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An Analysis and Critique of Mental Health Treatment in American State Prisons and Proposal for Improved Care

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AN ANALYSIS AND CRITIQUE OF MENTAL HEALTH TREATMENT IN AMERICAN STATE PRISONS AND PROPOSAL FOR IMPROVED CARE

by

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Abstract

Mental health treatment in state prisons is revealed to be highly variable, under-funded, and systematically inadequate. Existing literature exposes this injustice but fails to provide a comprehensive proposal for reform. This paper attempts to fill that gap, outlining a cost-effective, evidence-based treatment proposal, directly addressing the deficits in care revealed through analysis of our current system. In addition, this paper provides historical overviews of the prison system and mental health treatment, utilizing theoretical perspectives to contextualize this proposal in the present state of affairs. Lastly, the evidence is provided to emphasize the potential economic and social benefits of improving mental health treatment in state prisons. Significant findings suggest a clear financial, legal, and moral incentive for states to address this issue, while the proposal provides a viable method of doing so.

Keywords: mental health treatment, state prisons, social control, incarceration, cognitive-behavioral therapy, institutional reform

TABLE OF CONTENTS

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INTRODUCTION

Throughout American history, mental health and incarceration have shared a complex, deeply dysfunctional relationship. Today, the United States boasts the largest rate of incarceration in the world, with 655 out of every 100,000 citizens imprisoned; the two countries with the next highest rates (597 and 552, respectively) are El Salvador and Turkmenistan, nations fraught with social unrest and political dysfunction (Juhn, 2014; Freedom House, 2018; World Prison Brief, 2018). Over two million individuals are currently incarcerated in the U.S., with approximately 1.3 million being held in state prisons (Glaze, 2009; Wagner & Sawyer, 2018). More than half of these prisoners suffer from some form of psychological dysfunction, compared to around 18.5% of the general population (Glaze & James, 2006; Substance Abuse and Mental Health Services Administration, 2017). Despite a clear legal obligation to address the mental health needs of these inmates, evidence suggests a profound failure to do so (Wilper et al., 2009). This paper analyzes and critiques the deficits in our current treatment system and proposes new avenues of reform. Section I examines constructs of social control and deviance, outlining the theoretical frameworks necessary to facilitate understanding of my analysis. Section II provides historical overviews of the American prison system and mental health treatment. Section III presents statistics on the prevalence of mental illness in prison populations. Section IV analyzes the current status of prison mental healthcare, focusing on state prison systems. In this section, I will also discuss the legal path that must be taken to affect meaningful change. Section V introduces my own proposal for evidence-based systemic reform. Section VI will then place this proposal in a larger social context, outlining the potential socio-economic benefits of adopting it–benefits that span far beyond legal and ethical obligation.

SECTION I: DEVIANCE AND SOCIAL CONTROL

To contextualize an analysis of our current prison mental health treatment systems, this section will provide an overview of historical conceptions of social control and deviance. I will begin with a general discussion of social contract theory and theoretical interpretations of social control and deviance. This will be followed by a brief theoretical discussion of psychiatry and an analysis of Foucauldian views on prisons' role in society. Then, I will introduce several frameworks regarding the intersection of prisons and mental health treatment, finally exploring the socio-economic, political, and racial factors that influence the American prison system.

The conceptual evolution of social control and deviance is closely tied to the development of mechanisms of maintaining control and power structures in society. According to Carmichael (2012), social control in the academic sense can be understood as the study of the methods through which society maintains order and cohesion. These methods may be found on an individual and institutional level, and include such components as restraint, coercion, and force (Carmichael, 2012). In this analysis, social control on an institutional level will be examined, focusing on institutions of criminal justice and psychiatry as mechanisms of social control. In particular, this section will discuss the employment of subjective analysis of behavior deemed "deviant" in imposing criminal sanctions designed to enforce social conformity. According to Carmichael (2012), "deviance" can be understood as a word used to capture a variety of behaviors that defy social norms, including those seen as problematic, threatening, abnormal, or simply undesirable. Deviance has a complicated relationship with criminality and mental illness. Deviance from legal standards results in punishment administered by the criminal justice and prison systems. Legal norms are inherently determined by ethical and psychosocial values, giving rise to the complex intersection of mental illness, crime, and punishment. According to psychiatrist-theorist Thomas Szasz (1960), mental illness is established through

assessment of behavioral deviance from norms. In the modern age, the determination of mental illness is made by physicians or psychiatrists, who then determine a course of action to remediate or correct the deviance. Psychiatry itself, in concert with the criminal justice system, imposes a form of social control designed to reinforce acceptable societal norms (Szasz, 1960).

Some evidence suggests that social control has always been an inherent part of our society, traced back to the very roots of civilization. The earliest written record of social control was discovered in Mesopotamia, with the Sumerian Code of Ur-Nammu (c. 2100-2050 BC) and the more notable Code of Hammurabi (c. 1750 BC) which details over 282 laws and corresponding punishments (Prince, 1904; VerSteeg, 2000). A multitude of ancient legal codes have been unearthed around the globe, from the Twelve Tables of Roman Law to China's Tang Code, all containing enforceable societal rules (Pound, 1954-1955; VerSteeg, 2002). The prevalence of these ancient codes suggests that as long as civilization has existed, humans have struggled to maintain order and power balances through the creation of laws and punishments.

Throughout history, philosophers and theorists have struggled to understand the concept of utilizing a legal system to impose social control. Many individuals have contributed to the study and debate of social control in various societies. Since this paper focuses primarily on American prison systems, I have concentrated on several commentators who have had a significant influence on Western society's understanding and implementation of social control in America. I will begin with a brief discussion of philosophers who mused on social order in the broader sense, working towards those who focused specifically on incarceration as a means of ensuring it.

To begin this discussion, it is important to examine the age-old idea of the "social contract" between the state and the citizens it governs. While this concept was pioneered by the

ancient Greek philosopher Socrates, it gained modern traction from the writings of Thomas Hobbes and John Locke. These philosophers of the seventeenth century–among many others–shaped modern conceptions of social order and control (Friend, n.d.). Englishman Thomas Hobbes is perhaps most well-known for his defense of social contract theory, which is explored by author David Gauthier in his modern analysis of Hobbes' *Leviathan*. According to Gauthier (1969), Hobbes maintained that the natural state of man is one of insecurity and instability, and that man's eternal quest for increased security through increased power will inevitably lead to war. Therefore, Hobbes proposes the necessity of a governing system designed to terminate this war. Gauthier (1969) explains how, according to Hobbes, men ought to submit themselves to this governing body–which in theory, represents their own best interests–in order to maintain peace and order. Through this submission, the governing body and the people enter into a "social contract" with established moral and political rules for acceptable behavior. When these rules are broken, the state intervenes to reinstitute order. Along with Hobbes, John Locke was an extremely influential philosopher of the time, emphasizing the importance of the social contract in justifying citizens' uprising against governments which fail to act in their best interest (Tuckness, 2016). Legal theorist Anita Allen (1999) puts Hobbes' and Locke's ideas in a modern American context, citing the U.S. Constitution and case law as examples of social contracts at work.

