FORMERLY *THE CORRECTIONAL PSYCHOLOGIST*

THE

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A Publication of the International Association for Correctional and Forensic Psychology

JENNIFER SKEEM, PH.D., RECEIVES MEGARGEE AWARD

Jennifer Skeem
Associate Dean of Research and Mack Distinguished Professor, University of California, Berkeley

The International Association for Correctional and Forensic Psychology (IACFP) Board has selected Jennifer Skeem, Ph.D., as the 2018 recipient of the Edwin I. Megargee Distinguished Contribution Award. This award honors scholars and practitioners of national and international prominence who have made outstanding contributions to the field of forensic and correctional psychology, juvenile justice, the IACFP, or any combination. Dr. Skeem, who serves as Associate Dean of Research and Mack Distinguished Professor at the University of California, Berkeley, has made multiple contributions that distinguish her as both a scholar and practitioner. The IACFP Board also recognized the positive and significant impact Dr. Skeem has had on practitioners who work with justice-involved individuals.

Dr. Skeem is a clinical psychologist who writes and teaches about the intersection between behavioral science and the justice system. Her research is designed to inform legal decision-making about people with emotional and behavioral problems. Specific topics include improving outcomes for justice-involved people with mental illness, understanding psychopathy, and promoting prosocial behavior among juveniles at risk for violence. Her recent work addresses the use of risk assessment to inform criminal sentencing—including how this practice may affect racial and economic disparities in imprisonment. Professor Skeem has authored over 100 articles and edited 2 books. Skeem is past President of the American Psychology-Law Society and has served on advisory boards for the Council of State Governments Justice Center, U.S. Administrative Office of the Courts, and U.S. Sentencing Commission to inform policy development and improve understanding of risk assessment and risk reduction.

The IACFP Newsletter readers may be interested in reading some of Dr. Skeem's recent publications. In 2014, she co-authored an article on relationship quality between officers and offenders and the supervision process as evidence-based practice. A link to that article, which was published in APPA Perspectives can be found here, http://risk-resilience.berkeley.edu/sites/default/files/attachments/projects/perspectives_manchak-kennealyskeem_2014.pdf. Readers can also download "top articles" that she has written and co-authored at http://risk-resilience.berkeley.edu/publications. These articles are organized by key

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INTERNATIONAL ASSOCIATION FOR CORRECTIONAL & FORENSIC PSYCHOLOGY

The IACFP Newsletter is being published twice during 2018 and will return to its normal publication schedule in 2019. The current newsletter will be available on the website: www.myiacfp.org. An archive of prior newsletters is available to IACFP members in the members only area of the website. Members who require a printed copy of the newsletter should contact executivedirectoriacfp@gmail.com.

Comments and information from individual members concerning activities and related matters of general interest to international correctional mental health professionals and others in international criminal and juvenile justice are solicited. The IACFP is particularly interested in highlighting promising research, programs, and practices that are consistent with our vision of engaged criminal justice practitioners implementing innovative and humane practices worldwide. Toward that end, we also aim to spotlight those members who are doing great work. All materials accepted for inclusion in *The IACFP Newsletter* are subject to routine editing prior to publication. Opinions or positions expressed in newsletter articles do not necessarily represent the opinions or positions of the IACFP. Please send materials or comments to Dr. Robert R. Smith at smithr@marshall.edu and Cherie Townsend at executivedirectoriacfp@gmail.com.

Deadlines for submission of all material are:

November 2018 issue—
December 1

January 2019 issue—
November 1

April 2019 issue—
January 1

July 2019 issue—
March 1

October 2019 issue—
June 1

SKEEM RECEIVES MEGARGEE AWARD

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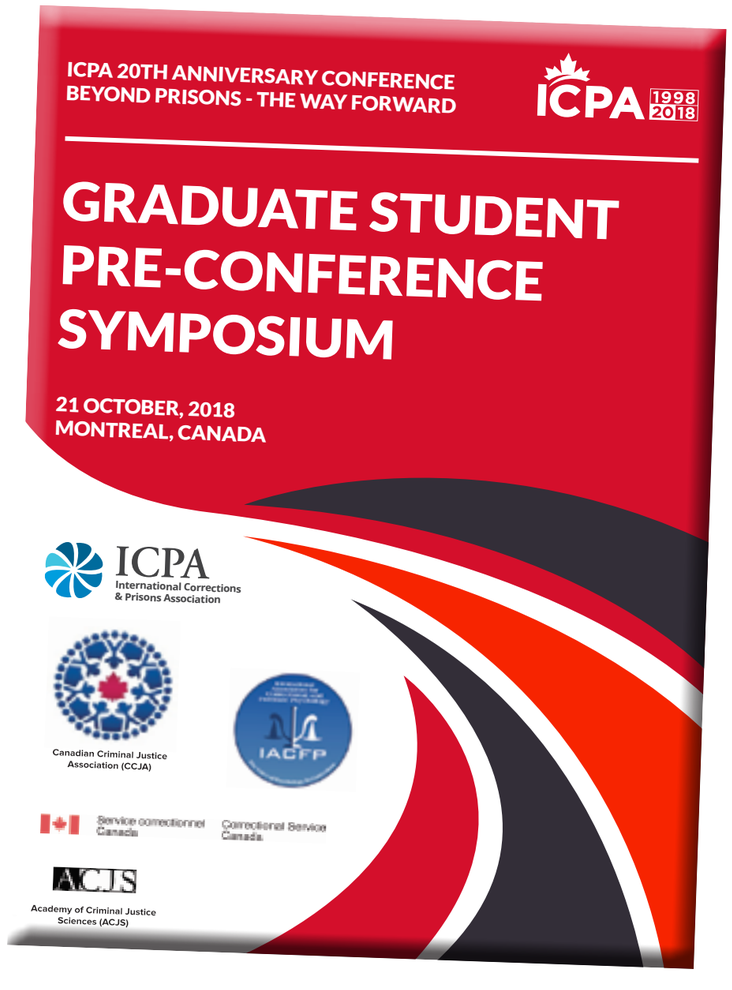
area, i.e., dual relationship and risk reduction; high risk juveniles and crime prevention; mental illness, violence, and correctional policy; psychopathy and its variants; and risk assessment and sanctioning. In the last area, one article that stands out is "Risk, Race, and Recidivism: Predictive Bias and Disparate Impact." This article is co-authored with Christopher T. Lowenkamp and provides a framework for examining the important concerns that practitioners and others have related to race, risk assessment, and recidivism.

The Megargee Award was established in 2014. The first recipient, and the individual it is named after, was Dr. Edwin (Ned) I. Megargee. Subsequent recipients have been Dr. Jeremy Mills, Dr. J. Stephen Wormith, and Dr. Jeffrey Metzner. Prior to 2014, Dr. Ida Dickie and Dr. John Gannon were the Edwin Megargee Honorary Lecturers during the International Community Corrections Association (ICCA) annual research conference.

GRADUATE STUDENT SYMPOSIUM

In 2018, the IACFP Board identified students as a key area for development, providing support, and association membership. Toward that end, the IACFP is a sponsor of the "Graduate Student Pre-Conference Symposium" that is being held immediately prior to the ICPA 20th Anniversary Conference, "Beyond Prisons—The Way Forward," in Montreal, Canada. The IACFP has provided scholarships to four of the students that were selected to present at the Symposium, Nicole Ryan, Jennifer Peirce, Daina Stanley, and Orla Gallagher. The student presenters will have the opportunity to highlight their applied research not only to other students but also to correctional leaders and researchers from around the world. The Symposium has reached its maximum capacity for attendees as of this time. Summaries of the presentations by the students receiving IACFP scholarships will be included in the next issue of *The IACFP Newsletter* to kickoff a new section of the newsletter, Student Research Corner. The agenda for the Symposium is included in this link (journals.sagepub.com/pb.../ICPA_Pre_ConferenceSymposium_Montreal_2018_v7.pdf) for your information and to highlight the areas that students are examining as part of their graduate studies.



REFLECTIONS—WHY I THINK THE WAY I DO ABOUT CORRECTIONS: IMPRINTS FROM MY EARLY CAREER

Frank Porporino
Ph.D.
President Elect, IACFP

I like to think that most of my views are evidence-informed, including those about corrections. I do my best to stay up-to-date with the literature, scanning Journal content and downloading articles that pique my interest. Of course, I struggle to find the time to delve into everything. My collection of research articles I want to read now numbers in the hundreds. But at least I read the Abstracts. Over the span of a 45-year career, some of my views have changed. I've re-examined a number of my beliefs, in some instances substantially, especially where the evidence has accumulated, when it's been replicated, and perhaps most importantly, when I've been able to integrate and reconcile the evidence with my own experience. A good example is the turn towards gender-responsive intervention. Twenty-five years ago, I didn't see it as a big issue. Today, I'm pleased to have seen it finally evolve (I hope!) into mainstream correctional thinking. As I've gotten older, some of my long-time academic friends have accused me of getting 'softer.' But I like to think that I've tried to become more open-minded. I've tried to expose myself to a variety of perspectives rather than hanging my hat on only one paradigm (e.g., RNR). I also find myself more often engaged not by sophisticated quantitative, data-oriented research but by richer, insightful ethnographic and qualitative analysis. If we want to claim to be professionals, respect for evidence—of different types—should continue to influence and help us steadily adjust our views over time. But I want to discuss something else in this short paper—something that I've come to appreciate as a strong determinant of what I still hold as fundamental truths for corrections. Our early experiences in corrections, I believe, set the tone for how we continue to think about corrections—and how we think we can make a difference or influence change. Some of this may be because of our 'implicit' cognitions, but if we reflect on the impact of our early experiences, maybe some of the implicit can become explicit. I want to welcome our IACFP membership to consider this from their own base of experience and contribute to our Newsletter. But let me share some of my own thoughts as an example.

Corrections is an addicting, invigorating, collegial, and maybe above all, a very meaningful profession that

> "Our early experiences in corrections, I believe, set the tone for how we continue to think about corrections—and how we think we can make a difference or influence change."

seems to force us to remain committed despite some very real challenges and frustrations. At the core, I think, is a belief that we are trying to bring some semblance of social justice and security to our communities—a very noble objective. No doubt, the perspective of our front-line staff can be quite different and unique from ours, as can that of our other important stakeholders—politicians, the judiciary, legislators, and our communities. Experience in corrections, hopefully, helps us gain broader perspective, patience in understanding why our perspective may not always coincide with that of others, and maybe some greater skill in trying to align perspectives and help them come together. But some of our early experiences may leave an enduring imprint and set of unshakable perspectives.

