reduced the recidivism rate among Adult Drug Court participants by 78%, Jordan said. And that's one of the biggest benefits of accountability courts. "We are taking those people who are in and out of jail constantly," said Solomon. "That's how we're saving the state and the taxpayers' dollars. We're taking the people who should be incarcerated otherwise."

Excerpted from an article (by Alva James-Johnson) in the December 12, 2016 issue of the *Ledger-Enquirer,* Columbus, Georgia, page 1A.

CORRECTIONS AND APOLOGIES

In the April 2017 issue of *The IACFP Newsletter,* we failed to provide the full university name for Dr. Becky Nash's article titled, "The Application of Network Analysis in the Study of White Collar Crime, Terrorism, and Counter-Terrorism Strategies" on p. 22. Her complete author line is: Becky Nash, Ph.D., School of Criminology, Criminal Justice, and Emergency Management, California State University, Long Beach, Long Beach, California. We apologize for any confusion and/or inconvenience.

GEORGIA HAS HIGHEST CORRECTIONS RATIO IN THE U.S.

Though Georgia has made great strides reforming its criminal justice system in recent years, the state still has the highest percentage of people under correctional control in the nation, experts said on February 2, 2017. "The Prison Policy Group out of Massachusetts just published a report that accentuated what many of us know, that Georgia not only has the highest number of people under correctional control, we have double the amount of people compared to any other state," said Douglas B. Ammar, Executive Director of the Georgia Justice Project. "... We have almost 6,000 people per 100,000 in jail, prison, probation, or parole."

Ammar made the comments at a Justice Day at the Capitol event held January 26, 2017, in Atlanta. The meeting drew more than 250 people to the capitol building to lobby in favor of criminal justice reform. Sponsoring organizations included the Georgia Justice Project, American Civil Liberties Union, Emory Law School Barton Child Law and Policy Center, Georgia Appleseed, Georgia State Conference of the NAACP, the Georgia Public Policy Foundation, and the Southern Center for Human Rights.

Among those in attendance were several Columbus, Georgia, residents who met briefly with State Senator Josh McKoon, as well as State Representatives Calvin Smyre, Carolyn Hugley, and Debbie Buckner. The group included some members of the local branch of the National Association for the Advancement of Colored People. Waleisah Wilson, a local advocate for ex-felons trying to reenter society, served as one of the speakers, sharing her personal experience as an ex-felon.

The gathering started at Central Presbyterian Church, across from the State Capitol building. The Reverand Raphael Gamaliel Warnock, pastor of the historic Ebenezer Baptist Church in Atlanta, described mass incarceration as the most pressing civil rights and moral issue facing this generation. He reminded the audience of the significant role Atlanta played in the Civil Rights Movement, and challenged the group to continue fighting for justice. "We have to keep reminding our people that 'The Land of the Free' is the incarceration capital of the world," he said. "... All of the regimes whose human rights we like to deplore, none of them come close—not Iran ... not North Korea, not China.

"We're 5% of the world population, and we warehouse 25% of the world's prisoners," he continued. "That's a human rights catastrophe. And it's something—whatever your faith tradition, by whatever name you call God—it ought to raise your moral ire to say, 'No, we can't live with this.' "

Warnock said his church held the first Expungement Day in the state in October, 2016, streamlining the process for ex-prisoners who wanted their records expunged. He said the effort was coordinated by the congregation's nonprofit arm, the Martin Luther King Sr. Community Resources Collaborative.

"It's really a miracle," he said. "I discovered doing this work that our government agencies are not used to cooperating with one another. So we had to bring them all to church and pray over them, and suddenly the Public Defender's Office, District Attorney's Office, the Sheriff's Office, the GBI, and the judges were all there, cooperating with one another. And it was just amazing.

"Literally hundreds of people came through the door, and we were able to get dozens of records restricted that day," he said. Throughout the day, several people commended Governor Nathan Deal for his criminal justice reform initiative, which has reduced the prison population and placed Georgia at the forefront of reform throughout the country.

Stacey Abrams, the House Minority Leader, who is Democrat, was among those who praised the Governor. "Governor Nathan Deal has done something extraordinary in Georgia," she said. "This is coming from someone on the other side of the aisle, but on the same side of the issue."

Before walking to the Capitol building, each participant was given a packet containing a legislative summary with proposed House bills they were asked to lobby for and against.

(Continued on page 11)

CORRECTIONS RATIO *(Continued from page 10)*

The bills the group supported were described as follows:

• HB 151 prevents correctional officials from shackling women who are incarcerated during labor and delivery.

• HB 53 raises the age for juvenile court jurisdiction from 17 to 18, which would prevent 17-year-olds from being tried as adults.

The bills they opposed were explained this way:

• HB 34 modifies certain parole and pardon procedures, which would make it more difficult for some people to be released from prison.

• HB 116 expands the list of offenses for which a young person can face charges in adult criminal court, which would make it easier for more young people to be tried outside of the juvenile court system.

After the morning session, participants walked across to the Capitol building and requested meetings with their legislators. McKoon, a Republican, stepped out of the Senate chamber to meet with the Columbus delegation. When the group asked him about House Bills 151 and 53, he said they seemed like legislation he could support, but he'd have to do some research.

He also encouraged the group to push for legislation that would allow an ex-prisoner's criminal record to automatically be restricted after a period of time. "How long are you punished after you have done your sentence and been a productive member of society?" he asked. "How long do we brand people that way? And so, that's something that Georgia really needs to look at."

Later, the group met with Smyre, Hugley and Buckner on the House side of the building. The three Democrats said they would also look into the proposed bills. "Anything we can do to lower our prison population in Georgia I favor," Smyre said. "It's been spiraling out of control, and that has an effect on our budget. We need to continue to work toward bringing down the prison population."

Excerpted from an article (by Alva James-Johnson) in the February 3, 2017 issue of the *Ledger-Enquirer,* Columbus, Georgia, page 1A.

GEORGIA LEADS NATION IN NUMBER OF EXECUTIONS AS TEXAS SLOWS

Georgia led the nation this year in the number of inmates put to death, an anomaly that's due at least in part to executions in Texas dipping into single digits for the first time in 20 years. With nine lethal injections in 2016, Georgia accounted for nearly half of the 20 executions nationwide. It was the most inmates the state has put to death in a calendar year since the U.S. Supreme Court allowed executions to resume 40 years ago. It was almost twice as many as the state's previous record of five, set in 1987 and matched last year.