While social contract theory set the stage for modern interpretations of government and social order, more recent theories have further examined concepts of social control and deviance. Nineteenth-century theorists such as Karl Marx and Emile Durkheim have had widespread influence on academic and political conceptions of power. According to Stanford-based author Wolff (2017), Karl Marx supremely impacted political formations of the modern world by

inspiring the rise of many communist regimes. Wolff explains Marx's exploration of the class struggle, which emphasizes the exploitation of the 'proletariat' or lower-class worker to create capitalist profits. Class, which Marx determined by ownership of property, is at the center of all social conflict. According to Wolff's analysis of Marxist theory, upper classes use exploitative practices to maintain power over the proletariat. These practices, borne out of capitalism, can be viewed as a form of social control in which the ruling class maintains power over the working class. While Marx's theories can be used as a helpful backdrop to inform interpretations of American capitalist society, the writings of Émile Durkheim more poignantly emphasize social control theory and deviance. According to an analysis of the origins of social control theory by Kempf-Leonard and Morris (2012), Durkheim, a prolific French writer, construes crime and deviance as "social facts" which are integral parts of all society. In particular, Durkheim cites deviance as being a functional part of society, in which members initiate change through nonconformity. He argues that the punishment of deviant acts effectively maintains social order. This process serves to create and alter social boundaries as well as initiate change (Kempf-Leonard & Morris, 2012). Based on the ideas of Hobbes, Locke, Marx, and Durkheim, it can be inferred that the individual's desire for order and security will necessitate the formation of some type of government. This government will establish behavioral expectations of its citizens in order to create an 'ordered' society, stepping in to enforce these expectations by punishing deviance from them. Within a capitalist society, ruling classes will struggle to maintain power over working classes through exploitative practices. The combination of punishment of deviant acts and exploitative capitalist practices are methods of social control in which individuals are subjected to the will of governing bodies and ruling classes in order to maintain an orderly society.

Another mechanism of social control central to this discussion is the institution of psychiatry and the conceptions of mental health it imposes on society. The term "mental health" is inherently difficult to define and depends on the socio-cultural and political environment in which it exists (Galanek, 2012). In a sociological-philosophical investigation into mental health care legislation, Bob Symonds (1991) asserts that psychiatry, an institution borne out of the desire to identify, define, and 'fix' mental illness, is and has historically been a form of social control. Similar to the legal system, psychiatry is dictated by moral norms which it attempts to force upon society. Symonds argues that the origins of modern psychiatry correlate with the subjugation of individuals whose mental capacities appeared to deviate from established norms. He explains how clinicians hold the authority to diagnose and impose treatment upon patients, exerting power with the intent to normalize. Symonds finds this power to be value-laden and highly subjective, as mental health professionals utilize their own biases, experiences, and educational backgrounds to inform their diagnostic and treatment processes. In an analysis of Michel Foucault's 1961 *History of Madness in the Classical Age*, Gutting and Oksala (2018) find similar themes in Foucault's writings on the emergence of modern psychiatry. Challenging the alleged medical neutrality of modern psychiatric treatments, Foucault argued that these treatments are in fact facades designed to temper challenges to upper-class morality and social norms. To Foucault, the modern psychiatric conception of mental illness is not neutral or objective at all, but rather a social construct derived from subjective social and ethical standards (Gutting & Oksala, 2018). For the purposes of this analysis, American psychiatry can be understood as an institution of social control–distinct from yet comparable to governing bodies such as the criminal justice and prison systems. This institution subjectively shapes society, creating and implementing notions of deviance and normalization. This understanding will

facilitate a deeper investigation into the relationship between mental health treatment and American prisons.

Moving from general conceptualizations of social control to the mechanism of incarceration as a means of enforcing it, the writings of Michel Foucault are again highly applicable. In recent years, Foucault's writings have largely dominated discourse on topics of prisons and social control (Carmichael, 2012). In his famed *Discipline and Punish*, Foucault (1977) examines the gradual shift of state punishment from direct violence to psychological control. Rather than torturing the body as punishment, modern penal systems aim to reform the soul of the individual. This seemingly milder form of punishment is actually a more effective one, facilitating the extension of psychological control beyond prisons to society as a whole. Essentially, Foucault argues, this model of control permeates all modern institutions, from factories and schools to medical and psychiatric hospitals. All of these institutions, created for apparently innocuous purposes, converge to form an omnipotent system of disciplinary power. To Foucault, the primary function of this disciplinary power is to correct deviant behavior. Reform is therefore achieved by the implementation of precise and detailed norms. Foucault examines this reform as it is carried out in prisons, but emphasizes the ubiquitousness of normalization throughout society. Foucault highlights the inseparable nature of power and knowledge and their simultaneous exertion by institutional actors. As patients, for example, become 'objects of care' by medical professionals, they are subjected to exercises of control. Observations are made and recorded, subsequently used by institutions to classify and control on the basis of norms. The mechanisms of control and surveillance are utilized within and without the prison, part of an all-encompassing carceral network that governs all those subjected to it (Foucault, 1977). Foucault's conceptualization of discipline can be used to help explain the mass

housing of individuals with psychological dysfunction in modern prisons. This systematic incarceration can be seen as a state effort to correct or normalize: as individuals deviate from the norms of our society, their aberrant behavior is criminalized and subsequently punished.

The writings of Foucault can also help explain the role of prisons in society as a normalizing force with far-reaching social effects. However, to further contextualize the American prison system and its relationship to mental health treatment in the modern U.S., the discussion of additional theories is imperative, for these theories expand the analysis of the historical relationship between prison and mental health institutions (explored in later sections).