Forty-five years ago, when I first began working in Canada's oldest maximum-security prison, Kingston Penitentiary, now closed and transformed into a popular museum, I remember walking through the big, wooden front gate for my first time and wondering with trepidation 'what in heaven's name have I gotten myself into.' Several weeks into my job as the new prison psychologist, well dressed in my suit and tie, I began to question whether I could tolerate all of the suspicious stares from the prison officers and the whistles from the inmates! I thought I perhaps had

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WHY I THINK THE WAY I DO

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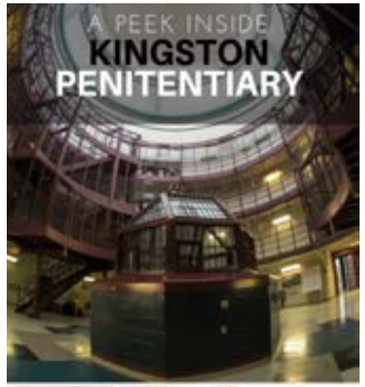

made a terrible mistake. I didn't belong in this strange culture.

Not long into my job, I remember getting quite anxious one day when the Warden called me into his office. I had been to Europe and bought myself a small black leather bag in Italy which I thought was quite functional to carry my wallet, keys, cigarettes … etc. I carried it to work every day, cheerfully unzipping it to get my ID to show to the officer at the front sally-port. You can guess what happened. The Warden, an old-timer who I later learned to admire tremendously, looked at me piercingly from across his desk and said "My officers tell me you carry a purse and they want to know if you're a homo-sexual … I never wanted no psychologist in this prison but I sure didn't want no homo-sexual psychologist." I could have become incensed at this accusation and insistent on carrying my leather bag to work regardless of what this unfashionable Warden and these homophobic 'guards' might think. Instead, on reflection, and after discussion with my partner, we concluded that I was indeed the strange one in this circumstance.[1] After all, I had cut my long 'hippie' hair to fit in, so why should I think I could carry a 'man purse' into prison. Slowly, I began to accept that this prison culture I was now part of was a very traditional culture, often quickly judgmental and reactive, not especially welcoming of any new-fangled ideas, and where senior administrative staff are acutely tuned-in to the perceptions of line staff, not exclusively but certainly primarily. If you want to introduce some new kind of prison regime or practice, don't worry about getting the administration on side, worry about getting line staff on side. It's a lesson, and a view I've held on to and tried to act on, for my entire career.

A few months later, as I was walking across the central dome of the institution, the Head Keeper, China Mike he was known as, a very big and scary bald-headed man sitting at a desk in the middle of the dome, yelled out at an inmate who was walking across the floor … "Where the fu*7*67ing hell do you think you're going, you SOB." I froze on the spot, and wondered once again, even more intensely, "what the hell I have gotten myself into." I could have easily retreated into my office and did my counselling and politely minded my own business. But instead I was once again challenged with trying to understand this strange discipline-centric and seemingly aggressive officer culture. I began to mix more with the officers in the units, chatting and

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[1]Incidentally, I've also been happily married for 45 years to a very 'fashionable' woman.

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even occasionally swearing with them, listening to them, asking their opinion, patiently trying to appreciate all of the different perspectives around me, and eventually, as I kept walking through that front gate every morning, it became "Morning Doc … how you doing" … instead of a suspicious stare. China Mike, generally quite sullen, but as it turned out, a rather lonely and sensitive man, decided to befriend me, and would even call me on occasion to ask if I would intervene with a distressed offender. I learned to appreciate the context, the experiences, and the perspectives of line staff, and that set the tone for my career in many ways. I began to accept that what seemed superficially punitive and discipline-centric was often the officers' way of 'correcting' the offenders, or you could say 're-educating' the offenders for their lack of respect for authority and rules. Their methods were different, but even if I didn't agree, their aims were often the same as mine. To this day, I believe that the single most important imperative for corrections is to welcome the involvement of ALL staff in our 'rehabilitative' efforts. Our primary aim should be to create 'whole environments' that can promote desistance—not just to introduce a little program here or a better service there. We may have to help some staff refine or adjust their methods, but we should always build on that common aim. Most practitioners (and perhaps especially those working at the 'street level' where the rubber hits the road every day) either don't know or don't care about our research evidence. We need to learn how to bring knowledge 'to the people' in a way that engages them as collaborators and not just followers. In medicine, most nurses and doctors around the world operate from a common base of knowledge—which they then adjust/refine with their experience. We don't have that in corrections. There is no real common notion of what it means to be a 'corrections professional.' Sometimes we get commitment, but too often we don't see much curiosity, respect for evidence, or interest in self-reflection. Educated as supposed experts in human behaviour, I believe it behooves us as correctional psychologists to help develop correctional cultures of life-long learning. As we move towards trying to implement more effective practice, we have to avoid creating barriers and always attend to ways of professionalizing and dignifying the nature of the work of ALL staff. An old African proverb I first noticed on a wall at Johannesburg airport says "If you want to go fast, go alone. If you want to go far, go together." Our new IACFP motto says that we stand for 'Helping the Helpers.' I'm convinced that we can go further as correctional psychologists if we focus on encouraging and supporting others to join us in the helping—prison officers, nurses, teachers, workshop instructors, counsellors, volunteers, family…and I could go on.

When I began my career, the field of corrections was under the grip of widespread pessimism, spearheaded by a confluence of social-political forces in the United States, and buttressed by the now famous, but not very 'evidence-informed' slogan coined by Robert Martinson that 'Nothing Works!' As a clinical psychologist and student of the complexity of factors impinging on human behavior, I never bought that idea. Effecting change in human behaviour might be difficult, I thought, but not impossible. That perspective gave me momentum, energy, and determination to counteract the pessimistic views of what might be achievable in corrections—something that sustains me till today. And, when I think back to some of my earliest client contacts with offenders, I always recall one individual in particular who helped me solidify that belief perhaps more than any outcome study I've ever read.

Tom was a notorious biker who approached me one day with an interesting proposition. He was serving a minimum 10-year sentence for attempted murder and he said that he was fine with that even though he wasn't guilty, because he had done a lot of other 'bad' stuff in his life that he should pay for. His proposition was that I should see him regularly for two years, talk about whatever I wanted to talk about with him, but if I then concluded he was a safe bet for release, I should write a report for the Parole Board to that effect. Years later as I began to read some of the wonderful literature on 'desistance,' it all became coherent for me. Tom had found his 'hook for change' (he now had a young daughter) and he subscribed strongly to a 'redemption script' (he wanted to make up for his past). He wanted me to see him for what he was trying to 'become' and not just judge him for what he 'had been.' While in

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prison, he worked tirelessly on the Inmate Committee to keep the peace in the prison; he established a ten-plus discussion group, and he spearheaded an Annual Olympiad for disabled kids which still runs to this day. After release, he lost his legs in a car accident, but he nonetheless organized an employment service for ex-offenders where, by virtue of his incredibly forceful personality, was successful in convincing employers to hire hundreds of ex-offenders. Tom didn't just desist from offending, he gave back in innumerable ways. The incredible variety and reach of bottom up initiatives spearheaded by ex-offenders to assist other offenders, with little or no resources to help kickstart their efforts, deserves someday to be documented. I suspect it would surprise most of us.

I still believe offenders can change, and often with only just a nudge of genuine support rather than the poorly delivered, one-size-fits-all, manualized offending behaviour programs, we keep designing. Our way may not be the only way. Some offenders will find their own fulcrum and path to change and, as professionals, we should learn to respect that what we might prescribe may not always be what they need. When offenders do change, we also often do little to leverage their potential to work alongside us, not just as volunteers, but as credible and dedicated justice professionals in their own right. I've had the feeling for some time now that our profession of psychology in corrections was going awry, getting too elitist, and becoming too specialized and preoccupied with assessment rather than helping. More than ever, I now believe we have drifted away from being primarily a 'helping' profession, to being too often a 'judging' profession—scaring offenders with our latest basket of risk prognostication tools and instruments more than reaching out to them.

A favourite criminologist of mine studying the culture of contemporary prisons in the United Kingdom observed the following:

> "Most prisoners had little objection to psychological insight per se. A large proportion expressed concerns about mental health issues and longed for help to deal with deep-rooted personal problems … Indeed, prisoners were crying out for neutral forms of intervention and explanation. Yet, the system left little room for unpartisan judgment. Personal problems . . . were quickly subsumed into institutional discourse, and transformed from needs to risks in the interests of public protection."
>
> Crewe (2009) *The prisoner society: Power, adaptation, and social life in an English prison*

A similar disconnect in relating to offenders at a human level is occurring as a consequence of the 'technology revolution' in corrections. Traditional 'relational' teaching and learning is being replaced with tablets, for example. Offenders are being supervised in the community by answering a few questions on their mobile phone or at a kiosk. We have an obligation as psychologists, I believe, to examine these trends and counteract them, where necessary, in the interest of preserving the human side of corrections.

To this day, I have no reservation in saying that the job of line staff in corrections, whether in prisons or in the community, is one of the most difficult, depleting, demanding, and stressful social and human service-oriented jobs in society. We all respect this in some way but I'm not at all sure whether, as professionals, we show sufficient gratitude to our colleagues on the line. Only a year or so into my first prison psychology job, one of my female colleagues and our secretary were taken hostage for 18 hours in the office next to mine. To this day, I am left with pride and gratitude for the incredibly determined, focused, and very professional efforts to resolve the incident without harming either the perpetrator or our colleagues. A few years later, one of my research assistants was taken hostage for several hours by an offender holding an X-Acto knife to her throat. A very focused and quick-thinking prison officer who stood outside the office door for

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[2] https://www.researchgate.net/profile/Dianne_Groll/publication/319315936_Mental_Disorder_Symptoms_among_Public_Safety_Personnel_in_Canada/links/59a4391245851570311720ac/Mental-Disorder-Symptoms-among-Public-Safety-Personnel-in-Canada.pdf

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the entire time saved her life. Still another few years later, one of my favorite ex-military prison officers was stabbed and killed by a drunk, knife-wielding offender who had just killed the kitchen steward and was out for more blood in the hallway outside the kitchen. I had just walked down that same hallway minutes earlier on my way to the staff cafeteria. The sadness and trauma that permeated the entire prison for months afterwards still stays with me today.