Texas, meanwhile, executed seven inmates, the fewest the state has put to death since 1996, when three people were executed. Alabama had two executions, and Florida and Missouri had one apiece.

Executions and new death sentences have been on the decline in recent years for a variety of reasons, and that continued in 2016. Even as Georgia carried out 14 executions in 2015 and 2016, no new death sentences were imposed in the state. Texas sent four people to death row in 2016 and two in 2015.

Georgia typically sets an execution date once an inmate has exhausted all of his appeals. In recent years, however, executions have been halted for months at a time, essentially creating a backlog of inmates who were eligible for execution that was cleared this year.

A legal challenge to the change in the execution method from three drugs to one drug stopped executions in Georgia from July 2012 to February 2013. Executions paused again from July 2013 to May 2014 while lawyers challenged a law that makes secret the source of the state's execution drugs. And another lull came from March to September 2015 after a drug intended for use in an execution was found to have precipitated, leaving solid chunks floating in what should have been a clear solution. There are currently no Georgia inmates who are eligible for execution, according to the Attorney General's Office, and the state is unlikely to have another record year in 2017. In Texas, a dozen condemned inmates had their scheduled executions postponed in 2016, some more than once, according to records kept by the Death Penalty Information Center, a nonprofit that provides analysis and information about capital punishment.

"A combination of factors led to the 20-year low in Texas," said Kathryn Kase, Executive Director of the Texas Defender Service. "The state was the first in the country to create a junk science writ, which can give defense attorneys an opportunity to reopen convictions and ask the courts to take a closer look if evidence used to convict the inmate is no longer considered scientifically sound," she said.

The state's highest court, the Court of Criminal Appeals, has been raising more questions than in the past, causing cases

(Continued on page 12)

NUMBER OF EXECUTIONS *(Continued from page 11)*

to be delayed. And the U.S. Supreme Court has continued to consider challenges to practices used in Texas, including taking two cases this fall, Kase said. "We've got a hell of a lot of reform going on in a lot of different spheres," she said. "But that is owed to Texas' very shameful record of a broken capital justice system." Texas already has scheduled nine executions for the first half of 2017. There's no way to know how many will happen, Kase said.

One thing Georgia and Texas have in common that has allowed them to execute more inmates than other states is a seemingly reliable supply of execution drugs. Both states use pentobarbital made by compounding pharmacies whose identities are shielded by law. That has allowed them to overcome shortages caused when traditional drug manufacturers, some bowing to pressure from opponents of capital punishment, refused to sell their products for use in lethal injections. Ohio, on the other hand, postponed all scheduled executions in 2016 because the state wasn't able to secure the drugs it needed, and other states also have struggled to get the necessary drugs.

"Other states slowed their pace because courts have declared death penalty statutes and systemic practices unconstitutional, said Death Penalty Information Center Executive Director Robert Dunham. "That has ended up reversing sentences in cases where people might have been executed otherwise," he said.

Excerpted from an article (by Kate Brumback) in the December 21, 2016 issue of the *Ledger-Enquirer,* Columbus, Georgia, page 20A.

A BOOK REVIEW SUMMARY R.C. SMITH'S *SOCIETY AND SOCIAL PATHOLOGY: A FRAMEWORK FOR PROGRESS*

Richard Althouse, Ph.D., At-large Member of the IACFP Executive Board, former IACFP President, and former Chair of the IACFP Executive Board
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R. C. Smith believes that our traditional way of thinking about social pathology is wrong, and opens the introduction to his book with a question penned by Erich Fromm: "Can society actually be sick?" With that question in mind, Smith sets out to provide the most comprehensive answer to Fromm's question, opining that society is not only ailing and in crisis, it is caught in a pathological circle of ritual social crises. Looking at the prevalence of "unreason and irrationality" in contemporary society, he concludes that the conditions of modern capitalism have introduced new social, economic, and political forces that, over time, naturalize needless suffering and irrationality and leads to a tolerance of hunger, poverty, and other forms of human suffering that persist, despite the technological and scientific potential to mitigate or eliminate them altogether.

The most fundamental point in Smith's book is his emphasis on social structures that affect individuals rather than defining social pathology by how individuals behave in ways that offend society, and promoting the identification of systemic links among a variety of ailments that suggest an underlying social pathology. Although focusing on other symptoms of an ailing society, there is no doubt that much of what Smith elucidates and proposes can be applied to our criminal justice system and treatment of offenders.

Smith draws from a variety of sources to support his position, from cognitive science to anthropology to critical systems theory and psychology to offer one of the most comprehensive studies of social pathology to date as well as recommendations for a more humanistic approach to mitigate needless human suffering. I found Smith's book very thought-provoking. His book is one of a number of books that are part of the "Critical Political Theory and Radical Practice" series sponsored by Springer Publishers.

Letters to the Editor

We would like to hear from you about our newsletter. Please let us know if the articles or material provide helpful/useful information. What other articles or material would you suggest or recommend? Please send your letter to:
smithr@marshall.edu

ICPA'S 19TH AGM AND CONFERENCE

Event Start Date: 22 October 2017
Event End Date: 27 October 2017
Event Theme: Innovation in Rehabilitation: Building Better Futures
Location: Novotel London West, London, United Kingdom

In joint collaboration with the National Offender Management Service, ICPA is pleased to invite corrections professionals from around the world to attend our 19th Annual Conference in London, 22-27 October 2017. The theme for this event is: "Innovation In Rehabilitation: Building Better Futures" where delegates can expect to learn about the latest approaches, ideas, and technologies in relation to the rehabilitation of offenders and their reintegration into the community.

Join us in London at the largest annual gathering of international corrections professionals with a huge variety of presentations and topics across a full 6-day programme of events. Network with like-minded colleagues and experts, see the latest innovations, discuss real-world case studies, challenges, and solutions and much more. The conference will be held at the Novotel London West.

ICPA 2017—INNOVATION IN REHABILITATION: BUILDING BETTER FUTURES

The ICPA Programme Committee invites individuals, agencies, and organisations interested in presenting papers at the Association's 2017 Annual Conference to submit abstracts aligned to our 19th Annual Conference theme: "Innovation in Rehabilitation: Building Better Futures."