The first theory examining this relationship is "balloon theory." A term first coined by Penrose (1939), balloon theory refers to the balloon-like relationship between prison and mental health systems across time and history. In particular, it aims to describe the correlational relationship between prison and mental hospital populations, and how as one decreases, the other tends to increase at a similar rate. Palermo, Smith, and Liska (1991) use balloon theory to explain how the movement of deinstitutionalization of patients with mental illness in America led to dramatic increases in the incarceration of that same population; or so to say, as one part of the balloon was pushed in, another bulged out. Discourse by Fisher, Silver, & Wolff (2006) on the criminalization of mental illness can help further explain balloon theory in the context of twentieth-century America. An analysis of political and institutional trends reveals how changing laws restricting or prohibiting involuntary commitment to psychiatric hospitals have encouraged additional agents of social control (e.g. police and courts) to impose criminal as opposed to psychiatric consequences on individuals with deviant behavior (Fisher et al., 2006). Balloon theory can be used in conjunction with political theories to explain rising incarceration rates in the decades following the 1960s. In particular, politics can be seen as another driving force

behind increasing rates of incarceration from the 1960s to 2009 (Shannon & Uggen, 2012). These rates have steadily climbed at an average of 6% per year (Sabol, West & Cooper 2009). Shannon and Uggen (2012) point to retributive penal policies as the cause (from minimum sentencing requirements to three-strikes laws), disproportionately affecting minority populations alongside the deinstitutionalization movement. Driven by political strategy, American politicians capitalized on "moral panics[1]" to gain political capital, often using racialized rhetoric and media sensationalism to garner support (Beckett, 1997). The "tough on crime" policy that occurred as a result (especially throughout the 1990s) did not correspond to actual increases in crime, yet led to the massive increase in the American incarceration rate (Shannon & Uggen, 2012). Analysis of demographics within State prisons shows consistent widening of racial and socioeconomic disparities, revealing a sinister consequence of the use of fear-mongering to gain political influence (Disproportionate Impact Study Commission, 2010; Gramlich, 2018). While it is important to examine the overall trends of increasing prison populations and forces behind them, the racialized aspect of these trends cannot be overstated. The racialized nature of politics and policy propelling rising incarceration rates can be further explained by yet another theoretical framework–Critical Race Theory. This theory and its tenets will be used to discuss additional socio-political, economic, and racial factors that define and perpetuate the prison system.

When attempting to unravel the mechanisms underlying the historical evolution of the United States prison system, a Critical Race Theory (CRT) perspective is extremely useful. CRT is a scholarly movement aimed at re-examining relationships between power, race, and racism (Delgado et al., 2017). A CRT structural determinist lens allows for a deeper analysis of the subjective nature of our penal institutions. Structural determinism is borne out of the concept that the very foundation of existing structures–all part of a larger system–determine their outcomes,

[1] Defined as widespread public fear over particularly violent or noteworthy crimes

and the outcomes of all those subjected to them (Graham et al., 2011). When put in a CRT context, structural determinism can be used to examine the racist origin of the American prison system: since this system was created and expanded to serve the needs of those in power by oppressing marginalized groups, it is inherently incapable of rectifying the racial and socioeconomic disparities it has perpetuated. This lens provides a particularly valuable backdrop for the historical overview of incarceration.

This perspective can also facilitate an understanding of the large disparities in mental health care along racial lines. Researchers have found persistent unfair differences in access to and quality of mental health treatment according to race and ethnicity; African Americans and Hispanics are much more likely to have no access or delayed access to substance abuse and mental health care than their Caucasian counterparts (Wells et al., 2001; McGuire & Miranda, 2008). Regression analyses of physician care have also revealed that medical professionals are less likely to detect mental health problems in African Americans (Borowsky et al., 2000). This evidence reveals extraneous barriers to care experienced by racial minorities, further exacerbated by the racialized nature of the prison system. From a CRT standpoint, both medical care and prison systems are institutions that serve the privileged classes, perpetuating socioeconomic and racial inequalities.

Overhauling mental health treatment in prisons would not solve this problem. However, it could present a powerful opportunity to address the needs of individuals who have been repeatedly oppressed by state and social forces. Since the vast majority of prisoners are eventually released into society, treating these prisoners could have an important communal impact through treatment of underprivileged groups (Wilper et al., 2009).

Lastly, it would be imprudent to engage in a discussion of mental health treatment without mentioning the historical and socio-cultural precedents for stigmatization of the individuals with mental illness. The intense stigma present in American society has a far-reaching influence on help-seeking behaviors, often discouraging individuals in need from reaching out to mental health services (Fink & Tasman, 1992; Gary, 2005). Even when services are reached, stigma (both external and internalized) can have profoundly negative effects on treatment outcomes. Stigma has devastating effects on the lives of individuals who experience it– effects compounded in an institutional setting.

Factors such as race and substance abuse play a role as well. Dually diagnosed individuals (those with a mental health problem and a substance use or abuse disorder) experience increased rates of homelessness and recidivism in comparison to those with only a mental disorder (Hartwell, 2004). Furthermore, the stigma surrounding mental illness is made doubly destructive when experienced by underprivileged groups in America, such as ethnic minorities. According to a research article investigating the experience of individuals of ethnic minorities with psychological dysfunction, this acute combination can greatly "impede treatment and wellbeing" (Gary, 2005, p. 979). Considering the demographics of our prison populations– with African Americans and Latinos far overrepresented (a phenomenon further explored in Section II) these findings have powerful implications for treatment (Gramlich, 2018). Apart from offering services, to be effective, mental health treatment programs in prisons must work to reduce stigma, with a special focus on providing help geared toward ethnic minority groups. In order to do so, it will be exceedingly important to hire mental health staff that belongs to these groups, who can provide a neutral forum to adequately serve the needs of these individuals.

Throughout this paper, I will utilize a combination of the theoretical perspectives discussed in this section to analyze, interpret, and understand the historical and current states of mental health care in prisons. I will also explore alternative options with these frameworks in mind, working to create viable solutions for treatment in the current penal setting.

SECTION II: HISTORICAL OVERVIEW

PART I: INCARCERATION

The history of mass incarceration in the United States is wrought with undercurrents of racism, stigma, and profiteering. While often touted as tools of rehabilitation, James and Glaze (2006) found that American prisons are places of punishment; a punishment that is disproportionately inflicted upon minorities, the impoverished, and individuals with psychological dysfunction. Recidivism rates demonstrate the massive failure of our system: a 2005 study that tracked over 450,000 prisoners released in the U.S. found that within five years, over 76% of these individuals were rearrested (Durose, Cooper, & Snyder, 2014). Researchers Matejkowski and Ostermann (2015) found that persons with mental illness are statistically likely to recidivate more–and more quickly–than their non-afflicted counterparts. Yet despite this compelling evidence, we continue to maintain our failed system, eagerly building new prisons and incarcerating ever more citizens, ironically imposing a great cost to the moral integrity of our nation (Goldberg & Evans, 2009). To create a comprehensive picture of mental health treatment in U.S. state prisons, it is necessary to examine our illogical loyalty to this broken system by taking a closer look at the historical roots of American incarceration over the last two centuries.