There is no disputing the statistics on the level of stress among correctional staff. Some recent research in Canada[2] has been receiving lots of media attention for what is perhaps the largest epidemiological study of stress in prison staff. The research has found the same kind of things other researchers have found—high levels of depression, alcohol abuse, PTSD, marital breakdown…etc. But here is the rub. I've always believed that we need to fully understand the root of the problem before we try and implement our solutions. Otherwise, as another IACFP colleague of ours is fond of saying (Richard Althouse), our solutions of today, quite often, can become the problems of tomorrow. The problem of staff stress in corrections, I think, is rooted in the very nature of the correctional culture that we create in most of our prisons. We keep creating fundamentally 'unhealthy prisons' but then expect staff to make super human efforts for remaining 'healthy' within those toxic environments. What happens when we introduce all of our new 'staff wellness' programs but most staff remain unengaged and uninvolved—and stress continues? As usual, do we then 'blame' the person for not trying to rise above the stress of their work. Do these folks become increasingly alienated? Does even more stress and divisiveness get created?

We recruit prison staff who often have the wrong kind of mindset—and who are unprepared to deal with the onslaught of extreme human emotions day in and day out (the prison as a laboratory for extreme emotional reactions—anger, frustration, depression, loneliness…etc.). We then reinforce that mindset with recruit training that focuses mostly on the 'security and control' aspects of their job. These recruits get indoctrinated into an officer culture that promotes toughness and stoicism in the face of danger and tension. The job becomes one of enforcing rules and instilling discipline. The prisoners resist. The staff amplify and solidify their attitudes. The leadership doesn't have the courage to challenge. An unhealthy prison environment gets sustained.

Another lesson I learned from my early experiences in corrections is that prisons are like miniature communities (in a sense, staff become connected like families, with always some level of dysfunction but also with always some level of real mutual caring). Staff wellness programs will make little difference in systems that sustain mostly 'unhealthy prison environments.' You need to initiate a quantum change in culture and values to achieve true staff and prisoner wellness—because you can't get one without the other!!

I could go further with examples of early experience and how it has affected my views about corrections. But, let me end with what I suppose is the biggest lesson I've learned from my early experience. Prisons are not nice places—neither for prisoners to live in nor for staff to work in. It's a lesson that's been reinforced after my visits to hundreds of prisons in dozens of countries, even after my visit to particularly 'nice' prisons like Halden[3] in Norway. We should use prisons sparingly and we should always remember that correctional excellence can only go so far in achieving social justice. At the end of the day, we should realize that prisons are not a solution but only a necessary option for the time being. I will leave it to Pope Francis for some last words.

> "Penal populism promises to solve society's problems by punishing crime instead of pursuing social justice...it suggests that by means of that punishment we can obtain benefits that would (actually) require the implementation of another type of social policy, economic policy, and policy of social inclusion…it offers up sacrificial victims, accused of the disgraces that strike the community.
>
> Pope Francis, October 2014

[3]https://www.nytimes.com/2015/03/29/magazine/the-radical-humaneness-of-norways-halden-prison.html

[4]Taken from http://ncronline.org/blogs/francis-chronicles/pope-francis-calls-abolishing-death-penalty-and-life-imprisonment

BENEFITS OF AN INTEGRATED BEHAVIORAL HEALTH MODEL FOR LATINOS AND OTHER MINORITY POPULATIONS IN CORRECTIONAL ENVIRONMENTS

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Due to disproportional minority confinement and mass incarceration, racial, and ethnic minorities have become a large proportion of correctional populations across the United States. Latinos, specifically, make up 34% of the federal prison population and are one of the fastest growing prison populations (BOP Prison Count, 2016). There is also concern that ethnic minorities are underserved in correctional environments (Biswanger et al., 2012; Hartwell, 2001).

Minority inmates face numerous barriers to physical and mental healthcare access that may be eased through the integrated behavioral health model. For many inmates from marginalized groups, the healthcare services obtained while incarcerated may represent their only substantial contact with healthcare providers. Therefore, incorporating behavioral health providers and services into routine correctional healthcare systems is critical to ensure that mental health concerns are assessed and addressed.

For Latinos specifically, there are lower rates of healthcare utilization and lower rates of health insurance (Manoleas, 2008). This lack of access to healthcare services is surely magnified even further for individuals who are marginalized due to multiple intersecting minority identities. In correctional settings, mental health stigma, language barriers, and cultural distance may limit Latinos and other minorities from seeking services (Hartwell, 2001). These barriers have created tremendous limitations in access to care and further contributed to health disparities.

Within correctional settings, there may also be a sense of alienation, isolation, and lack of social support for minority populations. Providing integrated health care services can help meet some of these needs and reduce the barriers to care by providing one comprehensive service which meets multiple health needs simultaneously. Also, Latinos often experience psychological distress through somatic complaints which can complicate their clinical presentation (Tofoli et al., 2011). Allowing physical and mental health providers to work together to conceptualize their physical health, mental health, and criminogenic risk/need areas could improve outcomes.

One known contributor to recidivism of criminal conduct is the lack of access to appropriate behavioral and physical healthcare (Wallace & Papachristos, 2014). Some studies have shown that facilitating relationships between minority inmates and both healthcare and mental healthcare professionals during incarceration correlates with lower recidivism rates after release (Patel et al., 2014; Vigilante et al., 1997). By providing integrative services to Latinos and other ethnic/racial minorities, it may reduce their recidivism rates which, in turn, could help reduce the immense problem of disproportionate minority confinement that plagues us today.

While there is evidence to suggest that integrated behavioral health may decrease mental health disparities among Latinos and other minorities, and that elements of the integrative behavioral health model contribute to reduced recidivism rates, further research is necessary to explore the impact of integrated behavioral health on incarcerated Latinos and other

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MINORITY POPULATIONS

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minority populations. However, it seems only logical that employing integrated behavioral health models in correctional environments would benefit inmates with less access to care, minority stress, and other layers of marginalization while simultaneously reducing the risk of recidivism and return of minorities into correctional custody. Further, viewing incarceration as an opportunity to assess and treat physical and mental health conditions that disproportionally impact Latinos and other minorities creates an opportunity to improve health outcomes at the individual and public health level in a manner that is also cost-saving.

References available from the author.

DIFFICULTIES AND DILEMMAS OF INMATE SUICIDE PREVENTION

The IACFP Newsletter has often highlighted the issue of suicide in prisons and juvenile confinement settings. It is an international problem. While there has been research about suicide rates, the more pressing issue is the individuals who die by suicide within these settings. Inevitably, the questions raised are about prevention, who is vulnerable, and how can we better contribute to their safety and wellness.

A recent paper, "Suicide in prisons: an international study of prevalence and contributory factors," triggered the editors to take another look at the difficulties and dilemmas of suicide prevention. This article is open access and available at: http://www.thelancet.com/journals/lanpsy/article/PIIS2215-0366(17)30430-3/supplemental. The authors analyzed 3,906 suicides that occurred during 2011-14 in the 24 high-income countries they studied. This included Europe, Australia, and North America. The study looked at not only the rates of suicide but also incarceration rates, characteristics of offenders, factors related to the prison environment (as well as reforms), and national strategies that aim to prevent suicide in prison. The authors concluded that:

"Overall, our findings suggest that there are no simple ecological explanations for prison suicide. Rather, it is likely to be due to complex interactions between individual-level and ecological factors. Thus, suicide prevention initiatives need to draw on multidisciplinary approaches that address all parts of the criminal justice system and address individual and system-level risk factors."[1]

The next article, looks at how those risk factors may be assessed within the context of civil litigation.

[1]Fazel, Seena, Taanvi Raamesh, and Keith Hawton, "Suicide in prisons: an international study of prevalence and contributory factors", *Lancet Psychiatry 2017; 4*:946-52.

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Brief Overview

As a result of numerous court decisions regarding inmates' constitutional rights to treatment, preventing inmate suicides became a significant focus of correctional training programs in jails and prisons. Over the past two decades, suicide prevention standards and procedures have evolved that are commonly referenced in and utilized in these programs (e.g., American Correctional Association, National Commission of Correctional Health Care, and the International Association for Correctional and Forensic Psychology). These standards are quite logical: identify inmates who are at risk for suicide, keep them safe during their incarceration, and treat mental illness and/or drug addiction as warranted. An inmate suicide presumes a failure in meeting one or more of these standards and can result in civil litigation against facility staff, including mental health services providers tasked with assessing an inmate's suicide risk.

How are we doing? Well, despite at least two decades of suicide prevention standards and correctional staff training, inmate suicide still remains a leading cause of inmate death (50/100,000 in 2014) and civil litigation consequent to inmate suicides remains an active legal enterprise. Jury awards can be substantive, ranging in some cases from $100,000 to $20 million dollars or more.

Difficulties

Why aren't we doing better? While all facility staff are responsible for identifying inmates at risk for suicide, it is the mental health services provider who is ultimately responsible for determining the level of risk and taking preventive actions, and there are difficulties and dilemmas these staff encounter that other facility staff do not.

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DIFFICULTIES AND DILEMMAS

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First, research has identified 60 or more correlates of inmate suicide including suicidal ideation, drug abuse/addiction, a major mental illness (depression, anxiety, psychosis), previous suicide gestures or attempts, age, first incarcerations, reports of hopelessness, emotional instability, bizarre behavior, etc. Unfortunately, for the assessing clinician, experts agree that no combination of these correlates are accurately predictive of an imminent suicide attempt (Lamis and Kaslow, 2015, pp 56-57), and many suicides are impulsive and are not necessarily preceded by suicidal ideation. Prediction is made even more complicated because most inmates who have histories that correlate with suicide risk never attempt or commit suicide, leaving the clinician to wonder "Is this inmate the exception?"

Second, while intake mental health and suicide screening procedures can be helpful, they must rely on inmates' self-reports. Identifying inmates who may be at risk can be difficult when an inmate lies about having any of the correlates of possible suicide. To make matters more difficult, there has been no empirical research on how an inmate's non-verbal behaviors affect clinical judgment, so the clinician must rely on his/her training and experience when assessing an inmate's suicide risk.

Third, although suicide prevention standards and training clearly delineate under what circumstances an inmate should be placed in a suicide watch status and what to do while the inmate is in that status (e.g., continuous observation, periodic observation, daily contacts with mental health services providers, psychiatric referral, etc.), they do not equally delineate how long to keep an inmate in that status so that after release the inmate is no longer suicidal. The assessing clinician must again rely on his/her clinical judgment based on training and experience.

Fourth, suicide watches are by definition restrictive and aversive to the inmate. It is not uncommon for inmates to falsify their suicidal inclinations just to be released from suicide watch status in order to commit suicide at a later date. Again, the clinician must… etc., etc.

What about clinical judgment? After almost 50 years, research of the predictive accuracy of clinical judgment regarding suicide risk has revealed it is no better than a "coin toss" (American Psychological Association, 2016).

