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This Issue in Brief

Divided by a Common Language: British and American Probation Cultures.—American and British probation officers speak the same language but—according to authors Todd R. Clear and Judith Rumgay—have very different approaches to their jobs. The authors explore the important differences between the two probation traditions and their impact on the development of probation supervision in both countries.

Alternative Incarceration: An Inevitable Response to Institutional Overcrowding.—Authors Richard J. Koehler and Charles Lindner discuss alternative incarceration programs—programs for offenders who do not require the total control of incarceration, but for whom probation is not an appropriate sentence. The authors highlight New York City's Supervised Detention Program, a program which provides an alternative to pretrial jail incarceration, as an illustration.

Variations in the Administration of Probation Supervision.—Authors Robert C. Cushman and Dale K. Sechrest explore the reasons for the great diversity in the operations of probation agencies, including differences in caseload size and services provided. They document variations in felony sentencing and use of probation for 32 urban and suburban jurisdictions using data primarily collected by the National Association of Criminal Justice Planners.

An Evaluation of the Kalamazoo Probation Enhancement Program.—Noting that few studies have evaluated halfway houses designed exclusively for probationers, authors Kevin I. Minor and David J. Hartmann report on a study of a probation halfway house known as the Kalamazoo Probation Enhancement Program (KPEP). Findings reveal that while relatively few residents received successful discharges from KPEP, those who did were less likely than those who received unsuccessful discharges to recidivate during a 1-year followup period.

Criminalizing Hate: An Empirical Assessment.—Author Eugene H. Czajkoski focuses on a fairly new phenomenon in the criminal justice taxonomy, hate crime. He discusses the recent movement to criminalize certain forms of hate and examines data officially reported by the State of Florida regarding the first full calendar year of operation of its hate crime law.

Pretrial Bond Supervision: An Empirical Analysis With Policy Implications.—Author Keith W. Cooprider discusses policy and operational implications derived from an empirical analysis of bond supervision data obtained from a county-based pretrial release program. He analyzes the use of electronic monitoring and describes patterns of success and failure on bond supervision.

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Redefining the Boundaries of Mental Health Services: A Holistic Approach to Inmate Mental Health*

By Margaret M. Severson, J.D., M.S.W
Assistant Professor, School of Social Work, Louisiana State University

Defining the Existing Problem

In June 1991, a record 804,524 adult prisoners were under state or Federal correctional jurisdiction.[1] The number of juveniles held in long-term facilities in 1989 totaled 36,156, a 14 percent increase over 1985 census figures.[2] Most state and Federal prisons were operating from 18 percent to 29 percent over capacity at the end of 1990.[3] Despite widespread activity, construction will not keep up with the number of beds needed to house new Federal and state prisoners. By 1995, United States detention and correctional institutions will house over 2 million people, with Federal, state, and local governments devoting over $60 billion per year to the industry.[4]

The increasing demand for prison beds is not likely to change in the foreseeable future. According to one estimate, recidivism rates stand at 62.5 percent for released prisoners[5] and 43 percent for felons granted probation.[6] Mandatory sentencing laws, already a strong contributor to the burgeoning prison industry, will continue to impact on prison admission rates for first-time felony offenders.[7]

The current and anticipated influx of prisoners into correctional systems translates into increased demands for security and professional staffing within those prisons. Programmatic changes, to enhance efficiency in terms of both time and cost, are also required as a result of the growing prisoner population.

In particular, mental health staffing and program development and enhancement are factors that must be addressed. Between 1984 and 1990, statistics reveal a 16 percent increase in the number of state inmates actively participating in an alcohol, drug, or mental health counseling program.[8] Mentally disordered offenders may account for up to 35 percent of the prison population,[9] depending on the definition of mental disorder. The management of mentally ill persons in prisons may well be "the primary challenge at this point in time,"[10] even though "public and professional interest in them wanes" once they are incarcerated in a prison.[11] Correctional professionals have a choice: Staff and programming needs can be addressed in a piecemeal fashion or, as is advocated here, can be explored as complementary, overlapping components of a holistic approach to the "wellness" of inmates. While this approach can loosely be labeled rehabilitative, the demand for institutions to rehabilitate prisoners is virtually nonexistent in the 1990's. Furthermore, while rehabilitation may be the ultimate sought-for product, the term itself does not descriptively encompass the short-term gains that can be made in prisoners' mental health and the means by which these gains are made. The primary objective for redefining and expanding the boundaries of mental health services is not found in reduced recidivism rates or, in fact, in reduction or improvement levels in any one measurement category. Rather, a holistic program implies an approach to inmates which makes use of available resources and is acceptable to correctional administrators nationwide. It promises better security in the institution regardless of the number of inmates housed within its walls.