While penal incarceration gained popularity in England as early as the fifteenth century, the widespread use of imprisonment as a form of criminal punishment has been a recent episode

in American jurisprudence (Hirsch, 1992). According to Hirsch, before its emergence during the American Revolution, the confinement of persons for criminal acts was exceedingly rare in British North America. Ironically, this revolution–with liberty as its core motivation–would be responsible for creating a penal system whose sole purpose was to remove that very liberty (Hirsch, 1992). Before the revolution, criminal discipline emphasized corporal punishment, torture, and public humiliation; however, as the eighteenth century approached, methods moved away from the public eye to walled institutions with forced labor as penance (Forsythe, 1993). As Foucault observed in his *History of Madness*, a newfound emphasis on psychological reform accompanied this shift away from physical punishment. This served to create a more widespread form of social control, one expanding beyond prisons to other social institutions (Gutting & Oksala, 2018).

When discussing the history of incarceration in America, it is extremely important to examine the influence of slavery, an influence that even today permeates the very fabric of our criminal justice system. In particular, one must look at legislation and criminal enforcement following the abolition of slavery, created and practiced with the goal of reinstituting mass forced labor in a legal form. Critical Race Theory is a particularly helpful framework for understanding these racist origins of the prison system and their modern impact. Since the American penal institution developed largely in response to the end of slavery with the goal of serving the privileged classes, it will continue to oppress marginalized groups despite efforts for reform. On the other hand, from a Marxist perspective, one can view forced labor punishment as exploitation of the lower-class 'proletariat' at the hands of the upper class (Wolff, 2017). Below, I will use these perspectives to provide a general overview of the development of mass incarceration, with a particular focus on the driving forces behind it.

After the Civil War ended and slavery was abolished under the Thirteenth Amendment, racist legislation was utilized in its place to ensure the preservation of white supremacy (Foner, 2015). Some progress was made with the passage of the Fourteenth and Fifteenth Amendments, codifying the right to due process, equal protection of all citizens and voting rights regardless of race. However, new laws were simultaneously put in place to perpetuate the legal persecution of African Americans (LeFlouria, 2016). From a Marxist perspective, one can understand these laws as mechanisms used to ensure continued use of the dominant classes' exploitative practices, extorting labor from underprivileged groups to generate capitalist profit.

Historian Eric Foner (2015) describes how Black Codes and vagrancy laws prohibiting such acts as "mischief" and "insulting gestures" acted as catch-all umbrellas for police to arrest and incarcerate whomever they pleased. Incarcerate they did: Talitha Leflouria (2016) vividly recounts the injustices that accompanied the birth of convict leasing in 1846, describing how primarily African American prisoners were put to work on private labor forces that were used to rebuild the South. Pulitzer Prize-winning journalist Doug Blackmon (2012) detailed events over the next eighty years, as tens of thousands of African Americans were arrested on false or unfair charges, slapped with harsh sentences, and subsequently sold into what amounted to legal slavery.

In 1928, convict leasing was abolished (Lichtenstein, & Mancini, 1999). However, patterns of imprisonment had been long established; prison populations continued to be principally young, poor, and black (Gramlich, 2018). Penal labor continued as a retributive method, and African Americans and other minorities were disproportionately incarcerated, a condition that persists to the present day. In an analysis of data from the year 2016, Gramlich (2018) found that African Americans, 12% of the U.S. population, comprised of 33% of the

incarcerated population. Hispanics, just 16% of the population, accounted for 23% of U.S. prison inmates. In contrast, while 64% of the general population is Caucasian, whites make up only 30% of the total prison population (Gramlich, 2018). A Critical Race Theory perspective can be invaluable in explaining the demographic inequities rampant in present-day prisons. Borne of racist and classist intent, American penal institutions continue to reinforce the privilege of upper-class Caucasians while oppressing minority populations. From a structural determinist perspective, these institutions will continue to perpetuate patterns of oppression in the absence of radical structural change.

Today, the United States accounts for approximately 5% of the global population; our prison system houses over 22% of imprisoned individuals (Carson & Golinelli, 2013; U.S. and World Population Clock, n.d.). In a *Frontline* interview with Childress (2014), author Michelle Alexander describes how our criminal justice system also boasts the longest sentences in the industrialized world, with a crackdown on drug-related offenders spurring massive increases in prison populations in recent decades. Before the 1960s, prison populations remained relatively stable; since then, rates of incarceration have increased over 600% until the year 2000 (Colavita et al., 2017; Childress, 2014).

While much of this increase can be attributed to a movement discussed in the following section labeled *deinstitutionalization*, examining this data along with other socio-political factors can help explain this trend. According to the Substance Abuse and Mental Health Services Administration (2010), while drug use among racial/ethnic groups is revealed to be similar nationwide, the Illinois Disproportionate Impact Study Commission (2010) found that African American, Latino, and other minority populations are incarcerated for drug-related crimes far more than their white counterparts. These findings, set in the context of a political ‘war on drugs

and crime,' demonstrate how systems of social and racial control are perpetuated by the criminal justice system (Shannon & Uggen, 2012). Modern prison populations appear to reflect their geographic and racialized history: Southern states make up 8 of the top 10 states with the highest incarceration rates per 100,000 residents (Carson, 2018). These statistics highlight the use of our criminal justice system as an antiquated mechanism of social control, as law enforcement and courts incarcerate citizens according to racial and social class.

Prisons are institutions theoretically designed to serve the public good by protecting citizens from undesirable behaviors. To reiterate Hobbes' musings on the necessity of governing bodies in the promotion of common peace; criminal justice and prison systems are designed to step in when peace is violated (Gauthier, 1969). To Durkheim, the punishment of deviant acts– those that threaten or challenge social norms–is an effective and necessary method of maintaining social order (Kempf-Leonard & Morris, 2012). However, an investigation into the history of the American prison system reveals a much more complex and biased institution, disproportionately persecuting the poor and racial minorities while largely failing in its goal of promoting peace and safety. In the following section, I will delve into the history of mental health treatment, culminating in the virtual replacement of American psychiatric facilities with modern prisons and jails.