The conference, hosted by the National Offender Management Service (NOMS) will be held in London, United Kingdom, from October 22-27, 2017. With members from over 80 countries, the ICPA Conference is the foremost annual international gathering for correctional officials to learn from each other.

The Committee anticipates a conference agenda that reflects a strong focus on contemporary approaches, ideas, and technologies in relation to the rehabilitation of offenders and their reintegration into the community. The Committee is particularly interested in proposals that can provide a holistic overview of a program, service, or strategy. For example, a presentation of a program, may include co-author speakers with one addressing applied research findings and the other reviewing the results found by the practitioners who applied and implemented a practice based on the research. Any new technology to support the initiative could also be highlighted. For more information and to submit online, go to: icpa.ca/london2017

DOES THE DEATH PENALTY REDUCE THE MURDER RATE?

John A. Tures, Ph.D., LaGrange College, LaGrange, Georgia

The death penalty is under fire, as the U.S. Supreme Court debates whether or not the death penalty can be applied to convicted murderers with a low IQ, as justices question whether a person can be held accountable for actions that may not be fully understood. It seems an appropriate time to analyze the effectiveness of the death penalty in accomplishing its tasks: reducing the murder rate in the states where it has been applied.

To determine whether the death penalty has acted as an effective deterrent to murder, my Research Methods course students Katie Chancellor, Brandon Collins, Dan Garrett, Lauren Jones, Jeremy Maddox, Duncan Parker, Andy Peden, Nick Rawls, Lindsey Weathers, Karly Williams, and John Williamson contributed research to the report. We gathered data on which states have the death penalty, and which do not. We also examined whether both types of states have high or low murder rates for 2015.

We found that among the 25 states with the highest murder rate, 20 have the death penalty. These include Louisiana, Mississippi, Missouri, South Carolina, Alabama, Delaware, Nevada, Tennessee, Arkansas, Georgia, Oklahoma, Indiana, Florida, North Carolina, Pennsylvania, California, Texas, Kentucky, Virginia, and Arizona). Five states (Maryland, Alaska, Illinois, Michigan, and New Mexico) also have high murder rates, but not the death penalty.

Among the 25 states with low murder rates, 11 have the death penalty (Kansas, Ohio, South Dakota, Montana, Colorado, Washington, Wyoming, Oregon, Idaho, Utah, and New Hampshire). The other 14 states with low murder rates don't have the death penalty. They include Wisconsin, New Jersey, West Virginia, Connecticut, Nebraska, New York, North Dakota, Rhode Island, Minnesota, Iowa, Massachusetts, Maine, Vermont, and Hawaii.

For those keeping score, these results are far higher than what an expected model would show. Having the death penalty means you're more likely to be a state with a high murder rate as well, just as states which have eliminated the death penalty are, more likely than not, to have abolished the practice, or never ratified it. That's not good when you're trying to show that the death penalty deters serious crime.

I challenged my students to think of all kinds of reasons for the results. Some of the more conservative ones challenged the findings. One claimed that perhaps because it's some states have not executed anyone in a while. Others speculated on why the findings may have turned out the way they did.

This study replicates an earlier study I did with students nearly 5 years ago. Both showed that the observed cases were significantly different from what's expected from a random model (multiplying the relevant column by the relevant row and divide by the total number of cases). It's the same with our 2016 study.

Of course, there could be another explanation for the results. States may have the death penalty not as a deterrent, but due in response to higher crime rates (it would be interesting to run a time series model) to see which came first. Or it could be that the electric chair, gas chamber, hanging, firing squad, and legal injection are not used to deter crime, but for revenge, or to punish those arrested for breaking the laws for murder. Nevertheless, the inability of the death penalty to deter serious crimes should give its supporters some reason to question the effectiveness of capital punishment.

Excerpted from an article (by Dr. John A. Tures) in the December 3, 2016 issue of the *Ledger-Enquirer,* Columbus, Georgia, page 9A.

EGO, IDEOLOGY, PARANOIA: WHY DO KILLERS REPRESENT THEMSELVES?

By representing himself in the penalty phase of his trial for the church massacre in Charleston, South Carolina, Dylann Roof joins a roster of notorious killers who have gone that route—a list that could serve as a caution to anyone considering following their lead. Some criminal defendants who act as their own lawyers want a stage to promote an ideology; some apparently want the spotlight or think they can fare better than a real lawyer; some are too controlling to let anyone else be in charge; some are too paranoid to trust lawyers; and some are just delusional. Whatever the motive, it rarely ends well for the defendant. Judges routinely advise against it, and often insist that court-appointed counsel be on hand as a backup.

The Fort Hood Killer

Nidal Malik Hasan, in jail in Belton, Texas, in April 2010. Credit Bell County Sheriffs Department, via Associated Press Nidal Malik Hasan, an Army Major and a psychiatrist, killed 13 people and injured 30 in a shooting spree at Fort Hood, Texas, in 2009. He represented himself in his military trial, telling the court that he had, in effect, switched sides in the war in Afghanistan, and that his motive had been to defend the Taliban.

But Major Hasan made no attempt to grandstand at his trial, barely questioning prosecution witnesses, calling none of his own, and making no major statements. The lawyers appointed by the court to advise him indicated that his goal was to be executed and become a martyr. In 2013, he was convicted on all counts and sentenced to death.

The Beltway Sniper

John Allen Muhammad masterminded and carried out a series of seemingly random shootings that terrorized the Washington area in 2002, and he and his teenage accomplice, Lee Boyd Malvo, were suspected in as many as two dozen killings in several states around the country.

Muhammad insisted on representing himself at his two trials, in Virginia and Maryland, maintaining that he had nothing to do with the attacks and that he had been framed. His second trial featured the odd spectacle of his cross-examining Malvo.

Muhammad was found guilty of all seven murder counts against him, and he was executed by the State of Virginia in 2009. Malvo was sentenced to life in prison.

The 9/11 Terrorist

Accused of being one of the plotters behind the September 11, 2001, terror attacks, Zacarias Moussaoui, acted as his own lawyer, requesting access to witnesses and documents that the government said would create a national security risk, leading to years of legal wrangling.