Contemporary Correctional Mental Health Programs.

A 1988 survey of all United States correctional facilities reveals that there are 6.3 full-time mental health care staff for each 1,000 prisoners.[12] If 35 percent of the 1,000 prisoners require mental health services, the average professional carries a clinical caseload of 56 inmates. This startling number makes it readily apparent that if the hope of rehabilitation and the quest for lower recidivism rates rest solely on the shoulders of mental health professionals, these objectives will never be realized.

In order to compensate for the unyielding number of inmates, treatment programs have either been discarded or have gone the way of specialization. A review of the literature illustrates that these programs generally fall into four main categories.

"Generic" Treatment Services. While not a specific type of therapy, "generic," as used here, denotes services which do not focus on a specific population or on the specific goal of rehabilitation. Despite the label, they are the most prominent and prevalent services rendered in the institution. They include intake assessments, crisis intervention, suicide prevention, stress management, and situational conflict resolution services. These clinical duties are aimed at alle-

*This article includes subject matter referred to in the author's presentation at the 2nd Annual Midwestern Mental Health in Corrections Symposium, May 1992.

viating "emotional adjustment problems"[13] and/or are a method of identifying problem inmates and controlling the behavior of those who are antisocial, not mentally ill.[14]

Substance Abuse Treatment. One-third of state prisoners, one-fourth of convicted jail inmates, and nearly one-half of youths sentenced to state-operated facilities have admitted being under the influence of an illegal drug when they committed their crime.[15] Mandatory sentencing laws result in longer prison stays and an increasing inmate population. In the Federal system, prison sentences for persons charged with drug violations were "longer than for all other offenses except violent crimes and racketeering in 1988."[16]

The Bureau of Prisons uses drug education programs, limited individual drug-counseling sessions, and intensive residential treatment programs to respond to the substance abuse problems of its inmates.[17] State systems have responded with similar programming. Washington, DC, for example, has set up an alcohol and drug treatment program aimed at reducing recidivism rates. At an average cost per inmate of $31,000 to $36,500, these inmates receive individual and group therapy, vocational or educational instruction, and a pleasant environment in which to receive treatment.[18] The long-term results of these substance abuse programs are not yet available.

Sex Offender Treatment Programs. In 1988, of 757 United States prisons responding to a national survey, 191 had sexual offender/violent offender treatment units.[19] The success of such programs is not clear. Certain behavioral outpatient programs suggest that around 90 percent of all sexual offenders, except men who rape, benefit from treatment.[20] However, there are many different forms of behavioral treatment, all of which are still considered experimental relative to the treatment of sexual offenders,[21] and many of these behavioral methods are governed by ethical and legal codes.

Drug treatment, such as the use of depo Provera which causes a chemically induced castration, has been used in both Europe and the United States. While the nonpermanent reduction in sexual urges and capacities is said to result from the administration of such drugs, an actual reduction in sexual offenses has not clearly been seen. Still, the issue of chemical castration for sexual offenders is a heatedly debated topic. Note the recent Texas case involving Steve Allen Butler, a pretrial prisoner accused of sexually assaulting a 13-year-old female. Though Butler requested chemical treatment, the fervor that resulted from the court's willingness to go along with the idea ended his quest for now. Arguments for and against chemical castration have ranged from the absurd to the scientific: comparing the effectiveness of castration of animals to castration of humans as well as arguing that chemical castration does not result in a reduction of anger, said to be the real cause of sexual assault.[22]

Regardless of what treatment programs are in use in prisons, the majority of researchers suggest that programming available to sexual offenders within the correctional facility, to be effective, must be followed by appropriate treatment in the community.[23]

Therapeutic Communities. These relatively new programs are often geared for substance abusers, but have also been organized for the treatment of severe mental disorders. Of 757 prisons across the country in 1988, five percent of them provided treatment programs which included a therapeutic community.[24] Individual and group counseling is often available. The goals of treatment include behavioral control, environmental adaptation, and preparation for successful living outside of prison. Typically, education, therapeutic services, and vocational training are part of the community package.[25]

While these communities offer the most holistic approach available, they can be expensive to operate, and the jury is still out on the actual programmatic benefits.

Legal Mandates for Prison Mental Health Programs

Correctional mental health programs have been driven by case law which addresses medical and mental health programming, as well as by litigation challenging the conditions of prisoner confinement.