PART II: MENTAL HEALTH AND TREATMENT

Since the dawn of civilization, humans have struggled to explain and control aberrant, undesirable thoughts and behaviors. One result of this struggle has been the development of modern psychology. In this section, I will provide an overview of the origins of psychology and the evolution of mental health treatment methodologies. *A History of Modern Psychology* by James Goodwin (2015) will be used as a key resource in this overview, serving to

comprehensively recount the historical evolution of psychology. Along with this valuable source, supporting journal articles and books will be utilized to provide a brief summary of the histories of psychology and mental health treatment. Following this summary, I will discuss the evolution of society's treatment of those suffering from mental illness, from the American mental asylum to the movement of deinstitutionalization and the de facto transformation of patients into prisoners.

With deep roots in philosophy, the path to modern psychology is one of many twists, turns, and dead ends. While modern psychological treatments have shifted to favor evidence-based models, the struggle to correct mental illness has given birth to many ineffective, horrific, and inhumane "treatments" (Millon et al., 2004; Goodwin, 2015). To fully understand modern American conceptions of mental health treatment, one must delve into the twisted evolution underlying them.

Harkening back to ancient times, mental abnormalities have always been closely associated with the supernatural, the metaphysical, and the demonic (Biddle & Van Sickel, 1943). Millon et al. (2004) explore the foundations of Western psychiatry, tracing roots back to Greece in the fifth and sixth centuries B.C. when Greek philosopher-physicians began to consider a biochemical component of mental health. Peering beyond supernatural explanations, they began to investigate the root cause of disordered thinking. According to Millon et al., these thinkers, spurred by Galen, hypothesized that imbalances in bodily "humors" (fluids and excretions) played a central role in psychological disorders. While laying a meaningful groundwork in the foundation of modern medicine, Millon et al. describe how these Greek pioneers foundered with theory, unable to grasp the root of their patients' symptoms and thus

failing to effectively treat them. Touted as cures for "humoral imbalance," bloodletting, purging,[2] and trephination[3] became popular 'medical' treatments while religious explanations for the cause of mental illness continued to dominate throughout the Medieval era[4] (Millon et al., 2004). In addition to pseudo-scientific biological explanations, belief in demonic possession pervaded Western Europe and was oft used to explain deviant behavior and thought (Williams & Kemp, 1987). Isolation became another preferred method of treatment along with torture, exorcism, and prayer (Forcen & Forcen, 2014). Characterized by an austere aversion to abnormal behavior, belief in false biology, and religious obsession, the Middle Ages was a dark time indeed for the eccentric mind. (Mora, 2008).

As Western civilization emerged from the Middle Ages, the earliest asylums were built around Europe, with heavy religious influence and severe control and chastisement the going rule for treatment (Deutsch, 2013). It is at this point in time that Goodwin (2015) begins his modern historical account of psychology, first noting the European Renaissance of the fifteenth and sixteenth centuries. Marked by tremendous advances in the arts and sciences, the Renaissance served to facilitate the expansion of the theory of the human mind, most notably with the writings of Rene Descartes. Described by Goodwin (2015) as the "father of modern psychology," Descartes was an optimist of sorts, with a firm belief that everything in the world could be known (p. 24). He was also a rationalist, finding facts in only that which could not be doubted. To Descartes, the way to truth was through human reason. This notion presented a direct challenge to the Catholic Church, and Descartes suppressed widespread dispersion of his beliefs out of fear of persecution (Goodwin, 2015). This illustrates the supreme power of the

[2] Surgical removal of patients' blood or other bodily excretions for therapeutic purposes
[3] Surgical procedure where a hole is drilled in a patient's skull
[4] Medieval era defined as being from the fifth to the fifteenth centuries

Catholic authorities of the time, directly influencing (and preventing) the popularization of new ideas.

After Descartes' death, Goodwin (2015) describes how his ideas began to spread more widely throughout the European continent. Around this same time, a British empiricist tradition emerged with the likes of Hobbes and Locke. These empiricists focused on the study of human knowledge and its origin through experience, along with the construction of innate or universal truths. Goodwin describes how rationalist and empiricist traditions continued to compete in the following decades and even centuries. While many notable thinkers of the time contributed to the philosophical and scientific underpinnings of modern psychology, perhaps most applicable to this discussion are the ideas of Immanuel Kant–in particular, Kant's beliefs on the non-observable nature of the mind. Goodwin (2015) presents Kant's argument that psychology could never become a science comparable to the physical sciences, because of the inability to objectively observe mental phenomena. Kant's beliefs are echoed in later Foucauldian conceptions of the non-neutrality of psychology; as mentioned in previous sections, Foucault expressed severe criticism for the discipline of psychology in presenting its ideas as scientific fact. Rather, Foucault perceived these ideas to be constructed through subjective social beliefs, designed to control any challenge to upper-class morality (Gutting & Oksala, 2018). Nevertheless, despite Kant's declarations, psychology would soon be declared a science in the nineteenth century. Goodwin describes this declaration as being principally brought about by German scientists (most notably, Wilhelm Wundt) pioneering experimental psychology. Wundt's experimental psychology–in essence, the scientific observation of the human mind in a laboratory setting–greatly influenced American intellectuals of the nineteenth century (Goodwin, 2015).

Goodwin continues his review of modern psychology in post-civil war nineteenth-century America, with a great expansion of higher education based on the German model of university. In particular, he describes the emphasis on independent research in American education, modeled after the tradition of experimental psychology. Goodwin notes that as the founder of the first American psychology laboratory, journal, and psychological organization (the American Psychological Association or APA)[5] G. Stanley Hall was most responsible for "professionalizing" psychology in America. During this time of expanding research and education, a multitude of novel schools of thought emerged. Of particular importance was the writing of William James, a medically trained nineteenth-century philosopher-psychologist, who along with Foucault and Kant questioned the validity of psychology as a true "science." Despite his doubts, the physician-trained James was crucial in bringing about the new form of psychology as a scientific, physiological pursuit, and he became one of the modern key figures in biological psychology. By blending aspects of philosophy, biology, and psychology, James had immeasurable influence on subsequent schools of thought (Goodwin, 2015).