Moussaoui, who prosecutors claimed had planned to be one of the September 11 hijackers, repeatedly denied involvement in the attacks, but declared "I am a member of Al Qaeda," and stated in court papers that he was "a Muslim fundamentalist openly hostile to the Jews and the United States of America."

He eventually pleaded guilty to the charges against him, but still insisted that they were mostly wrong, factually. Rather than being involved on September 11, he said he was planning a different terrorist attack. He was sentenced to life in prison.

The Long Island Railroad Shooter

Long before he killed six people and wounded 19 on a Long Island Railroad commuter train in 1993, Colin Ferguson held to an angry, violent, and paranoid view of the world, in which Ferguson, who is Black, was routinely conspired against by White people. Seemingly holding firm to his delusions after the shooting, he rejected his lawyers' efforts to have him declared mentally unfit, and shunted them aside. Instead, he represented himself at trial, shouting "objection" at odd moments, asking apparently pointless questions of witnesses, referring to himself in the third person, claiming that someone else had committed the shootings with Ferguson's gun, and asking the judge to provide money to hire an investigator to find the "real" killer. He was convicted on all counts and sentenced to 315 years to life in prison.

The Serial Killer

One of the most prolific serial killers in American history, Ted Bundy defended himself at his murder trials in 1979; one of the lawyers assigned to advise him said he simply could not relinquish control, or admit guilt in return for a life sentence. The smarts and charm he had always relied on reached their limits in court. At two trials, he was found guilty of a total of three murders and three attempted murders, among other charges.

A suspect in many killings spread across the country,

(Continued on page 16)

KILLERS REPRESENT *(Continued from page 15)*

Bundy had been the subject of a long-running manhunt, escaping from custody twice before being caught for good. Sentenced to death in the Florida cases, he was executed in 1989. Shortly before he was put to death, he confessed to more than 30 murders, including some that investigators had not linked him to, and officials said they would never know the real toll.

Excerpted from an article (by Richard Perez, *New York Times*) in the January 8, 2017 issue of the *Ledger-Enquirer,* Columbus, Georgia, page 5A.

10TH EUROPEAN CONGRESS ON VIOLENCE IN CLINICAL PSYCHIATRY

On behalf of the scientific committee, we invite psychiatrists, practitioners, psychiatric mental health nurses, psychologists, health scientists, educators, trainers, researchers, managers, and policymakers engaged in the prevention, management, research into violence and aggression in mental health and intellectual disability settings to submit an abstract and/or attend the 10th European Congress on Violence in Clinical Psychiatry to be held in Dublin, Ireland, 26-28 October 2017. Since the first European Congress on Violence in Clinical Psychiatry, the meeting has expanded rapidly in terms of the number of scientific contributions and participants; the previous Congress in Copenhagen in 2015 was attended by more than 600 participants from 36 countries.

The 10th European Congress on Violence in Clinical Psychiatry is co-organized by the European Violence in Psychiatry Research Group (EViPRG) and the European Network for Training in the Management of Aggression (ENTMA08), and is a World Psychiatric Association (WPA) co-sponsored meeting. The 10th European Congress on Violence will focus strongly on clinically relevant and practically useful interdisciplinary scientific and practical knowledge with regard to interventions aimed at treating and reducing violence and aggression. The overall Congress theme: "Creating Collaborative Care: A Multi-Partnership Approach" reflects our commitment to partnership working between clinicians, researchers, educators, service users, and carers.

In line with previous congresses in Vienna (2005), Amsterdam (2007), Stockholm (2009), Prague (2011), Ghent (2013) and Copenhagen (2015) all contributions to the 10th European Congress on Violence in Clinical Psychiatry will be published in a "book of proceedings" reflecting the current state of knowledge about, and research into the prevention and management of violence and aggression in mental health and intellectual disability settings and the training and education of staff.

The Congress provides a wonderful opportunity to network and establish contacts with a diverse community of colleagues engaged in this important area of work. Apart from the geographical diversity of delegates, the Congress program reflects multiple perspectives including clinical/service, organizational, educational, research and regulatory.

Approval of accreditation will be requested from the World Psychiatric Association (WPA) for the award of Continuing Medical Education (CME) Credits, and from the International Council of Nurses (ICN) for the award of International Continuing Nursing Education Credits (ICNECs). We cordially welcome you to Dublin, Ireland, October 2017. For more information, go to: oudconsultancy.nl/dublin_10_ECVCP_2017

VIGNETTES OF GLIMPSES INSIDE

Ronald R. Mellen, Ph.D., Professor, Department of Criminal Justice, Jacksonville State University, Jacksonville, Alabama, and an IACFP Member
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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 max and 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. Another vignette titled: *Be Flexible and Watch Your Back* follows below.

BE FLEXIBLE AND WATCH YOUR BACK

Nyer was about 50 years old and had been in prison for many years. While his intellect was at least average, his voice made him sound mentally retarded. This was the end result of his jaw bone being noticeably extended, even in repose. Seems, that as a young man, he had raped a young girl and the family had caught him. Before he could leave the house certain family members beat him, as some say, "unto the edge of his life." Only then did the family call the sheriff's department.

As a result of that offense, Nyer was in prison completing a life-without-parole sentence. His reputation in the unit was one of being a "nuisance" inmate—not dangerous, but generally driving the Correctional Officers to the edge of violent themselves. Because of his behaviors and the resulting strain on the officers, he was frequently moved between the Arkansas' Department of Corrections (DOC) two mental health units, about every 3 to 4 months.

One of Nyer's problematic behaviors was a sexual obsession. He was quite proud regarding the large size of his penis and would harass other inmates trying to engage them sexually. When that didn't provide the human "connection" he desired he would masturbate in the dayroom area. Nyer proved unresponsive to staff efforts at bringing a halt to the dayroom activity. Consequently, his counselor, rising above principle, wrote up a treatment plan that allowed him to masturbate but only in his cell with the door shut and his back to the door. Nyer agreed and signed the document. Because all sexual behavior is prohibited in the DOC, she had the unit psychologist, psychiatrist, and warden also sign the treatment plan.