Ethical Dilemmas

Suicide watches are intended to prevent suicide, so they are restrictive and aversive. However, despite the "coin toss" status of clinical judgment, a "better to be safe than sorry" approach to maintaining an inmate in a suicide watch status risks overlooking an inmate's constitutional liberty interest. Consequently, suicide watches may raise the question of at what point do they actually violate an inmate's right to avoid cruel and unusual punishment even if it is in the interests of preventing suicide. No one wants to be sued for deliberate indifference, but retaining an inmate in a suicide watch status just to avoid that possibility is unethical. It is a fine line to be walked to be sure, but one that the conscientious mental health services provider should be aware.

Inmates may present with understandable reasons for wanting to die: chronic pain, a life sentence, being in chronic fear and stress because of the facility in which they are placed, and age, among others. These reasons may have an influence on a mental health service provider's decision regarding preventing that inmate from ending his/her own life. It is important to remember that there are constitutional mandates that require the clinician to intervene and prevent inmate suicides inasmuch as it is possible to do so, regardless of the circumstances.

Avoiding the Litigation Pitfalls: Do the Reasonable Things

How can a correctional mental health services provider avoid being named in civil litigation, and if not avoidable, provide clinically sound explanations for his/her suicide risk assessment conclusions?

There are pitfalls to be avoided if the correctional mental health service provider wants to either avoid litigation or manage it successfully. First, to avoid the allegation of deliberate indifference, it is necessary to take clinically reasonable and defensible actions to prevent a suicide. It is not necessary that these actions ultimately do prevent a suicide, but that their intention

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to that end is clear. Second, it has been my litigation experience that the most common failing is insufficient documentation regarding each step of the suicide risk assessment and clinical conclusions; particularly related to decisions to not place an inmate in and release an inmate from suicide watch status. Third, share and document clinical information with security staff responsible for monitoring the potentially suicidal inmate and medical staff that might be involved in follow up.

Given that the majority of inmates who have or exhibit correlates of inmate suicide do not go on to attempt or complete suicide, it is easy to become somewhat cavalier when assessing an inmate's suicide risk. After all, the odds are that the inmate will not attempt or complete a suicide. However, it is best not to leave it to chance. The most important action we can take is to save a life.

References available from the author.

THE USE OF CRANIAL ELECTROTHERAPY STIMULATION (CES) AS A TREATMENT FOR CLINICAL SYMPTOMS IN A YOUNG FEMALE POPULATION LIVING VOLUNTARILY IN A RESIDENTIAL TREATMENT SETTING FOR ALCOHOL AND DRUG ABUSE**

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Abstract:

There are relatively few studies which focus on using the Alpha-Stim AID, a cranial electrotherapy stimulation device (CES), with solely female subjects. The present study is the second to assess CES with a female population. This study examined the utility of CES in reducing clinical symptoms, stress levels, while improving executive functioning (prefrontal cortex) and increases in IQ within a young female alcohol and polysubstance dependent abusers (mean age 22 years).

The findings suggested the Alpha-Stim AID significantly reduced clinical and stress symptoms in the treatment group when compared to the control group. However, the Alpha-Stim treatment had a marginal positive impact on prefrontal cortex functioning and IQs. Results from this study and a previous research project with older females (mean age 44 years) suffering from domestic violence, demonstrated support for using the Alpha-Stim AID as part of a treatment protocol in female populations.

Review of the Literature:

The Mellen, Case, & Ruiz's, (2016) study focused on an all female population and used CES (Alpha-Stim AID) to reduce clinical symptoms in10 female subjects who were living in a shelter for victims of domestic violence. The subjects' average age was forty-four years and most reported having completed some college. Eighty percent reported not having a history of drug or alcohol abuse. There was no control group.

Results from this study included three stress scales from the Brief Symptom Inventory (BSI):

1. The Global Severity Index:.....p = ≤.02
2. The Positive Symptom Total: .....p = ≤.05
3. The Positive Symptom Distress Index .....p = ≤.012

The BSI also included nine clinical measures. However, the scales did not achieve statistical significance. Regardless, the trend lines for the nine clinical scales indicated positive changes, suggesting movement toward more normalized brain functioning. A T-score of 65 meant the subject scored above the ninety-third percentile of the general population while a score at the fiftieth was the norm.

Results of BSI Testing

BSI Scales	Pre-Test	Post-Test
Somatization	68.10	56.90
Obsessive-Compulsive	66.70	57.80
Interpersonal Sensitivity	62.00	50.00
Depression	65.50	56.40
Anxiety	64.80	56.60
Hostility	63.70	54.70
Phobic Anxiety	58.90	55.60
Paranoid Ideation	67.50	58.30
Psychoticism	67.40	60.90

Almost all of the clinical scales were at or above the

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ninety-third percentile prior to treatment and within normal range after using the Alpha-Stim.

The Behavioral Rating Index of Executive Function-Adult (BRIEF-A) provides measures of pre-frontal cortex functioning. Results from this study included:

*The Metacognition Index (MI): p = ≤.06. These scales addressed the following psychological variables: Inhibit, Shift in Thinking, Emotional Control, and Self-Monitoring

*The Behavioral Regulation Index (BRI): p = ≤.009. The scales addressed organizational tasks: Initiate, Working Memory, Plan/Organize, Task Monitor, and Organization of Materials.

*The Global Executive Composite (GEC): p = ≤ .028. The scale combined results from the MI and BRI.

Overall the results were encouraging. While the stronger results were associated with improvement in executive function, there were noteworthy results in the BSI.

The Mellen & Parmer-Shedd (2009) study examined the influence of CES on female and male subjects in an out-patient, court-ordered, drug treatment program. Because of the small sample size, no genderbased comparison was made.

However, significant differences in pre/post-treatment means for the experimental group vs. the control group were noted: Somatization (p = ≤.008), Obsessive/Compulsive (p = ≤ .020), Depression (p = ≤ .015), Anxiety (p = ≤ .015), Psychoticism (p = ≤.050), Global Stress Index (p = ≤ .007), Positive Symptom Distress Index (p = ≤ .042), and the Positive Symptom Total (p = ≤ .004).

In addition to reducing clinical symptoms in the treatment group, variances in completion rates in the alcohol/drug treatment program was noteworthy. The completion rate for the experimental group was 71% while the completion rate for the control group was 41%. This outcome suggests a possible positive global brain modulation effect secondary to CES. A similar positive completion rate was reported in Brovar's (1984) study, see entry below.

The single-case study by Mellen, R., Manners, K., & Ruckers, J., (2010), examined cortical changes in a violent inmate using qEEG readings among other dependent variables. Again the Alpha-Stim was the independent variable. The subject for this study was an inmate with a history of significant drug abuse and chronic violent behavior. He was in jail awaiting trial for attempted murder of a sheriff's officer.

Positive change in the inmate was observed secondary to treatment. The dependent variables demonstrated significant reductions in clinical symptoms and improved brain functioning (pre- and post-qEEG readings). In a five-year personal communication by the former inmate, he shared a successful adjustment to civilian life. Some of his life changes included being married, having fathered a child, and that professionally, he was now the computer systems technician in the office of a medical professional. He also was the apartment supervisor where they lived.

The previous qEEG research extended a Mellen and Mitchell, (2008) single-case study of an inmate who also had an extensive history of physical violence and drug dependence. The subject was a 19-year-old inmate who had been remanded by the court to the county's detention center drug treatment program. Completing the program was the only court ordered condition necessary for the inmate being returned home. If he washed-out of the drug program, he would be sent to prison. Despite the potential negative consequences the inmate continued physically fighting inmates and Security Staff. After being twice reprieved by the Director of the Detention Center, the inmate was only a few days away from being shipped to state prison when he began the fifteen-session Alpha-Stim treatment program. The treatment program helped in that the inmate was successful in completing the drug treatment program. In addition, because of changes in the inmate's thinking and behavioral patterns, the director of the detention center promoted the inmate to Pod Leader. These results also suggested improved global modulation of cortical functioning by the inmate.

Braverman, E., Smith, R., Smayda, R., & Blum, K.,

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(1990) used EEG bandwidths (Delta, Theta, Alpha, and Beta) to study the effects of cranial electrotherapy stimulation on brain functioning of alcoholics in a residential treatment program. Researchers found improvements in all four EEG bandwidths as well as improvements in P-300 amplitudes when compared to a control group whose members had received the same treatment protocols but did not receive CES. In fact, the control group showed no improvements in the four bandwidths, nor did they experience an increase in P-300 amplitudes.

The EEG was again used to measure cortical changes that resulted from treatments with the Alpha-Stim 100. Kennerly (2002) used (a variant of the Alpha-Stim AIM) with 30 non-clinical volunteers. He examined changes in cortical functioning as measured by qEEG. The qEEG measurements occurred before, during and following each 20-minute Alpha-Stim treatment session. The subjects received one treatment session each.

After treatment, there was a decrease in Delta and Theta bandwidths which coincided with an increase in Alpha. The increase in Alpha created a relaxed but focused response in the brain. Post-treatment subjects reported feeling more awake and experiencing less anxiety. In addition, subjects who were feeling pain prior to CES treatment reported significant reductions in their physical pain.

Schmitt, R., Campo, T., Frazier, H., and Bordern's (1961) study examined the ability of CES to improve brain function in subjects with organic brain damage. The subjects were alcohol, polysubstance abusers, and the dependent variables included the Revised Beta (IQ), and three clinical indicators of organic brain damage (Digit Symbol, Digit Span, and Object Assembly) from the Wechsler Adult Intelligence Scale (WAIS). Prior to treatment, 88% of the patients showed dysfunctions in one or more of the WAIS sub-scales. Results demonstrated that subjects treated with CES, compared to a control group and a sham control group, made significant gains on all three measures of brain function.

A later study by Smith (1999) found significant improvements in IQs, secondary to CES treatment. While there was no control group, changes between pre- and post-treatment IQs (WISC-R and WAIS-R) for the sample of 23 subjects were noteworthy.

Changes in IQ Scores Pre- and Post-

	Alpha-Stim Treatment			
	Pre & Post			
Test	Means	s.d.df	t-score	p-value
F/Scale IQ	103.20	13.70		
	117.60	14.28	22	15.18 .001
Verbal IQ	99.38	13.20		
	107.50	14.13	22	5.94 .001
Performance IQ	107.40	15.05		
	126.60	14.20	22	10.89
ccfr4gt x33.001				

The positive results CES produced in cortical functioning and subjects' intellectual abilities is another example of improvements in global modulation.