While Goodwin presents a thorough analysis of the many other notable researchers and theorists of the nineteenth and early twentieth centuries, a totally comprehensive discussion is necessarily beyond the scope of this review. To better promote understanding of my analysis and proposal of mental health treatment in prisons today, I will fast forward in time to focus on one particular school of thought: behaviorism. It is out of behaviorism that the treatment model most emphasized in my proposal was borne–Cognitive Behavioral Therapy. According to Goodwin (2015), emerging in the mid-twentieth century, behaviorism emphasized objectivity and shunned introspection, focusing on relationships between external stimuli and human or animal responses. Among other factors, the English translation of Pavlov's famed work on the conditioning of

[5] Not to be confused with the American Psychiatric Association

behavioral responses contributed greatly to the expansion of behaviorist views in America. While nineteenth-century behaviorists disagreed on a number of issues, Goodwin outlines three key principles underlying all behaviorist discourse of the time. The first of these concerns the continuity of behavior among species, which allowed for general behavioral rules to be extrapolated from the observation of animal behavior. The second principle entails the necessity of understanding the mechanisms through which organisms learn. The third principle refers to a general behaviorist understanding that research results should have practical application. In the latter half of the twentieth century, behaviorists sought to improve larger facets of society–such as education and child rearing–through the use of behaviorist techniques (Goodwin, 2015). In recent decades, behaviorism has undergone many transformations and alterations, most notably culminating in the Cognitive-Behavioral treatment of mental illness. This treatment will be a major focus of my proposal in subsequent sections, with its origins and tenets explained in much greater detail. In the next paragraphs, I will continue my historical overview of mental health and treatment with regards to the evolution of the asylum and the movement of deinstitutionalization.

When examining the history of mental health treatment, a troubling pattern begins to emerge–one that starts with the inhumane or ineffective treatment of individuals with mental illness, followed by some sort of exposé of or outcry regarding this treatment, followed by some reform effort or public movement intended to rectify the situation. Goldman and Morrissey (1985) note the consistent nature of this reform–one that begins with optimism but slowly gives way to pessimism, a loss of public interest, and dwindling funds. Ultimately, individuals with mental illness are once again shut away from society without effective or even humane treatment. In the paragraphs below, I will attempt to illustrate this pattern as it occurs from eighteenth-century Europe to the United States during the twenty-first century.

In previous paragraphs, I presented Goodwin's account of great theorists pondering the nature of the human mind throughout the seventeenth and eighteenth centuries, culminating in the spread of experimental psychology to America. The eighteenth century saw a wave of reform efforts across Europe, which Goodwin (2015) characterizes as largely a product of earlier Enlightenment-era thinking. In particular, Goodwin mentions French physician Phillipe Pinel, born in the mid-eighteenth century, who implemented humane reform in Parisian mental hospitals. Pinel originated the movement of 'moral treatment,' emphasizing improvements in living conditions, hygiene, and overall care for the institutionalized individuals with mental illness (Goodwin, 2015).

Meanwhile, a massive expansion of asylums occurred in both Europe and the United States. Prior to the nineteenth century, Goodwin describes the rarity of mental asylums in America; most persons with mental illness were kept at home, preferably out of sight as dictated by social norms. However, he notes that the urbanization of the nineteenth century combined with the moral treatment movement led to the explosive rise of institutionalization in both the United States and Western Europe. Individuals with mental illness were increasingly gathered and forcibly housed in communal facilities called asylums (Goodwin, 2015). According to Albert Deutsch (2013), while institutionalization was initially the result of the 'moral treatment' humanitarian social movement to better care for persons with psychological disorders, treatment of those housed in asylums was often cruel and rarely effective. Furthermore, the secluded, unmonitored nature of the institutions allowed for the proliferation of abuse at the hands of those in charge (Grob, 1973). According to psychologist Abraham Luchins (1993), American physicians during the nineteenth century 'used and abused' their power, resulting in a sharp incline of diagnoses, the mass building of asylums, and increased importance of the physician's

role. While the asylums of the time were referred to as “mental hospitals,” Luchins describes little resemblance to the modern hospital; rather, they were neglected, unhygienic, overcrowded warehouses placed far away from civilization. Luchins (1993) describes how the field of psychiatry was catapulted by the wave of institutionalization, and it became a formidable institution with emerging professionals’ exercise of power often having brutal consequences for so-called patients.

With neglect and abuse common in the newly widespread American asylums, Goodwin (2015) describes how reform advocates once again struggled to improve conditions. Perhaps most notably, he highlights the efforts of Dorothea Dix, a New-England educator in the mid-nineteenth century, who toured the country in search of reform. The author of detailed, scathing exposés regarding the abuse of mental asylums, Dix achieved success in the courts, prompting increased funding and the construction of almost 50 new, more humane asylums and schools for individuals with the mental illness. However, Goodwin notes this reform was short-lived; as populations in the new institutions grew, conditions quickly worsened. This series of events once again illustrates the aforementioned pattern of mental health treatment–from Pinel’s outcry to corresponding public reform, culminating in the institutionalization movement which ultimately led to increased instances of neglect and abuse. Dorothea Dix, along with other reformers, sought to expose and alter the conditions of persons with mental illness, achieving temporary success but ultimately failing in her pursuit of lasting reform (Goodwin, 2015).

Following Dix’s failed reform efforts, asylums grew in stature of the eyes of the general public, which largely ignored their abysmal conditions until well into the twentieth century (Gijswijt-Hofstra, 2005). Meanwhile, a “trio of barbarisms” swept through American medicine

as insulin coma shock[6], ice pick lobotomy[7], and electroconvulsive therapy[8] became the go-to methods of mental health treatment (Alanen et al., 2009). The mass popularization of the lobotomy, in particular, is primarily owed to the faulty science of famed American physician James Freeman (Breeding, 2016). While this now-disgraced practice is largely absent from modern medicine along with the insulin coma shock, it may be noted that forms of electroconvulsive therapy live on today and are often cited as effective as a last resort therapy (Mayo Clinic, 2018).

In an NPR report on American mental asylums, Joseph Shapiro (2009) describes the events that caused a massive change in public and political will regarding the treatment of persons with mental illness. In 1946, public perceptions of the asylum were permanently altered when photos exposing the shocking conditions of one Pennsylvanian institution were published in *Life* magazine. Shapiro recounts how Americans drew the natural comparison of the thin, impoverished men crowded against dark walls to images of the Nazi concentration camps. Consequently, the photos were met with uproar, giving birth to a movement of deinstitutionalization. This movement is again illustrative of the aforementioned pattern: *Life's* exposure of the conditions sparked a widespread reform effort, but one destined to repeat the pattern of alarm, followed by reform, followed by failure as public interest waned.