Landmark Prisoner Cases. *Estelle* v. *Gamble*[26] resulted in the "deliberate indifference" standard being applied to cases challenging the adequacy of medical and mental health standards. This litigation was initiated by a Texas inmate injured when a 600- pound cotton bail fell on him while working at the prison. He consistently complained to medical personnel, who responded, sometimes with delay, with diagnostic tests and medication. The Court found against Gamble's constitutional claim, insisting his was, at most, a case of medical malpractice. In doing so, the Court created a standard which looked at whether prison officials acted in a manner which could be seen as the wanton infliction of pain. Mere negligence is not enough to create a constitutional claim. To reach constitutional proportions, the indifference to serious medical needs must shock the conscience of the reasonable person who is privy to the facts.

In *Bowring* v. *Godwin*,[27] the Federal court of appeals extended the standard espoused in *Estelle* to those inmates with psychiatric problems. In this case, an inmate who was denied parole argued that the denial sprang from a psychological evaluation which sug-

gested he might not be a successful parolee. Bowring further insisted that the state had the responsibility to provide him with treatment. The court concluded that inmates are entitled to mental health treatment if a condition exists which can become harmful if not treated and can be improved if treated.[28]

A variety of other cases also set forth new correctional duties relative to prison inmates. *Ruiz* v. *Estelle*[29] mandated evaluation and screening standards by which inmates would be assessed for treatment needs. In *Pugh* v. *Locke*,[30] Alabama inmates successfully challenged the state on its insufficient classification system. The court ordered that a specifically detailed classification plan be prepared on each inmate incarcerated in the state system.

Despite this activity in the courts, there is still no clearly established right to rehabilitation.[31] In *Pell* v. *Procunier*,[32] the United States Supreme Court, in dicta, discussed the responsibility prison systems have to provide rehabilitative programming. Justice Stewart, writing for the majority in this case regarding free speech rights of inmates, remarked that rehabilitation is a "paramount objective of the corrections system," along with security and deterrence. Still, the actual requirement to provide prison rehabilitative programs has been addressed only in a narrow context. In *Ohlinger* v. *Watson*,[33] where sexual offenders were incarcerated on the basis of having a mental disability leading to their offenses, the court said that treatment was constitutionally required for these inmates because their sentencing was based on their mental condition.

Important Recent Decisions. *Wilson* v. *Seiter*,[34] decided by the U.S. Supreme Court in 1991, arguably changed the standard for determining deliberate indifference in prison litigation. Written by conservative Justice Scalia, the Court ruled that petitioner inmates must show that prison officials had a culpable state of mind when alleging incidents of cruel and unusual *punishment* (emphasis added). In this case, Wilson, an Ohio inmate, brought a condition of confinement suit, complaining of, in part, overcrowding, inadequate temperature control and ventilation, and classification-housing inadequacies. The Court ruled that a successful condition of confinement suit must show that a single, identifiable human need was deprived of satisfaction because of one or more conditions of confinement.

Rufo v. *Inmates of the Suffolk County Jail et al.* (1992)[35] is an important recent decision because it leaves an opening for state and local authorities to claim changed circumstances and ask for a modification to their consent decree. An original consent decree, entered into after the Federal district court found conditions in the Boston jail to be constitutionally deficient, called for single-cells to be designed into the new jail construction plans. The sheriff, during the building process, moved to have the decree modified to allow for double-bunking. The United States Supreme Court commented that institutional reforms have made it increasingly important for courts to acknowledge "changed circumstances" when called to modify a consent decree.[36] The Court outlined three circumstances under which modification should be strongly considered:

1) "when changed factual conditions make compliance with the decree substantially more onerous";

2) "when a decree proves to be unworkable because of unforeseen obstacles"; and

3) "when enforcement of the [original] decree would be detrimental to the public interest."[37]

Greason v. *Kemp* (1990)[38] involved a Georgia prison inmate whose relatives brought suit after he committed suicide. The court listed its prior decisions which firmly established the principle that inadequate psychiatric care could lead to violations of constitutional proportions. The court, in footnote 18 of this opinion, suggested that deliberate indifference could be causally linked to a constitutional violation when an "inmate's injuries result from the supervisor's failure to provide an adequate staff to administer medical or mental health care."[39]

Redefining Boundaries: The Holistic Approach

> *"The question we face today is not whether prisons will provide therapeutic services, but what is to be the role of services that are provided. . . . the latter is the more difficult question because it requires that we redefine the therapeutic activities of prisons in light of a somber reassessment of current etiological theories and of available treatment techniques."*[40]

Correctional practitioners and researchers have commented on the need to experiment with innovative concepts which will have a positive impact on the goal of reduced recidivism rates through creative rehabilitative programming.[41] Nonetheless, the courts have granted inmates no general right to rehabilitative treatment.[42] Addressing long-term treatment or rehabilitative needs for inmates is generally considered to be a policy issue rather than a legal mandate.