Brovar (1984) researched the issue of retention in a hospital detoxification and treatment programs. Twenty-five consecutive admissions to a hospital's detoxification unit were used as subjects. The hospital stay included a five-day in-patient treatment program. All five treatment subjects (100%) who agreed to the cranial electrotherapy treatment completed both detoxification and the hospital treatment program while 65% of the control group completed both. At an eight-month follow-up, no Alpha-Stim subjects had returned for treatment while 61% of the control group had been readmitted.

The issues associated with drug and alcohol detoxification, including retention in the programs, were also addressed in Patterson, M., Firth, J., and Gardiner, R's (1984), research. Their research was a seven-year CES project, 1973-1980. The study examined the possible positive influence of CES on drug addicts and alcoholics experiencing detoxification. The treatment group received continuous treatment during the first six days of detoxification with progressively shorter treatment times until day ten, the final day in the treatment center.

Again results were noteworthy. The dropout rate over the seven-year period was 1.6% for subjects given CES treatment. Conversely, the dropout rates for three comparable alcohol/drug treatment programs, without CES, were 90%, 75% and 45%. In addition,

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over 98% of the 186 patients in her research program were successfully detoxified and none of the treatment group experienced withdrawal symptoms. In addition, by the tenth day, 95% of the treatment group were free of cravings and 75% were free of anxiety.

Depression and anxiety reductions secondary to CES treatments were the goals of the Bianco's (1994) research. The subjects were polysubstance abusers living in an inpatient hospital residence. The researcher divided his sample into three groups. One was a standard control group which received the hospital's typical treatment program without CES. A second group was a sham control group, who thought they were receiving CES treatment but were not. The third group received CES along with the standard hospital treatment protocol. Significant post-treatment differences ($p = \leq .05$) were found between the CES group when compared to each of the control groups.

Research Objective:

The objective of the present study was to determine the utility of the Alpha-Stim AID as a treatment for reducing clinical symptoms, stress levels, and trauma symptoms. Researchers also examined the Alpha-Stim's influence on IQs, and prefrontal cortex functioning. The sample pool was young female alcohol and drug abusers living voluntarily in a residential treatment program.

Methodology

Subjects: Twenty-one subjects were included in the final sample with 10 in the control group and 11 in the treatment group. Eight were Caucasian, five African Americans, three Hispanic, one Caucasian/African American and one Caucasian/Hispanic American. The subjects' average age was twenty-two years. Seven of the subjects reported having received an Associate's Degree and ten reported having completed some college. Only three of the subjects reported having suicidal thoughts and none reported a suicide attempt. Two reported previously having experienced physical abuse, five emotional abuse, and two reported histories of sexual abuse. All of the subjects denied having been in jail or prison. All treatment sessions were given between Monday and Friday of each week. The study did not control for medications.

Independent variable: The Alpha-Stim AID was the experimental treatment. It was chosen for a number of reasons:

1. The Alpha-Stim AID is FDA cleared for the treatment of depression, anxiety, and insomnia. While not cleared for treating hostility, in six of the lead author's earlier studies using the device, it typically did reduce hostility to a statistically significant degree. It is used by mental health professionals in both the Veterans Administration and Department of Defense.

2. Over 100 human subject studies have been published using CES devices, including the Alpha-Stim AID, and all but a few have found positive results in treating numerous clinical and physical symptoms.

3. Alpha-Stem AID side-effects are generally mild. These include headaches, dizziness, and nausea. Such symptoms are almost always self-correcting or treated by reducing the micro-amperage (uA) level. The adjustable range of the electrical current is from 100 uA to 500 uA.

Subjects have only reported one serious side effect which was an increase in aggressive feelings following the initial treatment. This symptom usually occurs in about 1 in 5,000 subjects (Kirsch, 2002). These subjects are removed from the studies.

4. Brain modulation (see diagram) appears to be an important outcome of the Alpha-Stim. It uses a "proprietary square wave form that moves electrons at a variety of frequencies (harmonic resonance)" Giordano (2006). In this process, certain neuro-networks are encouraged to produce higher levels of serotonin and, inversely, reduce or block cholinergic activity in thalamo-cortico circuit.

6. In subjects, the greater the need, the greater the Alpha-Stim's effectiveness. If there is no need to increase serotonin levels, subjects tend to respond with boredom which makes it useful in working with drug-seeking populations. Conversely, for individuals with excessively high serotonin levels, the Alpha-Stim reduces the level of serotonin to a more normal level.

7. Subjects can read, talk with others, watch television, carry out written tasks, etc. while wearing the CES device.

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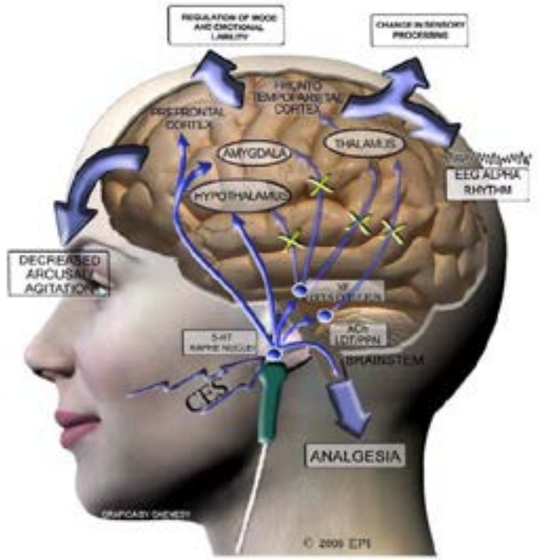

Giordano, J. (2006) Permission to use this picture granted by Electromedical Products International, Inc., Mineral Wells, TX 76067

Dependent variables:

The dependent variables were sub-scales on the Symptom Check List—90 (SCL), Behavior Rating Inventory Executive Functioning-Adult (BRIEF-A), Shipley IQ, Trauma Symptom Checklist—40, and the Emotion Identification scale.

The nine clinical and three global scales of the SCL-90 (Derogatis, 1994) were chosen as dependent variables. These are:

1. Global Index: the most sensitive measure of stress.
2. Positive Symptom Distress: degree of stress being reported.
3. Positive Symptom Total: total number of symptoms endorsed by a subject.

The nine clinical scales are:

1. Somatization: measures bodily complaints.
2. Obsessive/Compulsive: repetitive thoughts and actions.
3. Interpersonal Sensitivity: difficulties with interpersonal relationships.
4. Depression: sad mood, loss of energy, difficulty sleeping, or sleeping too much.
5. Anxiety: excessive worry
6. Hostility: feelings of anger toward others and the world
7. Phobia: excessive fearful reactions toward objects, insects, and such.
8. Paranoia: excessive fears that are not supported by evidence.
9. Psychoticism: these individuals can appear unusual and emotionally distant.

BRIEF-A

The subscales of the BRIEF-A provide measures of prefrontal cortex functioning (executive functioning). That information is potentially relevant given the number of earlier studies suggesting treatments with the Alpha-Stim AIM can lead to an increase in global modulation within the brain. The subscales Inhibit, Shift, Emotional Control, and Self-Monitor collectively form the Behavioral Regulation Index (BRI). The Meta-Cognitions Index (MI) is composed of the subscales Initiate, Working Memory, Plan/Organize, Task Monitor, and Organization of Materials. For this study, the BRI subscales which address intellectual flexibility and thinking as well as emotional control were deemed most important.

Trauma Symptom Checklist—40:

*The Trauma Checklist addresses six categories: disassociation, anxiety, depression, sexual abuse trauma index, sleep disturbance, and sexual problems.

Shipley-2 (IQ):

*The Shipley measures two areas related to intellectual functioning: vocabulary and abstract thinking.

Emotion Identification Scale:

*The Emotion Identification Scale was designed to identify prison inmates who have serious difficulties in identifying various emotions in others. Most people who take this assessment do very well averaging 8 to 10 correct responses out of a total of 10.

Findings:

1. SCL-90:

*Somatization..... p = ≤ .02

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*Obsessive/Compulsive..... p = ≤ .02
*Interpersonal Sensitivity..... p = ≤ .10
*Depression..... p = ≤ .045
*Anxiety..... p = ≤ .01
*Hostility..... p = ≤ .057
*Phobia..... p = ≤ .30
*Paranoia..... p = ≤ .029
*Psychesthenia..... p = ≤ .096

Results of treatment demonstrated statistically significant improvement in five of the nine clinical measures for the treatment group when compared to the control group. The positive changes suggested the subjects had fewer physiological complaints and were less obsessive and compulsive in thoughts and behaviors. Also, there were important reductions in depressive symptoms, feelings of anxiety, and paranoid ideation. While not statistically significant, feelings and expressions of hostility were reduced (p = ≤ .057). Also the GSI scale, a global measure of a person's anxiety levels, suggested an important statistically significant reduction in overall anxiety.

2. Trauma Symptom Checklist:

*Dissociation..... p = ≤ .01
*Anxiety..... p = ≤ .005
*Depression..... p = ≤ .16
*Sexual Abuse and Trauma..... p = ≤ .007
*Sleep Disorders..... p = ≤ .02
*Current Sexual Problems..... p = ≤ .56

The Alpha-Stim treatment appears to have helped the subjects to statistically reduce negative symptoms in four out of six categories when compared to the control group. The participants expressed fewer experiences of dissociation, anxiety, and sleep disturbances. Important reductions in the after effects of early sexual abuse and trauma were also noted after the twenty treatment sessions.

3. BRIEF-A:

*Inhibition..... p = ≤ .07
*Shift..... p = ≤ .64
*Emotion..... p = ≤ .23
*Self-Monitoring..... p = ≤ .29
*Initiate..... p = ≤ .24
*Working Memory..... p = ≤ .14
*Planning..... p = ≤ .53
*Motivation..... p = ≤ .30
*Organization..... p = ≤ .44

The results from the BRIEF-A suggest the brain's executive functioning in these young subjects was not changed in a statistically significant way as a result of Alpha-Stim treatment, when compared to the control group. That is the drug and alcohol-related struggles that they are dealing with may be driven more by emotion-related issues than structural dysfunctions in the prefrontal cortex.

In the earlier domestic violence study (Mellen, Case, & Ruiz, 2016) the treatment group subjects did have statistically significant results on the Metacognition Index (p = ≤ .06). As noted above, these scales addressed the following psychological variables: Inhibit, Shift Thinking, Emotional Control, and Self-Monitoring. The Behavioral Regulation Index: (p = ≤ .009) scales included the following organizational tasks: Initiate, Working Memory, Plan/Organize, Task Monitor, and Organization of Materials. The Global Executive Composite (GEC) which combines results from the MI and BRI also showed statistically significant improvement (p = ≤ .028). The difference between BRIEF-A results found in the earlier study of domestic violence subjects versus the subjects in the present study has yet to be explained.