After 2 weeks, the unit's Lieutenant came to the counselor's office and stated "Now we've got him!" He then showed her a Polaroid picture of Nyer masturbating. She asked, Was he in his room? Yes! Was the door shut? Yes! Was his back to the cell door? Yes! (she did not ask how the Lieutenant got the picture). She then told the Lieutenant that the inmate's behavior was within the treatment plan and while disgusting still acceptable. At which point the Lieutenant demanded to see the document. After reviewing it, the Lieutenant stormed out of the office.

A few days later, two inmates warned the counselor regarding comments they overheard from the Lieutenant. The inmates' advice to the counselor was "You better watch your back!" Interestingly enough, Nyer adhered to the treatment plan from then on.

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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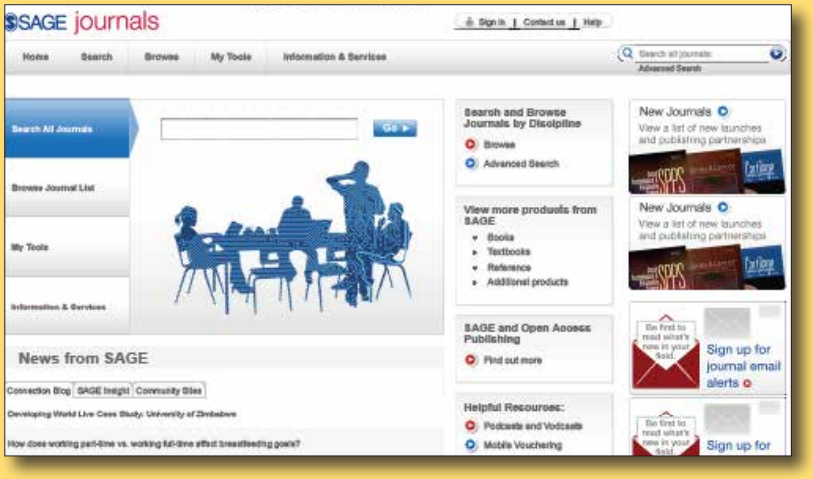

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(Continued on page 21)

42ND ANNUAL TRAINING INSTITUTE *(Continued from page 20)*

MENTAL HEALTH COURT SHOWING GAINS

A newspaper investigative series appears to be bringing a Florida mental health court back on track after a backlog of more than 1,200 cases led to many mentally ill defendants spending years in lockup without resolution of charges they faced. The *Sun Sentinel,* the main daily newspaper for Broward County and surrounding south Florida areas, began its investigation in January of last year, and the problems it exposed led to better use of a diversion program copied from one in Miami-Dade County. Judge Ari Porth, one of two judges assigned to the mental health court, told the paper its probe has led to more mentally ill defenders receiving treatment through the diversion effort and having the criminal charges against them dropped.

The felony mental health court was established in 2003 as a way to help people prepare for trial and get treatment, but for years prosecutors refused to let go of even minor, nonviolent cases involving mentally ill people too sick to face their charges. That began to change after the newspaper showed that the average defendant in the mental health court waited more than 3 years to have a case heard compared with 6 months in the regular court. Many simply languished in jail because no treatment beds were available.

Now, candidates for the diversion program are evaluated by psychologist Michael Collins, Ph.D. If he diagnoses them with a severe mental illness and the state attorney general approves, they can enter the diversion treatment program that provides individual and group counseling along with medication.

The 60 slots available in the $300,000 diversion program are full, but some began completing treatment in February to make room for others on a waiting list. Collins would like to see the program expanded. More than 380 cases were referred to the program for evaluation through the end of 2016. Most were denied, but many remain pending. "We still have individuals who have been approved by the state but are waiting to be evaluated," Collins told the *Sun Sentinel,* adding, "The referrals aren't going away."

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U.S. Department of Justice

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For more detailed information on these regional vacancies, please visit our website at: bop.gov under the Careers section (see top navigation bar).

Public Law 100-238 precludes initial appointment of candidates after they have reached their 37th birthday. However, waivers can be obtained for highly-qualified applicants in this field prior to their 40th birthday. To qualify for a position, the applicant must pass a background investigation and urinalysis.

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ICCA is looking forward to welcoming two of our keynote speakers to this year's conference:

Faith Lutze, Ph.D., Washington State University
Presenting Tuesday, October 31, 2017

Faith E. Lutze, Ph.D., is a Professor in the Department of Criminal Justice and Criminology at Washington State University. She received her M.A. in Criminal Justice from the University of Cincinnati in 1988 and her Ph.D. in the Administration of Justice from the Pennsylvania State University in 1996. Her current research interests include drug courts, the professional role of community corrections officers, offender adjustment to community corrections supervision, violence against women, and gender and justice with an emphasis on masculinity in prisons. She currently teaches criminal justice courses related to corrections, violence toward women, ethics, and gender and justice. Dr. Lutze has published the results of her research in various journals including *Justice Quarterly, Crime & Delinquency, Criminology and Public Policy,* and *The Journal of Criminal Justice*. She is also the recipient of the Coremae Richey Mann Leadership Award (2010) presented by the Minorities and Women Section of ACJS, the ACJS Corrections Section Award (2010) for scholarship and service in corrections, and the WSU Presidents Award for Leadership (2013).

Richard Cho, The Council of State Governments
Presenting Wednesday, November 1, 2017

Richard Cho is a nationally-recognized expert on the intersection of homelessness and criminal justice system involvement, and on the intersection of health care and housing. Before joining the Justice Center, he served as Deputy Director of the United States Interagency Council on Homelessness (USICH), the agency that leads the federal government's response to homelessness. Prior to his time at USICH, Mr. Cho served as the Director of Innovations and Research at the Corporation for Supportive Housing. He advised the City and State of New York in the design and implementation of the $1 billion New York/New York Supportive Housing Initiative. He also helped guide the implementation of New York City's Housing First program for people with active substance use disorders. Mr. Cho has a B.A. from the University of Chicago, an M.A. in city planning from the Massachusetts Institute of Technology, and is completing a Ph.D. in public administration at

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MENTAL HEALTH COURTS: A WORKAROUND FOR A BROKEN MENTAL HEALTH SYSTEM

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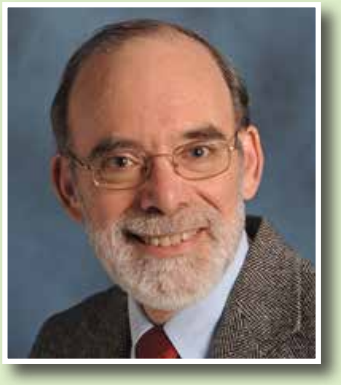

PAUL S. APPELBAUM

In the mid-1990s, Florida's Broward County had a problem. With a paucity of available mental health programs, police often had no alternative to arrest for people who were behaving bizarrely on the streets. Growing numbers of defendants with serious mental illnesses were appearing in criminal court, charged with crimes such as trespassing that often seemed driven by their disorders. After a short jail stay, usually without treatment, their charges would be dismissed or sentences reduced to time served by judges who knew that their reappearance in court was almost inevitable.