Mental health services have historically been viewed as encompassing only the treatment of inmate psychological problems. The emphasis has been on illness versus health, on inter-psyche components versus external forces which impact on the psyche, and on behavior management and maintenance of the status quo versus behavioral change with necessary accompanying disruption of the status quo. One study illustrated this when reporting that three-fourths of 155 prison security officers answered "keeping in-

mates from causing trouble is my major concern."[43] In spite of this response, those officers supported the concept of prison rehabilitation and expressed the belief that treatment was equally important as punishment.

There is a decipherable attitude, if not promotion, towards relinquishing any hope of progress toward the goal of rehabilitation. There has been relatively little interest shown in rehabilitation over the last two decades; those formulating policy have not tackled this objective with any enthusiasm.[44]

The failure of rehabilitation strategies has been alternately blamed on the use of the medical model as an approach to this objective, one that approaches the offender as being "sick,"[45] and on the failure of the so-called balanced approach, which places the success of rehabilitation on both creative programming by social scientists and willful participation by prisoners.[46]

The schism between treatment and security staff is widest in a rehabilitation approach.[47] This distance results from the belief that only degreed mental health professionals can render rehabilitative therapeutic services—a belief often reinforced by mental health professionals.

Mental health professionals have not enjoyed the greatest of reputations within correctional institutions.[48] Mental health practitioners have failed to singlehandedly reduce recidivism rates through offender programming, yet, to some extent, continue to take on the burden of rehabilitation. This burden may well result from unrealistic expectations of correctional administrators and planners. It may also be a by-product of the resistance of mental health professionals to sharing treatment responsibilities.

The Missing Ingredients: Ten Categories of Cooperative, Interdisciplinary, Wellness Services and Functions

> *"Today we have created a correctional system in which a man has little or no obligation to provide restitution to his victim, to the state, or to the community for his transgressions. . . . he can enter prison with no education, no job skills, no motivation to change, and suffer no adverse consequences for remaining that way."*[49]

This statement sums up much of what is missing in today's correctional programming and concisely illustrates the components necessary for the holistic approach to improving the mental health of inmates. The failings of the criminal justice system, the pain of victims, the importance of education, work skills, and psychological care, and finally, the imposed or assumed powerlessness of correctional administrators is reflected in these few lines.

There are at least 10 services and/or functions which need to be included in a holistic mental "wellness" program. For each, the traditional boundaries which have kept mental health practitioners separate from other professionals employed in the institution must be stretched or eliminated.

The following list of services and functions which belong in a holistic mental wellness program for prisoners is not exhaustive. In addition, a full explanation of the interaction between each category as it relates to holistic treatment of the inmate is more appropriately left for a future writing. For the present, this list serves as an introduction to the concept of a true interdisciplinary approach to mental health services.

Communication. All correctional staff members must regularly share information about the changes that are taking place within the inmate population. This entails the disclosure of information about both individuals and groups. For example, prisoners identified as being at high risk for victimization within the institution clearly have an impact on and create implications for security, mental health, classification, medical, and administrative correctional staff. In addition, good communication includes good record-keeping and a system by which pertinent records can be shared.

Medical Services. When is it appropriate to share medical and/or mental health information with other, nontraditional treatment personnel? Courts, for the most part, have become increasingly tolerant of a more liberal flow of information between medical personnel and nonmedical correctional staff, for example, in the case of a communicable disease.[50]

Environment. Environmental conditions can have an impact on the health of prisoners (and staff members). However, many of those incarcerated in state prisons, when released, will return to an environment even more bleak than the one they resided in while incarcerated. For the purposes of a holistic program perhaps the most valuable environmental variable will be to arrange for a treatment environment which has as minimal distractions as are practical.

Training. Tap the hidden therapist in every correctional employee. Enlist, through education, the assistance of security officers, classification personnel, medical staff members, educators, and administrators. Reap the benefits of bilateral communication by not only receiving information from the nonmental health employee, but also by sharing pertinent information. Employee participation is a key to the holistic approach. Each employee must believe he or she has a stake in a prisoner's health. This stake cannot be recognized when the mental health practitioner keeps him or herself at a distance (i.e., behind professional boundaries) from the line employee.

Employee Education. Offer to the staff what is offered to the inmates. Cut through the "inmates get

it all" attitude that can pervade the corrections environment. This can be done by offering college courses via correspondence schools and onsite classes. Physical fitness programs, financial management seminars, brown-bag special topic lunches, and other easily organized employee perks should be offered.