4. SHIPLEY IQ:

Results from the Shipley IQ, (p = .88), suggests that the Alpha-Stim did not enhance intellectual functioning in the experimental group. This seems to support the proposition that positive prefrontal cortex functioning and an adequate IQ are interrelated. However, these results do raise a question as to why IQs improved in two earlier studies but not the present subjects.

5. EMOTION IDENTIFICATION SCALE:

The Emotion Identification Scale was designed to identify prison inmates who were having serious difficulties in identifying varying emotions in others.

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Individuals with average, or better, ability to identify emotions in others tend to do very well averaging 8 to 10 correct responses out of a total of 10. These results suggest the subjects in this study did not have serious deficiencies associated with this task.

DISCUSSION:

Results from the SCL—90 found significant variations in five of the nine clinical areas addressed when the treatment group responses were compared with the control group. These included reductions in bodily complaints, compulsive thinking, depression, anxiety, and paranoid thinking. Reductions in feelings and thoughts of hostility were also noteworthy ($p = \leq .057$) though not statistically significant.

Results from the Trauma Symptoms Scale also revealed positive changes in the treatment group versus the control group, secondary to CES treatment. Most noteworthy were reductions in the subjects' tendencies to disassociate, experience anxiety, and depression. They also reported significantly lower levels of sleep disorders and negative consequences of sexual abuse and related traumas.

The results from the BRIEF-A are important in that they demonstrate the abilities of these young female subjects to maintain positive executive functioning while, at the same time, dealing with significant emotional issues. While statistically non-significant the results did show a tendency for subjects to experience some possible improvement in working memory and the ability to inhibit oneself.

The subjects' intelligence levels, as measured by the Shipley IQ, were not improved by the use of CES. The results from the study do not support the positive changes in IQ functioning as noted in earlier studies. This may be due to the small sample size used in the study or that the Shipley only addresses two areas: vocabulary and abstract thinking.

Overall the emotion-related assessments, SCL—90 in the Trauma Symptom Checklist, supported the use of the Alpha-Stim AID in helping female subjects to deal effectively with such issues. Having reductions in the clinical areas noted above could provide support as they confront their issues of alcohol/drug abuse.

References available from the author.

Special Recognition: The research team is most grateful to the residential staff who provided enormous help during the many stages involved in completing this research. We want to especially note Ms. Haley Beason, Ms. Pam Fuller, and Ms. Beth Shands. A residence providing services to victims of domestic violence has unique and challenging security issues which make it very difficult to carry out research. Without the ongoing help of these staff members, this research study could not have been completed.

HIGHLIGHTS OF INTERNATIONAL NEWS

Criminological Highlights is published six times each year by the University of Toronto Criminology Department. Each issue contains "Headlines and Conclusions" for each of the eight articles included in the issue. This is then followed by one-page summaries of each article. Since they scan approximately 120 journals to identify interesting criminological research, IACFP members may find this a welcome support for keeping up with current research.

The current issue of *Criminological Highlights*, Volume 17 (August 2018) addresses the following questions:

1. Why might it be useful for United States President Trump to read this *Highlight*? (Note: This study looks at the correlation between legal and undocumented immigration and crime.)
2. Are some people's lives made more difficult by prohibiting employers from asking job applicants if they have a criminal record?
3. Are there risks to encouraging gun ownership?
4. How can we predict which youth who offend as adolescents will still be committing offenses in 10 years?
5. Which Americans should prefer to be sentenced by a judge appointed by President Trump? (Note: This study looks at judicial ideology and appointment by both Republican and Democratic Presidents in the United States.)
6. How can police actions with youth lead youths to believe that violence is justified?
7. How have changes in the law in England and Wales affected sentencing and imprisonment?
8. Are youth from high socioeconomic families protected from the harmful effects of criminal justice contact?

You can access *Criminological Highlights* at www.criminology.utoronto.ca.

"What Works?: A systemic overview of recently published meta evaluations/synthesis studies within the knowledge domains of Situational Crime Prevention, Policing, and Criminal Justice Interventions, 1997-2018" by Jaap de Waard, The Hague: Ministry of Justice and Security, Law Enforcement Department, Unit for General Crime Policy.

This is an excellent analysis of research in these three domains. It is well written, highlights the key characteristics in each domain, and lists the recently-published studies relating to each domain. One interesting note in his review of effective criminal justice interventions was to ask why there is so much variation in reoffending between all the different interventions (from a 40% deterioration to a 60% improvement). It is critical that we answer this question. The author notes:

> "The available knowledge reveals that a number of characteristics can be identified which determine the level of effectiveness (read: reduction in reoffending) of criminal justice interventions. The effect declines as the intervention gets more removed from the concrete behaviour and the conditions in which that behaviour occurs. Of course, delinquent behaviour is personal. Nevertheless, the behaviour is often reinforced by the social context, which is often conducive to crime. If that social context is ignored, it will be more likely that the intended effects will not be achieved. The effectiveness of interventions is determined to a considerable degree by the way in which they acquire form in (difficult) practical situations. Important factors are then the duration of the intervention, the quality and enthusiasm of the practitioner, and the effectiveness of the implementation. Lastly, effective criminal justice interventions cost money. Only high-quality and intensive approaches produce results. A considerable personal effort also has to be made during the execution of the intervention."

The author ends his analysis with recommendations for putting knowledge into policy and practice. He states that dissemination of available knowledge can be improved by:

- Selecting the best channels to reach a target audience
- Excellent style and design
- Readable and understandable products
- Actively participate in bipartite discussions
- Well-timed making available of knowledge
- More interactions between research/policy and practice by organizing expert sessions

You can download the updated systemic overview at: https://www.researchgate.net/publication/326177292_What_Works_A_systematic_overview_of_recently_published_meta_evaluations_synthesis_studies_within_the_knowledge_domains_of_Situational_Crime_Prevention_Policing_and_Criminal_Justice_Interventions_1997-?_sg=cLwMsqBb83t7WZ7WvzPbcBORrFzhv4dMDjKmUKgQTDtx1XUE4mM3We8Qx3a6mjVS1r5-phqaWHam1imp3BIpTpRxs9zeECKUT--wt441.afXN4-6XeFRwY5cz_Ppp1SeMyeoztKxGZn4WBw1RtavB5ssHXc6AoSdIHKTPVDp4iefqy0g9sq4-f6PNz04fYw

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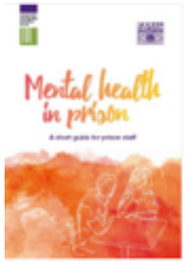
INTERNATIONAL NEWS *(Continued from page 21)*

Penal Reform International (PRI)



"Mental health in prison: A short guide for prison staff" was published by PRI in 2018. It is an excellent guide for prison staff to enhance their understanding and response to the mental health needs of adult offenders in confinement settings. While the material covered may be similar to existing staff training, it is written in a way that is both informative and practical, which will be appreciated by staff. The guidance that is given is based on a human-rights and holistic approach, as required by the United Nations Standard Minimum Rules for the Treatment of Prisoners (Nelson Mandela Rules). It is available at www.penalreform.org.

Additional Resources: www.europris.org, www.africanprisons.org, www.menace-project.org

MenACE
Mental Health, Aging and Palliative care in European Prisons

MenACE Mental Health, Aging and Palliative Care in Prisons aims to increase the response to mental health disorders within prisons and the quality of palliative and life care services provided by enhancing the competences of management and frontline staff to address prisoners' mental health needs and the special need of older prisoners.

IACFP BOARD MEETING

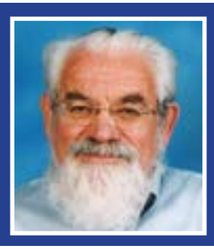
The IACFP Board met on August 7-8, 2018, in Minneapolis, MN. The meeting was held in this location to facilitate holding an IACFP Member Meeting at a time/place that was convenient for those attending the American Correctional Association's Congress of Corrections. Seven board members participated in person and three board members attended by video conference call from Australia, Portugal, and the State of Georgia. This meeting included an onboarding session for new board members before conducting the business of the Association.

The two days had a packed agenda and involved not only the board members but also Bob Morgan, *CJB* Editor; Tom Mankowski, SAGE Publisher; Ned Megargee, IACFP's representative to the NCCHC Board; and Sandy Crumrine, Earney and Associates. Agenda items included the following:

- Review of the Strategic Plan and Action Planning
  - o Student Membership Initiative
  - o Support for Membership
  - o Partnerships
  - o Branding
- Responses to an RFP for Investment Management Services
- Results of the 2017 Financial Audit Review
- Year-to-Date Finances
- *CJB* Metrics and Plans for Future
- NCCHC
- IACFP Institute
- New Policies
  - o Privacy
  - o Records Retention
- Current Challenges and Opportunities

Minutes of this meeting will be published on www.myiacfp.org following their review and approval at the next IACFP Board meeting.

THE PEERS GROUP PROGRAM:
SUCCESSFULLY REHABILITATED RELEASED PRISONERS AS PARTNERS OF NEWLY-RELEASED PRISONERS' REHABILITATION



Avraham Hoffman
Founder and
Former Director General
of the Prisoner
Rehabilitation Authority,
Israel, and an IACFP
Member
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Can we ensure a sustainable rehabilitation for prisoners?

From past times, the wise people of all generations have dealt with the question: How to ensure that a rehabilitated prisoner—who had done positive steps over the bridge that leads toward the normative society—will ***not*** revert his ways back to crime, leaving the rehabilitation specialists open-mouthed, disappointed, believing this is a strategic failure as Martinson concluded that "Nothing works."

Or, in a more positive formulation: how can we ensure that those we have invested so much effort in their rehabilitation will continue their long rehabilitation way. As said Professor Abraham Twersky, one of the major psychiatrists who dealt with offenders and drug addicts: when can you tell a man has been detoxicated and rehabilitated? When I escort him on his last way."

In Genesis, Kane is told "Is it not so that if you improve, it will be forgiven you? If you do not improve, however, at the entrance, sin is lying, and to you is its longing, but you can rule over it." (4:7)

In other words: the ***perseverance*** of the rehabilitatee is the ***top*** task of the rehabilitator.

Why does the Prisoner Rehabilitation Authority (PRA) aim at ensuring perseverance?

This issue has been preoccupying me since I began to deal with the rehabilitation of prisoners and their families. As I was searching for a method to ensure the rehabilitation's sustainability, I perceived its importance for:

- the prisoner himself,
- the rehabilitators, and
- the sceptical society—so they don't give up and despair.