Nevertheless, deinstitutionalization can be understood as the humanitarian movement promoting a "range of procedural, statutory, and ideological changes" that were designed to shift the care of individuals with mental illness from institutional to community settings (Steadman et

[6] A form of psychiatric treatment in which physicians injected patients with insulin to induce daily repeated comas over the course of several weeks
[7] A neurosurgical treatment performed by severing connections in the brain's prefrontal cortex
[8] A psychiatric treatment in which electrical currents are used to induce seizures in patients

al., 1984, p. 475). The breakthrough discovery of psychotropic medications[9] in 1954 further catapulted this movement as American physicians began treating patients with new drug therapies as opposed to locking them away (Pow et al., 2015). Gijswijt-Hofstra (2005) describes how the new wave of advocates for change struggled to replace the asylum with community-based approaches to treatment, and the overcrowded, understaffed, federally funded asylums began to close their doors. Turnover rates increased as new (and supposedly improved) hospitals began admitting more patients for shorter periods of time, administering diagnoses and treatment followed by rapid discharge. However, as asylums vanished across America, the promised community-based approach was left underfunded and swept aside (Gijswijt-Hofstra, 2005). According to Bassuk and Gerson (1978), federal and state-sponsored community health centers that were built lacked staff and resources needed to properly care for local populations. Tragically, the most severely ill were the most neglected. Many patients were released into society with very little in the way of financial or mental health support, often leading to their imprisonment for relatively petty offenses (Bassuk & Gerson, 1978). *Balloon theory* can help explain this series of events: while the community-based treatment approach failed to come to fruition, a more sinister solution crept in to take its place (Penrose, 1939; Palermo et al., 1991). The movement of deinstitutionalization, rather than obliterating the institution as a place of treatment, seemed only to shift mental health care from one institution to another. A 1984 study examining the interdependence of prison and mental health systems found a profound negative correlation between prison and mental hospital populations during the crux of the deinstitutionalization movement. Between 1968 and 1978, the U.S. mental hospital population fell 64%, from 399,000 to 147,000, while the prison population rose 65%, from 168,000 to

[9] Medications that affect the brain: antipsychotic, anti-anxiety, and antidepressant drugs as well as mood stabilizers

277,000 (Steadman et al., 1984, p. 475). While the precise nature of this relationship is not clear, its covariation is undisputable, with researchers attributing the severe overcrowding of American prisons in the following years to the collapse of the state mental hospital system. Subsequently, the inability of prisons to address the special management needs of inmates with mental illness inmates created vicious cycles of neglect and recidivism (Steadman et al., 1984; Pogrebin & Poole, 1987).

Fisher et al. (2006) explore the criminalization of mental health accompanying deinstitutionalization, as the push away from forced hospitalization had the unintended effect of encouraging courts and police to impose criminal sentences on individuals with mental illness in the absence of viable alternatives. In particular, policy changes prohibiting involuntary hospitalization (e.g. California's Lanterman-Petris-Short Act passed in 1967) resulted in massive increases of individuals with mental illness in the criminal justice system (California Legislature, 2018). In response to this, in 1980, President Jimmy Carter signed the Mental Health Systems Act, aimed to promote community-based services for mental health treatment. However, this act was quickly repealed by Ronald Reagan in 1981, with the Omnibus Budget Reconciliation Act shifting responsibility for mental health from the federal to state governments. In the following years, federal spending on mental health consistently decreased, as states increasingly assumed the burden of treatment (Ellwood, 1982).

The deinstitutionalization movement, propelled by the belief that psychiatric patients would find a higher quality of life outside the asylum, left communities woefully unprepared for chronic sufferers who were increasingly delegated to substandard living, homelessness, deteriorating mental health and incarceration (Bassuk & Gerson, 1978; Novella, 2010). The initial reform movement–largely sparked by *Life's* exposé–became yet another failure. Criticism

soon spread as the public decried the new policy's neglect of the chronically ill, spurring a 'new wave' of reform efforts known as the 'Community Support Movement' (Goldman & Morrissey, 1985). This movement differed from its predecessors in that it advocated a holistic system of care, including direct care for people with chronic mental illness in addition to rehabilitation efforts (Parrish, 1989). The newfound search for balance between specialized treatment of the less-severely ill and continued life-long support for the severely afflicted represented a positive shift in American mental health care: However, this approach neither solved the problem of homelessness nor improved the treatment of the incarcerated with mental illness (Goldman & Morrissey, 1985).

Today, the number of individuals with mental illness in the prison system exceeds the number in state-run hospitals tenfold (Torrey et al., 2017). With the asylum a relic of times past, jails and prisons now make up the largest mental health 'treatment' centers in the U.S (Helfgott & Huffman, 2013). The fact that these prisons are disastrously ill-equipped to treat mental illness assures most inmates with mental illness will leave prison with the same issues that led to their incarceration in the first place. Indeed, evidence suggests that a substantial portion of inmates with mental illness inmates are not receiving any treatment at all, while the treatment that is administered is wholly inadequate. According to a 2014 survey of >18,000 American prisoners, more than 50% of inmates who were taking medication for a mental illness upon admission to prison did not receive continued medication or treatment while incarcerated. While many prisons utilize screening procedures to detect mental illness, there is little if any follow-up. Compounding this systemic dysfunction, evidence suggests that confining persons with mental illness often results in rapid exacerbation of their symptoms, making effective treatment ever more necessary (Gonzalez & Connell, 2014).

In addition, recent decades have seen a rapid increase in co-morbidity of mental illness and substance abuse, as individuals with untreated psychological disorders attempt to self-medicate (Wallace, Mullen, & Burgess, 2004). Coinciding with a massive increase in the prosecution of drug-related offenses across racial lines, this development may help explain the prevalence of mental illness in incarcerated populations today (Blumstein & Beck, 1999). The inability of states to properly treat prisoners with mental illness (often with co-curring substance use disorders) condemns hundreds of thousands of individuals to years of suffering as untreated symptoms continue and often worsen with tangible societal consequences (Insel, 2008). Recent years have seen little improvement. In 2009, state funds to address this issue were greatly diminished when, in the aftermath of the Great Recession, states cut $4.35 billion in public mental health funds. No significant efforts to increase funding have since succeeded (Glover, Miller, & Sadowski, 2012). Once again, the relevance of the aforementioned pattern of treatment must be reiterated: outcry at abuse has led to reform efforts, which have ultimately failed with a lack of public funding and waning interest.

I would argue that the repeated mass warehousing of individuals with mental illness, first in asylums and now in prisons, serves only to create the short-term facade of a solution by simply removing evidence of deviant behavior from public view. To meaningfully break this pattern, effective treatment must be administered on a large scale. Rather than simply creating new spaces or methods of shutting away persons with psychological disorders, my proposal seeks to address the root problem by rehabilitating and treating these individuals, albeit within existing institutions. The ultimate goal of this proposal would be to break this repetitive cycle by providing those in need with focused and effective treatment to facilitate their successful reintegration into society. In the following section, I will set the stage for my proposal through an

investigation of the current status of mental health treatment in American state prisons, examining our blatant failure to treat and ultimately, rehabilitate.