Judges around the country, usually with no background in mental health, faced dockets clogged with similar cases. Epidemiologic surveys of jails and prisons found that 14 to 24% of inmates suffered from serious mental illnesses, conditions more often neglected than treated during confinement. With little public interest in funding adequate services, the problem of how to deal with persons with mental disorders was being left to the already overburdened criminal justice system. Broward County, though, decided to do something to try to tackle the problem: it established the first mental health court (MHC) in the United States.

Drawing on the earlier model of drug courts, aimed at treating rather than punishing addicts, MHCs were designed to divert defendants with serious mental illnesses from the criminal justice system. Models differ across jurisdictions: some MHCs intervene before trial, others only after a finding of guilt; misdemeanants are the exclusive focus of the Broward court, but defendants accused of felonies are also eligible in some places; most MHCs don't control their own treatment resources, but a small number—like the Miami-Dade Program in South Florida—do. Violent or sexual offenders are often excluded from participation, and some jurisdictions impose other limitations. What they have in common is the ability to offer defendants the opportunity to avoid jail or prison time if they agree to follow a court-approved treatment plan. The MHC participation is always voluntary, but participants who complete the program will have charges dropped or sentences suspended. However, failure to abide by the terms of the program can result in a return to the criminal justice system and the prospect of doing time.

The MHCs are often paired with other reforms aimed at keeping the mentally ill out of jail. In Allegheny County, Pennsylvania, hundreds of police officers have gone through a 40-hour "crisis intervention team (CIT)" training course on how to manage individuals with mental illnesses. These cops wear small blue CIT badges that signal to street people with mental illnesses that they are dealing with officers who understand their conditions and aren't interested in putting them behind bars. As an alternative to jail, police can escort those who commit minor crimes or disturbances—such as a man who repeatedly tried to direct traffic on a busy main thoroughfare, according to the *Pittsburgh Post-Gazette*—to special units at local hospitals.

The MHCs have become extremely popular, perhaps not surprisingly given the ubiquity of the problem they are meant to address. At last count, there were 357 adult MHCs in the U.S. and another 60 tribunals dealing with juveniles. The MHC model has been adopted in other countries, including Canada and Australia, and has spawned a similar approach for veterans of the armed forces, who often have a combination of mental health and substance abuse problems. Several of the bipartisan legislative proposals stutter-stepping their way through Congress in 2016 would encouraged additional jurisdictions to create MHC programs. But as with so many public policy initiatives, enthusiasm for MHCs has often outstripped the evidence for their effectiveness and advocates tend to ignore the downsides of the programs.

What do we know about how well MHCs work? After some early equivocal findings, most recent studies have confirmed that MHC participation is associated with reduced rates of rearrest and reincarceration compared with ordinary handling by the courts and correctional system. A newly-published study of the District of Columbia MHC, for example, found that 25% of misdemeanor defendants with serious mental illnesses who "graduated" from the program were rearrested within 2 years, compared with 48% of defendants who were eligible for the program but didn't enter it. (Interestingly, MHC dropouts had the highest recidivism rates of all, at 55%.) Similarly, positive results come from Ramsey County, Minnesota: misdemeanants

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who went through the usual criminal process were two and a half times more likely to be convicted in their first year in the community and served almost five times as many days in jail in that period compared with MHC completers.

Although it is often assumed that reducing rearrest and incarceration will result in a net savings, data on costs associated with MHCs has been inconsistent. A Rand Corporation evaluation of the MHC in Allegheny County, Pennsylvania, suggested that savings begin to accrue after the first 18 months of participation, largely accounted for by reduced jail time. However, an analysis of four MHCs in different parts of the country funded by the John D. and Catherine T. MacArthur Foundation showed that MHC involvement led to increased annual costs of $4,000 per participant compared with a matched group of non-MHC jail detainees, as the costs of enhanced mental health treatment consistently exceeded the savings from fewer days of incarceration. When it comes to dealing with offenders with serious mental illnesses, MHCs are not offering a free lunch.

What has been harder for researchers to pin down is why MHCs seem to work. Advocates for MHCs, perhaps not unreasonably, assumed that many of the charges faced by defendants eligible for the programs stemmed from behaviors related to the illnesses themselves. Perhaps the euphoria and grandiosity associated with a manic state might lead to the kind of public rowdiness that could result in a charge of disorderly conduct. Or the delusional thinking seen in acute psychosis could cause a homeless person to believe that he owned all the retail stores in the city and hence, to walk out of a convenience store without paying for a candy bar. Treat the symptoms of the underlying illnesses, the theory went, and the criminal behavior would go away. Although that commonsense proposition has been remarkably difficult to substantiate, a recent reanalysis of data from the MacArthur Foundation study has confirmed that increased medication compliance and use of mental health services were linked to significantly lower rates of arrest. Nonetheless, it's still possible that more intensive supervision or other nonspecific factors play a role in reducing recidivism, too. Family members desperate to obtain treatment for a loved one may see no alternative but to have the person arrested, hoping detention will lead to diversion to a mental health court.

Family members desperate to obtain treatment for a loved one may see no alternative but to have the person arrested, hoping detention will lead to diversion to a mental health court.

Often neglected in the rush to embrace the MHC model are the limitations and potential negative effects of the approach. Since MHCs rarely control their own mental health services, the treatment plans they can impose are necessarily limited by what is available in a given area. Thus, participants who need a service that no local provider offers are simply out of luck. Moreover, given that community mental health services are "maxed out" in many locales, often with waiting lists of weeks or months in duration, creation of an MHC may simply alter who gets access to a scarce resource. Even if a judge's order jumps an MHC participant to the head of the queue, it will only be at the cost of another person with serious mental illness who has never broken the law but now will have to wait even longer for help. In short, MHCs are not an easy solution to the problem of an underfunded mental health system.