And that in a democratic regime, believing in rehabilitation entails providing means, while disbelief becomes a self-fulfilling prophecy. My presentation will discuss the therapeutic aspects of the model, its target population, principles, implementation, and structure.

Then, what are the ways to achieve a sustainable rehabilitation?

We all know too well that the amount of time a social worker has for each patient is limited, and, therefore, they are content with a relatively short-term supervised rehabilitation process—one year up to a maximum of two years.

At the PRA, we have developed a few programs to increase the chances of achieving a sustainable rehabilitation:

- Employing successfully rehabilitated inmates as guides in our residential hostels for released prisoners.
- Transforming the Hostels as rehabilitation centres, even for the rehabilitatee after he leaves the hostel. He knows it is his second home, where he can come back to, when he feels his weakness and the danger of relapsing.
- We organise gatherings of the hostels' graduates before every holiday, where the graduates together with their family members gather. These meetings have great positive and strengthening impact on the rehabilitatees and those presently rehabilitating.
- **The Peers group program** that I will present today: After clarifying the importance of the rehabilitation sustainability, I will present the methods used by the **PRA**, Israel to achieve this target, namely the ***Peers program***:

The ***Peers program*** was developed by the PRA over 20 years ago. This program trains released prisoners who have successfully sustained rehabilitation for 2 years since their release from prison, to become active partners in the rehabilitation process of newly-released prisoners.

What makes a released inmate eligible to become a "peer"?

1. Being drug free for at least 2 years—according to

(Continued on page 24)

PEERS GROUP PROGRAM *(Continued from page 23)*

urine tests.
2. Hasn't been involved in crime for at least 2 years—according to police intelligence reports.
3. Has been persevering at a steady work for at least 2 years.
4. If married—he is conducting healthy and non-violent family relations.

The "***Peer***" must steadily participate in an 80 hours course (during 20 weeks) after his working hours. Following the course, the "peer" is required to accompany released prisoners and integrate them into the "***Peers group***" during a year following their release from prison. The Peers' group, together with the newly rehabilitatees, form a **rehabilitation community:** strengthening the peer's rehabilitation and offering the newly-released prisoner a role modelling and a meaningful support during his rehabilitation process.

A former offender cannot stay neutral toward crime. He cannot just ignore it, he must take a stand. Therefore, the only way to prevent him from being swept away by crime is by making of him a crime fighter, by helping the rehabilitatee and strengthening his perception of the positive life style.

The program's theoretical basis:

This unique program was developed by the rehabilitation psychologist Anna Kadmon-Telias together with major Israeli academics. The therapeutic model is based upon the existential theory of Frankel, that man searches for meaning through suffering as developed by Professor Shoham in 1980. This is a trial to realise this idea through a peer group where the social worker translates this idea into reality.

The therapeutic method is taken from the Winnicott's ***Object relations***[1] theory, and focalises on the permanence of the object. According to this therapeutic perception, the development of the group is parallel to the development of the baby as the individual, the subject, the baby, grows and develops through his relations with the primary object – the mother, the concept "***permanence of the object"*** relates to the permanent mother that is available to the baby.

In our program the permanence of object includes 4 elements:

1. Permanence of psychotherapist.
2. Permanence of place.
3. Permanence of time.
4. Common task.

These elements are the basis of the therapeutic work in the peers group, and thanks to them, the individual experiences inclusion, a sense of "togetherness" that enables growth.

1. **Permanence of psychotherapist:** According to Winnicott "a baby cannot exist without his mother. Through their relation, he develops the ability to love and give." According to Biran (1983), what is needed from the primary figure is needed from the group therapist: to be the 'good enough mother' to enable the not 'good enough mothers' from the patient's past experiences to express in therapy.

   The 'good enough mother' has the ability to understand the needs, to capture and understand the coded messages, and translate them and to provide a holding environment for the client so they have the opportunity to meet neglected ego needs and allow their true self to emerge.
2. **Permanence of place:** a person develops a relation to a permanent work room that symbolises his inner world even when it is composed of only 4 walls that contain his experiences and thoughts. In the groups, the permanent therapy room is a part of the group as individuals are projected onto him in the form of emotions, expectations, and disappointments. In comparison, in the prison therapy room all the projections belonged to a place outside **the walls.** The intervals created between the meetings enable the individuals to cope with separation and differentiation.[2]
3. **Permanence of time:** the interval between the meetings obliges the rehabilitatee to stay alone and practice the ability to decide, internalise, and apply. The meetings develop the ability to meet and live with the differences. This permanence is needed because of the passage of the patient from the reality behind walls—where most of the projections came from the world outside the walls and with no intervals—these intervals enable the therapeutic process to be examined. The

(Continued on page 25)

[1]Winnicott 1958, 1965; Segal 1973; Farbain 1952; Kerenberg 1975.

[2] Mahler, cited in Biran 1983.

PEERS GROUP PROGRAM *(Continued from page 24)*

interaction between the intervals and the meetings makes the growth possible.
4. **Common task:** The common task of the peer and his trainee offers them the understanding of their common fate that developed before prison and between its walls, their belonging to other norms and to a world where different principles live and operate, and other codes of language and norms of the offenders' sub-culture exist. Thanks to these, the peer and his trainee are able to find a real ground to their common positive task—not to return to prison.

The therapeutic tools:

A therapeutic educational framework: the 6-month training for the peers creates a group consolidation. Through the education, the therapy is achieved. The peers learn tools that are therapeutically effective. During the training they learn:

- The Maslow hierarchy of needs model.
- The coping with stigma and belonging to a new social group.
- To differentiate between power and aggressiveness.
- To differentiate between different kinds of communications: aggressive, passive, and assertive. Hence, they learn to stand for their rights without hurting others rights.
- They acquire tools for problem solving.
- They learn to negotiate.

The principle of pair and cooperation between the peer and his trainee: the common past of both the peer and his trainee enables the creation of a special bond that the therapist doesn't have.

"together" – we have a common history.

"apart" there are limits between us.

The cooperation and sharing helps solve conflicts. The message of the peer to his trainee is a message of hope, growth, like a "generational message:" the peer was in the same place as his trainee and today he is in another place. This relation enables a common language, openness because they have the same "mother tongue."

The group meeting: the meeting between the peers and their trainees states a brave message: **"bent trees do straighten."** Each trainee is like a tree who suffered a great trauma and after receiving good treatment and rehabilitation, he can grow. Although different trees suffer of different trauma, the dilemmas are the same:

- Should I tell where I come from, what in my early development caused low self esteem, with which I have dealt by avoiding dealing with it, and through demonstrating aggressiveness.

or

- Should I continue to hide my past.

It seems that all trees that straighten have the same dream, the same challenge to stand straight and upstanding in front of society, and obtain a second chance to prove themselves in front of society's test.

The program's elements:

The program is composed of 5 components:

1. Professionals—therapists.
2. Peers—released prisoners that successfully rehabilitated.
3. Trainee—released prisoners at the beginning of their rehabilitation process.
4. Pairs—a peer and a trainee.
5. Group—a therapeutic setting where the professional, the peers, and the trainees participate.

First stage: the professional locates, chooses, and trains the peers. Hence, an educational therapeutic group is created.

Second stage: after the integration and training of the peers, the trainees are chosen according to professional criteria and pairs are formed. The peer-trainee meet once a week.

Third stage: the core group of the professional and the peers is expanded to include the trainees that join them, and hence, is created the ***Group***: the goal of the ***peers program***. This group setting moderates the problem of released prisoners: the lonely man. As the rehabilitatee becomes active in integrating a newly-released prisoner, his own rehabilitation motivation to persevere is strengthened.

Conclusion

This program contributes to the rehabilitation

(Continued on page 26)

PEERS GROUP PROGRAM *(Continued from page 25)*

theory a method that has succeeded in securing the rehabilitation's sustainability and the prisoner's perseverance as a positive citizen choosing the right path of life.

The contribution of this program that has been operating in Israel for over two decades, to the rehabilitation theory, lies in the fact it has succeeded in ensuring the preservation of rehabilitation and the released prisoner's perseverance as a positive citizen in his community, and eventually his choice to proceed with this positive path while at his ***eternal*** crossroad between the return to crime or the perseverance on his rehabilitation road.

Every program needs preservation because it should be connected to the reality of life. In real life each one has his own obligations, and there is a danger that a participant will disconnect from the network that supports him. Therefore, we sought the creation of a community of rehabilitatee in which the members help and support each other with the accompaniment of a professional, so that just as one starts stumbling—before he commits crime—he can find remedy.

In Deuteronomy (22:8) it says: "When you build a new house, you shall make a guard rail for your roof…" these people need a guard rail, some throughout their lives. But a pleasant guard rail, such as friends, offers a community where he doesn't have to pretend = a ***rehabilitative community*** that is both a purpose and a means of perseverance.

Letter to the Editor

Dear Editor:

A friend of mine who is an IACFP member lets me ready your newsletter which has opened my eyes to many things not taught in college in our criminal justice courses/classes, especially those articles by two of your prolific writers, Dr. Richard Althouse and Dr. Ronald Mellen.

Their articles bring several questions to my mind which are listed below and I truly hope both of them would jointly answer:

1. Are any of us born with criminal genes?
2. If so, can these genes or DNA cause criminal minds?
3. We are told that a society or civilization is judged by the way it treats its women. If so, why do we have so many females abused, murdered, and incarcerated?
4. Do we really want and try to rehabilitate criminals or is this a cruel joke or mockery of our justice system?
5. Based upon public media, we have many unconvicted criminals in public office who are arrested, convicted, given light to suspended sentences, or, in spite of strong evidence them, as exonerated by juries. Could this be a reason or factor why so many of us have no respect for law and order and continue in lawlessness?

I would like to see your answers in one of your upcoming IACFP newsletters. Your answers will help me and all of my classmates. Two of our professors intend to join your organization. Thank you very much.

Sincerely,
Gina Marie d leAngelo
Criminal Justice Student
Wayne State University
Detroit, Michigan

VIGNETTES OF GLIMPSES INSIDE

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

RON MELLEN

After retiring from Saint Mary's University in San Antonio, Texas, and before returning to teach at Jacksonville State University in Jacksonville, Alabama, I worked in the Arkansas Department of Corrections for 6 years. The first 3 years in Arkansas corrections was as Clinical Director of the Special Program Unit (a mental health unit) and the last 3, I was staff psychologist for the 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: *Sometimes You Have To Rise Above Principle* follows below.