Classification. Housing decisions must involve input from other professionals who are in contact with the inmate. Mental health, medical, educational, security, and religious employees are likely to have information that bears on the appropriate placement of a prisoner within the institution.

Work/Academic/Vocational Programming for Prisoners. Job education/training. Team up with government and privately funded programs. The objective is to "train" in conjunction with the other nine ideas discussed here. One example is found in the Bureau of Prisons' "TIE" program,[51] an acronym for training, industry and education. Based on the premise that 200,000 prisoners leaving prison each year have needs for employability, the Bureau of Prisons formed a partnership with the private sector. Career counselors assist the inmate in determining the latter's career interests and skills and place the inmate in appropriate education and training classes with the goal of assigning the inmate to a job for which he has been trained. Similar programs are in effect in some state prison systems.

Visitation. Visits with family and loved ones, while historically used as rewards, are presently noted to be an important part of rehabilitation, contributing to the success an inmate will have when released into society.[52] Though the bane of some administrators, a holistic, "wellness" approach would emphasize the importance of a prisoner's support systems, while incarcerated and after his/her release.

Employee Counseling. "We're all doing time, some of us are just doin' it in eight-hour shifts."[53] Each mental health professional can reserve a day a week (or month) for employees only. Counseling services as well as specialized services can be offered in support of the employee.

Administrative Duties. New programs need the support of prison administrators. One survey showed that prison psychologists objected to having to fulfill general administrative duties and sought to increase the clinical time spent with inmates.[54] What for? If mental health treatment alone has not been effective in the rehabilitation of prisoners, should the effort be directed towards this endeavor? More wisely, mental health staff members need to develop alliances with administrators in order to muster support for the creation of innovative programming, such as the holistic approach. In addition, they must assume a leadership role in breaking down the boundaries which have kept mental health professionals at a distance from other correctional employees who are working toward the same goals.

Implementation of the Holistic Approach

Implementation of the holistic approach requires dedicated periods of time. It is not how much time is spent on the process that is important, but rather how the time is spent.

The holistic approach postulates that correctional mental health professionals need to resolve their own internal conflicts before being able to successfully help inmates resolve theirs. Reexamine why you are working in corrections. Is it simply to have a job? Help an inmate? Contribute to the body of knowledge on prison mental health programming? Note that most of the 10 categories encompass services/functions rendered by divisions that are not necessarily at the heart of the security operation, i.e., they are also secondary agents (like mental health) in this primary security organization.

Finally, start small—a pilot program. Begin with a self-study. How often does the phone ring in the mental health office, and who is the caller? Where do the interdepartmental memos received originate? In what departments are the personnel found whom mental health most frequently seeks out? These questions provide keys as to where energy should first be directed when working to broaden the boundaries of mental health services. Look at governing policies and procedures. Do they unnecessarily bind the delivery of mental health services? Do they reflect territoriality, exclusivity, protectionism? How can they be altered to further the holistic approach to inmate mental health?

Create a council, with a representative from each institutional program which offers direct services to inmates. As a council, approach the inmate as a person having needs, all of which are related to mental health, but which cannot solely be handled by counseling. Staff inmates regularly to check their status in the holistic program, to gather both qualitative and quantitative data about the inmates' institutional and interpersonal functioning, and most importantly, to strengthen the investment in the council itself.

Skeptics will insist that the old professional boundaries are firmly rooted in case law, licensure statutes, and professional codes of ethics. Those are notions worthy and capable of challenge in a future discussion. There is growing evidence of a lack of faith in the skills and responsibilities of mental health professionals as a whole.[55] Those who have dedicated their careers to corrections must be the forerunners in expanding the treatment approach to persons requiring psychiatric services. This can only be accomplished through true interdisciplinary, holistic programming.

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[53]E.D. Poole and R.M. Regoli, "Alienation in Prison: An Examination of the Work Relations of Prison Guards," *Criminology, 19*, 1981, pp. 251-70, 268.

[54]R.F. Otero, D. McNally, and R. Powitzky, "Mental Health Services in Adult Correctional Systems." *Corrections Today, 43*(1), 1981, pp. 8-18.

[55]Aside from the writings of criminal justice authorities in this regard, two recent noncorrections cases have cast some doubt on the skills of mental health practitioners. See, e.g., *Briscoe et al.* v. *Prince George's County Health Department et al.*, 593 A.2d 1109 (Md. 1991)(an equal protection suit filed by social workers requesting parity of pay with psychiatric nurses), and *Boynton* v. *Burglass*, 590 So.2d 445 (Fla. App. 3 Dist. 1991)(a decision in which the Florida court decided not to impose the "duty to warn"/"duty to protect" standards on mental health professionals).