Moreover, given that community mental health services are "maxed out" in many locales, often with waiting lists of weeks or months in duration, creation of an MHC may simply alter who gets access to a scarce resource.

Embedding access to mental health treatment in the criminal justice system can have other perverse effects as well. Family members desperate to obtain treatment for a loved one may see no alternative but to have the person arrested, hoping detention will lead to diversion to an MHC. In addition to the risk associated with an encounter with the police—nearly a quarter of victims of police killings each year have an identifiable mental illness—an arrest record can lead to subsequent difficulty finding housing, getting a job, and accessing community services, all consequences of endowing a person with the dual stigmata of mental illness and a criminal record. Yet, the temptation to gain access to treatment by characterizing illness-related behavior as criminal is real. The ironic result may be an increased flow of people with serious mental illnesses into the criminal justice system, exactly the opposite of the original goal.

Finally, we need to acknowledge the paradox of the "success" of MHCs: if adequate community-based services and

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hospital beds were available for the treatment of serious mental illnesses, it is unlikely that Broward County and the hundreds of jurisdictions that have followed its lead would have developed MHCs in the first place. To be sure, even with an optimal system of mental health care some people with mental illnesses would end up facing charges and could benefit from MHCs and other diversion programs. But as we listen to politicians, bureaucrats, and others extol the MHC model, we would do well to keep in mind that it is only a workaround. Ultimately, our badly funded and poorly organized mental health system itself needs to be addressed in a more thoughtful and systematic way.

References available from the author.

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PSYCHOLOGY'S ROLE IN THE NATIONAL DRUG EPIDEMIC

Jodi Andes, B.S., Associate Editor, The National Psychologist, and a former newspaper and television journalist currently working on a True-Crime Book about one of the nation's greatest con artists
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JODI ANDES

Drug overdose deaths continue to soar, while the prescriptions of opioids continue at alarming levels and public discontent has been overflowing into the streets. Those are signs that the nation's drug epidemic is not likely to level off anytime soon and may continue to worsen. But is there anything psychologists can and should be doing to help fight this epidemic? Psychologists whose work has them on the front lines of the problem say yes and advocate small steps that could help curb the problem.

Amanda Merchant, Ph.D., is a clinical psychologist and the past president of the Kentucky Psychological Association who, in dealing with her work with chronic pain, has combated the problem for years. She said psychologists, no matter what their specialty, can help.

"Because of the widespread nature, everyone needs to take a part now," Merchant said. "The opioid epidemic has affected everyone's life at this point whether through a family member, a friend, or your community."

For starters, psychologists can make small changes in their daily practices, such as adding new questions in initial evaluations. "We ask for medication lists, and use of substances like alcohol, smoking, and marijuana, but we often don't ask about use of pills like pain pills or anxiety medications for recreation use. As this has become more prevalent, we should try to ask more regularly. And if someone is prescribed potentially addictive medication, such as opioids or benzodiazepines, take time to assess for potential red flags for abuse or misuse," she said. Gleaning for such details could help better treat the patient and in return, help society.

There is no question the epidemic is getting worse. Deaths have been on the rise over the last 15 years with more than half a million people having died from addiction between 2000 and 2015. There is also little debate that opioids are a large part of the problem; six out of 10 of those deaths can be connected with opioids, according to the Centers for Disease Control (CDC). So the approach each psychologist takes with patients can make all the difference, said Gail

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PSYCHOLOGY'S ROLE *(Continued from page 26)*

F. Melson, Ph.D. Melson is a research psychologist and a Professor Emerita for the Department of Human Development and Family Studies at Purdue University and works with many graduate students as they prepare to enter the profession.

The effects of the epidemic are so broad they should be treated with the care of other widespread health issues, such as Ebola, she said. The U.S. government spent more than $2.3 billion in fighting Ebola, and there were 513 deaths in 2 years worldwide due to the disease, according to the CDC.

Melson said, "her point is not to disagree with how Ebola is handled, but rather to show how being proactive can make a difference. Consider," Melson said, "how societal issues like domestic abuse began to be more recognized and treated after the mental and medical profession took a more proactive approach in patient screening. Addiction should be viewed in the same light," she said. Questions about personal or family drug use will likely be as equally hard to get people talking about, but the conversation needs to start. "We need to think through a non-threatening but good way to get at that information," Melson said.

Another way psychologists can play a role in battling the epidemic is simply by treating patients once considered too transitional. A big problem with the epidemic is the lack of sufficient treatment beds; meaning even those who want to move into recovery must wait until space is available. Many psychologists don't like to treat someone in such a transitional phase, but this is not a typical illness. "Be willing to see people while they are waiting to get into treatment programs. Be that bridge," Merchant said.

"Overall, the psychologist's approach is key," she said. "There needs to be a community perspective. We are hearing a lot about stresses where factories shut down and people have a sense of hopelessness and depression. This makes them more vulnerable to addiction. If you only focused on the individual, you may never see the risks that could feed into the addiction."

"Addiction is spreading more into traditional practices than many people realize," Merchant said. For example, law enforcement agencies have closed pain clinics in many states that served as pill mills for virtually any patients who wanted drugs. The closures, though, mean that patients are going somewhere else for the drugs.

Some have turned to traditional physicians, who, as a result, are seeing addiction at rates greater than they have ever seen before. Psychologists helping physicians identify which patients are most at risk for addiction could make a significant difference. This approach only works if psychologists are willing to take the extra step and commonly communicate with more than just the patient.

"Be a part of the health care team. If you have a concern about opioid medication use or how it affects their medical care, get a release. It works better with a team approach," Merchant said. The last piece of advice from both is for psychologists to stay up to date. New information is becoming available regularly on neurobiology, substance abuse, and other aspects related to the disease, so taking continuing education courses on these topics are important.

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Overview

Breaking Free Group is an innovative, dynamic, and fast-growing digital healthcare company based in the UK.

It was founded in 2010 by Dr. Jonathan Ward, who practiced as a clinical psychologist before setting up leading psychological consultancy CPA.

The mission of Breaking Free Group is to create the widest possible access to evidence-based psychological interventions. To realise this, we have developed a powerful and adaptable digital health platform which targets the underlying psychological and lifestyle factors that drive addictive behaviours.