SOMETIMES YOU HAVE TO RISE ABOVE PRINCIPLE

"Count" was made and a quiet but determined search was, suddenly, under way for inmate Don. While not a trouble maker, today had been particularly challenging for inmate Don. The first round of the search was unsuccessful and as one officer said "This can't be good!" In fact, the officers' moods were, as with the early evening light, fading a bit more into darkness.

Meanwhile, Sarge was searching the grounds outside the buildings when he walked up to an inmate leaning against a fence that enclosed one of the unit's radio towers. The inmate said nothing but his right hand, in a subtle movement, pointed Sarge's glance to the top of the tower. "Lo and behold", near its top sat inmate Don. Having found a fairly comfortable place to settle in, the inmate appeared relaxed with a slight smile suggesting smugness.

Sarge made a number of attempts at talking the inmate into coming down, but all efforts resulted in failure. With each attempt Sarge did notice an increasing sense of fatigue on the inmate's part. Sarge then lit up a cigarette and had the other inmate bring him a cup of coffee. Word traveled fast and soon other officers and administrative types stood around in the shadows waiting to provide assistance, if needed.

With coffee and the cigarette in full view, Sarge continued an on-going comfortable, relaxed conversation with inmate Don. While Sarge was into his second cup of coffee and third cigarette the inmate made a tentative offer... "I'll come down for a coffee and cigarette but I'm afraid you will grab me." Sarge replied, " I promise not to grab you when you get your coffee and cigarette."

The bargain was struck and inmate Don came down and gratefully and suspiciously partook of his drink and cigarette. However, as the inmate turned to go back up the tower, he was grabbed and handcuffed by Sarge. In disgust, inmate Don complained about how the "deal" that he and Sarge had made had been violated. Sarge replied that he had indeed honored the "deal" and not grabbed the inmate while enjoying his cigarette and coffee. However, the bargain did not include what Sarge would do after the cigarette and coffee had been finished.

I guess there is a little of Captain Barbossa in every successful Correctional Sergeant or as Sarge said later, "Sometimes you just have to rise above principle."

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.

NCCHC SPRING CONFERENCE BROUGHT PURPOSE, PROGRESS, PERSPECTIVE TO CORRECTIONAL HEALTH PROFESSIONALS

Javel Jackson, PsyD, International Association for Correctional and Forensic Psychology (IACFP) president and chief psychologist for the Georgia Department of Corrections, presented an educational session at the National Commission on Health Care's (NCCHC's) 2018 Spring Conference on Correctional Health Care, held April 21-24, 2018, at the Hyatt Regency in Minneapolis, Minnesota. Her talk, titled: "Creating Success Stories for the Moderately Mentally Ill at a Transition Center," focused on a transition center in Georgia that accepts moderately mentally ill offenders for placement, highlighting the criteria, the supportive environment needed, the collaboration of staff, success stories, challenges, insights learned, and what must occur to successfully manage moderately mentally ill offenders. The IACFP is a supporting organization of NCCHC, the nation's leading authority on health care in jails, prisons, and juvenile facilities.

The conference theme, "Purpose, Progress, Perspective," reflected the uniquely challenging and rewarding nature of correctional health care for the many nurses, physicians, and mental health professionals who practice in the field. The conference featured more than 50 educational sessions on clinical, administrative, and legal aspects of correctional health, plus in-depth preconference seminars on NCCHC's newly-revised Standards for Health Services in Jails and Prisons, which reflect the latest understanding of best practices in providing quality, constitutional care. The new versions of the Standards were available for purchase at the conference as well. Other preconference seminars explored hot topics such as trauma-informed care and cultural competence, as well as continuous quality improvement and pain management. Educational sessions on mental illness, substance abuse, women's issues, suicide prevention, and much more were presented by leading experts in the field. Professionals could earn up to 26.75 hours of continuing education credit by attending the conference and preconference seminars.

The four-day conference was recommended for any correctional professional who was interested in learning more about health care for the incarcerated population—currently more than 2 million adults and juveniles—and its implications for public health and safety. Highlights also included networking activities, educational lunches, and an exhibit hall featuring hundreds of products and services to support correctional health care.

All conference activities took place at the Hyatt Regency Minneapolis, 1300 Nicollet Mall. Visit the website at: www.ncchc.org

National Commission on Correctional Health Care

About NCCHC: The National Commission on Correctional Health Care is a not-for-profit 501(c)(3) organization working to improve the quality of care in our nation's jails, prisons and juvenile detention and confinement facilities. Programs and resources include standards for health services in correctional facilities, a voluntary accreditation program for facilities that meet these standards, educational trainings and conferences, publications and professional certification. NCCHC is supported by the major national organizations representing the fields of health, law and corrections. Each of these organizations has named a liaison to the NCCHC Board of Directors.

NCCHC Supporting Organizations
Academy of Correctional Health Professionals, Academy of Nutrition and Dietetics, American Academy of Child and Adolescent Psychiatry, American Academy of Family Physicians, American Academy of PAs, American Academy of Pediatrics, American Academy of Psychiatry and the Law, American Association of Public Health Physicians, American Bar Association, American College of Correctional Physicians, American College of Emergency Physicians, American College of Healthcare Executives, American College of Obstetricians and Gynecologists, American College of Physicians, American College of Preventive Medicine, American Correctional Health Services Association, American Counseling Association, American Dental Association, American Health Information Management Association, American Jail Association, American Medical Association, American Nurses Association, American Osteopathic Association, American Pharmacists Association, American Psychiatric Association, American Psychological Association, American Public Health Association, American Society of Addiction Medicine, International Association for Correctional and Forensic Psychology, National Association of Counties, National Medical Association, National Partnership for Juvenile Services, National Sheriffs' Association, Society for Adolescent Health and Medicine

PRISON-BASED MEDICATION TREATMENT IN RHODE ISLAND IS REDUCING OVERDOSE DEATHS

When Rhode Island officials discovered that three of five overdose death victims in the state in 2014 had an incarceration history, it became clear that a cultural shift in how offenders' needs are addressed had to begin. Much broader access to gold-standard medication treatment for opioid dependence had to be offered, in order to mitigate the threat of relapse and potentially deadly overdose for individuals returning to the community from custody.

Now in 2018, Rhode Island has what is believed to be the first federally-recognized opioid treatment program (OTP) delivering methadone treatment directly within a correctional facility. Overdose deaths among the recently incarcerated in the first six months of 2017 compared with the same period a year earlier were down 61%. That striking statistic was among the data most frequently cited in presentations by national leaders at a recent National Rx Drug Abuse & Heroin Summit in Atlanta.

"The cultural shift is happening," Linda Hurley, president and CEO of CODAC Behavioral Healthcare, the Rhode Island-based provider operating the opioid dependence treatment services in the corrections system, tells *Addiction Professional*. Still, she acknowledges with regard to the effort, "When you're turning a Titanic, it takes time."

The effort, which Hurley describes as growing out of a "really cool convergence" among CODAC, the Rhode Island Department of Corrections and evaluators at Brown University, involves screening of all inmates upon commitment and prior to release, with medication-assisted treatment (MAT) targeted to three distinct populations:

Offenders who have already been on MAT in the community and can be maintained on their medication (methadone or buprenorphine) while in custody for up to one year. Upon release, these individuals are immediately connected to an appropriate treatment clinic in the community. This group accounts for more than half of the overall correctional MAT population being served.

Sentenced individuals who are not currently on medication treatment but have a history of opioid dependence. Hurley explains that these individuals can request induction to any of the three federally-approved medications for opioid dependence: methadone, buprenorphine or injectable naltrexone.

(Continued on page 30)

MEDICATION TREATMENT *(Continued from page 29)*

Individuals who arrive at the state correctional system's intake center and may end up staying only a few days before court disposition or who may serve a very short sentence. These individuals can be initiated to methadone or buprenorphine where appropriate pre-release, and are also connected to a community provider. Hurley suggests that this population's needs often go unaddressed because "the shorter amount of time we have them, the lower the engagement."

Rehabilitative history

Hurley says Rhode Island's corrections system always has been progressive on inmate rehabilitation, even before that word came into vogue nationally. As far back as the late 1970s, CODAC was working in the state prison complex, counseling DUI offenders in a weekend custody program.

In the mid-1990s, pregnant inmates and inmates with HIV were identified as priority populations for receiving methadone while in custody. However, the vast majority of the total inmate population still was being withdrawn from MAT while behind bars.

A major goal of the corrections department's medical Program Director, Jennifer Clarke, MD, MPH, was to keep offenders on medication treatment longer, thus increasing retention in treatment post-release and reducing overdose death. An infusion of state funding brought in CODAC in a competitive bidding process to operate the enhanced MAT program.

Strong support from Clarke and former Corrections Director A.T. Wall built momentum for shifting the outlook about medication treatment in prison and overcoming any potential resistance, Hurley explains. CODAC offers supportive counseling, discharge planning, and ongoing care in the community along with its medication management services for inmates.

The recognition of CODAC's program as an in-prison OTP reduces wait times for initiating an individual on medication treatment, which Hurley considers a critical benefit.

For inmates who are being newly initiated on medication, the breakdown of which medication they're receiving stands at around 60% methadone and 40% buprenorphine, says Hurley. "If they know something worked for them before, that influences their decision," she says.

Data from the state indicate that around 7 in 10 individuals from the three target populations combined are remaining on MAT after release. This is seen as a crucial development, as inmates returning to the community after having been withdrawn from medication treatment face a huge risk of relapse to opioid use—a potentially fatal consequence given the presence of fentanyl in the drug supply.

The data on reduced overdose deaths in the offender population, published in *JAMA Psychiatry*, are receiving national attention. A careful integration of correctional and rehabilitative goals, with realistic timelines in an area of government that can be slow to change, could bring about similar results in other states, Hurley believes. "This is replicable," she says.

Excerpted from an article (by Gary A. Enos) in the April 9, 2018 issue of the *Addiction Professional*, published by the Institute for the Advancement of Behavioral Healthcare on AddictionPro.com

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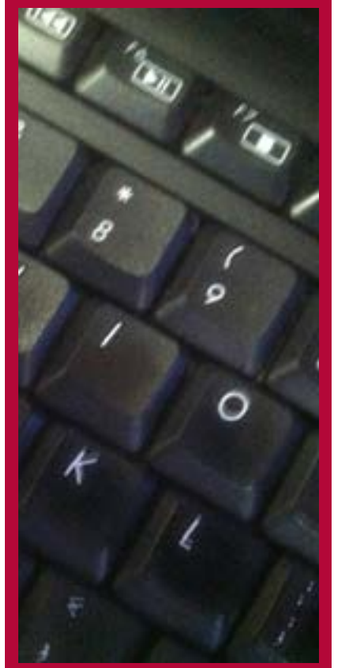

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