Based on this platform, our clinically-robust online programmes for alcohol and drug dependence overcome many of the key barriers to treatment and recovery—such as stigma, concerns about confidentiality, time constraints, and difficulties accessing substance misuse services or support groups.

Our programmes are helping people achieve measurable and enduring behavioural change in a diverse range of settings. We are evidencing this through systematic mixed-methods research in line with the Medical Research Council framework for developing and evaluating complex healthcare interventions. This research has led to a series of publication in UK and U.S. peer-reviewed journals.

Breaking Free Online is an evidence-based treatment and recovery programme that has been commissioned by over 60 local authorities and NHS Trusts across the UK, and adopted by several leading national substance misuse treatment providers, including CRI, Turning Point, and Addaction. It is augmented by Staying Free, a powerful relapse prevention toolkit in a mobile app that is now available on the Android and iOS platforms.

Breaking Free Online (Health and Justice) is the world's first online healthcare intervention for offenders to be implemented in prisons. It was developed in consultation with the Ministry of Justice, and has been commissioned by NHS England as an integral part of the Gateways pathfinder. This is a major UK Government initiative to reduce reoffending rates by improving the continuity of care between prison and the community.

Both versions of Breaking Free Online comply with National Institute for Health and Care Excellence guidance (CG51, CG90, CG113 and CG115) and the National Drug Treatment Monitoring System.

They are also accredited by leading awarding body OCR (Oxford Cambridge and Royal Society of Arts). This means that as well as facilitating recovery from substance dependence, for many people the programmes also provide a springboard to education, training, and employment.

Breaking Free Group won an E-Health Insider Award in 2012 and a Smarta 100 Award in 2014, and was a regional winner in the Most Innovation Small Business category of the Great Faces of British Business competition run by the UK Government in 2015.

Breaking Free Online is the world's first online healthcare intervention to be implemented within prisons.

It has been commissioned by NHC England as an integral part of Gateways, a pioneering 'Through the Gate' pathfinder.

It provides essential continuity of care between prison and the community.

Criminal justice services: prisons and probation

The Breaking Free Health and Justice interventions are two evidence-based treatment and recovery programmes for substance misuse and offending behaviour—Breaking Free Online and Pillars of Recovery—that have been developed specifically for use in prisons.

- Allows the consistent and seamless delivery of effective psychosocial interventions between custody and community settings.
- Approved by NOMS as an Effective Regime Intervention (PSO 4350), with the online component accessed via Virtual Campus.
- Commissioned on a licence basis so there are no restrictions on the number of offenders that can be treated.
- Strengthens 'through the gate' provision as offenders can use Breaking Free Online in prison and the community post-release.
- Guides offenders to plan for their release and take positive steps to avoid relapse and overdose.
- Builds recovery capital through Pillars of Recovery, a fully-manualised 12-session group and keyworking programme.

Also available are separate versions of the Breaking Free Health and Justice Interventions that have been tailored to the specific needs of probation services. This also includes Staying Free, an Android and iOS smartphone app that gives offenders an effective relapse prevention toolkit on their release.

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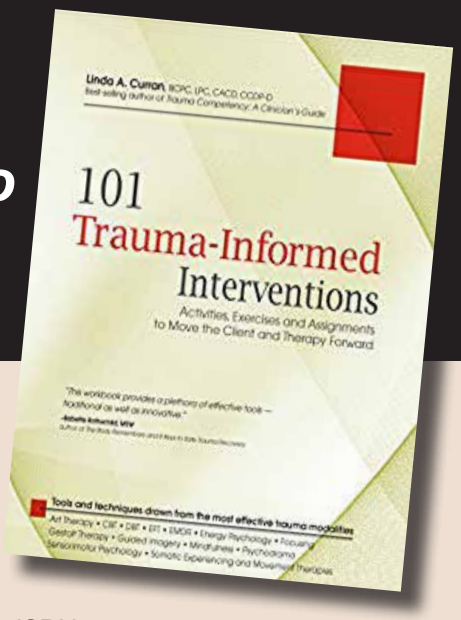

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Author
R.C. Smith

ISBN: 9783319503257

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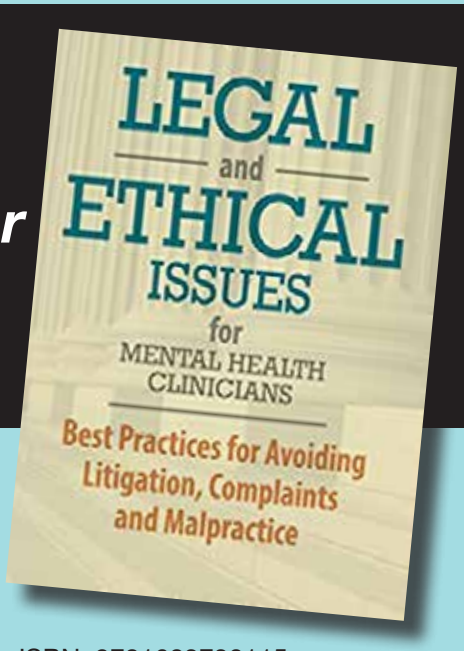

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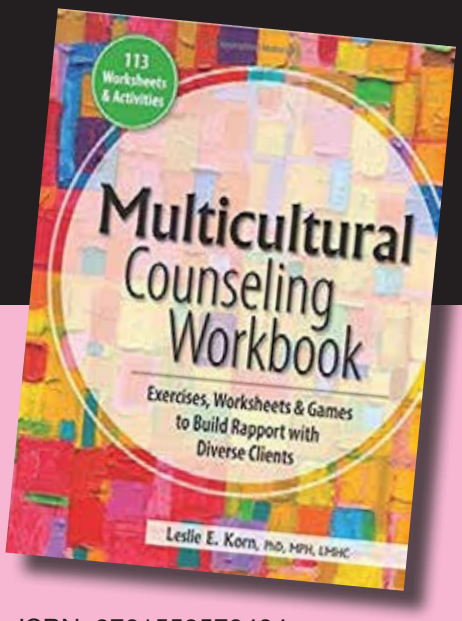

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Leslie Korn, Ph.D., MPH, LMHC, RPP, NCB

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