SECTION III: PREVALENCE OF MENTAL ILLNESS IN PRISONS

With jails and prisons housing vastly more individuals with mental illness than modern psychiatric hospitals, we must begin to view prisons as not only places of punishment, but failed centers of treatment that beg major reform (Torrey et al., 2010). Dumont et al. (2012) describe how this overpowering trend is indicative of a deeper social issue, reflecting the de-facto criminalization of mental illness in America. As the movement of deinstitutionalization led to laws prohibiting forced hospitalization, police and courts were encouraged to implement criminal solutions (Fisher et al., 2006). Balloon theorists Palermo et al. (1991) further illustrate how deinstitutionalization in the latter half of the twentieth century led to a rapid increase in the prison system's housing of persons with mental illness. The burden of care simply shifted from one institution (the asylum) to another (the penal system), with a brief interlude of neglect in between (Bassuk & Gerson, 1978). This series of events is illustrative of a deeper pattern of society's treatment of persons with mental illness, a pattern described earlier in Part II of Section II: Overview of Mental Health Treatment. The current phase of this pattern appears to be one of institutionalized neglect, as persons with psychological disorders are shut away in prisons, out of the public eye and without meaningful treatment.

As noted earlier, the prevalence of mental illness in U.S. prisons is severely disproportional to that of the general population–54% compared to 18.5%. (James & Glaze, 2006; Substance Abuse and Mental Health Services Administration, 2017). According to data collected by the Bureau of Justice Statistics and analyzed by James and Glaze (2006), 56% of

state prisoners, 45% of federal prisoners, and 64% of jail inmates have some sort of "mental health problem." In this report, two measures were used to determine a mental health problem: if inmates had a recent history (were clinically diagnosed or treated) or reported symptoms of psychological dysfunction (as defined by the DSM-IV–[10]the most current edition of the DSM at the time this research was published). James and Glaze also found that not only do individuals with a mental health issue typically receive longer sentences, but they serve more time of those sentences: on average, state prisoners with a mental health problem had mean maximum sentences of five months longer than their counterparts, and remained imprisoned an average of four months longer than those given the same sentence who had no symptoms. Within the prison, their risk of victimization is also higher, and once released, they are more likely to recidivate (Matejkowski & Ostermann, 2015). Courts have consistently held that the Eighth Amendment of the Constitution imposes a legal obligation on American prisons to provide medical care for inmates in need (Estelle v. Gamble, 1979). In our carceral institutional landscape, mental health services appear superficially to make up an integral part of this care (Galanek, 2012). However, as one examines the reality of mental health treatment in prisons today, consistent patterns of inadequacy clearly emerge.

In the U.S. prison system, treatment typically manifests itself in a three-pronged approach. All federal and most state prison policies mandate 1) the screening of inmates in some method of diagnostic assessment, 2) the provision of therapy or counseling by trained professionals, and 3) the distribution of psychotropic medications when deemed necessary (James & Glaze, 2006). While this approach may appear relatively straightforward, its actual application is highly variable and subject to a wide range of socio-cultural biases, geographic,

[10] The fourth edition of the *Diagnostic and statistical manual of mental disorders* published by the American Psychiatric Association; the DSM-5 is the most recent edition

and financial influences (Galanek, 2012). Moreover, while an initial assessment is a relatively common practice, the subsequent steps of counseling and drug therapy are severely lacking in substance (James & Glaze, 2006). Since state prison populations far outnumber federal inmates, this section will focus primarily on treatment procedures in state prisons. In addition, state prisons hold inmates for longer periods of time than jails, presenting more opportunities for treatment (James & Glaze, 2006; Wagner & Sawyer, 2018). While the sheer size and scope of American state prisons (along with a paucity of existing literature on the subject) makes a universal assessment problematic, in Part II of this section, I will attempt to provide a general overview of these prisons' current implementation of the aforementioned three-pronged approach (James & Glaze, 2006).

SECTION IV: CURRENT STATUS OF TREATMENT

INTRODUCTION

In this section, I made the decision to limit the discussion to the current status of mental health treatment in state prison systems. While this choice presents serious challenges of consistency, it offers the undeniable benefit of a comprehensive assessment of mental health treatment in the American prison system. First, I will outline the drawbacks associated with my decision to analyze data from state prison systems, followed by the respective advantages it presents.

Each state prison system uses its own distinct guidelines and enforcement practices, making a conclusive summary all systems impossible. In addition, the mistreatment of individuals with mental illness in the U.S. penal system spans federal, state, and county systems. While it would be desirable to address each of these systems individually, there are several

reasons for focusing on state prisons. State prison systems house vastly more prisoners than the federal prison system, and they do so for much longer periods than jails (James & Glaze, 2006; Wagner & Sawyer, 2018). In essence, my choice is a calculated assessment of quality and quantity–the quality or length of treatment available, and the number of prisoners receiving this treatment. Since I aim to examine the treatment of the largest populations of prisons being incarcerated for the most amount of time, a focus on state prisons is most applicable. While it would be preferable to examine conditions of treatment in all U.S. penal facilities (federal and state prisons as well as jails) the data available is inconsistent across these penal levels. Therefore, I concluded that an analysis focusing on treatment in state prisons is the most reliable and effective means to assess (and subsequently, address) the mistreatment of individuals with mental illness in the American penal system, even considering large discrepancies in state prison systems.

It is also important to note the flawed nature of the data available regarding mental health treatment in state prisons. One key resource used in this section is a Bureau of Justice Statistics report in which Beck and Maruschak (2001) analyze data from 1,394 of America's 1,558 state adult correctional facilities (both public and private) that reported providing mental health services for prisoners. In the following chapters, I will utilize this report among other sources to investigate the provision of care [*reported by prison officials*]. It should be noted that the inherent biases of these self-reported sources may prevent an objective assessment. However, there is little reliable data available from other sources (including inmates themselves).

PART I: DIAGNOSTIC ASSESSMENT

One of the primary processes for mental health treatment in state prisons today is the diagnostic assessment, where clinicians or technologies are used to assess the mental health

status of prisoners (Beck & Maruschak, 2001). One can use Foucault's musings on panopticism to understand this relationship as a complex exchange in which the prisoners are, in essence, "fixed objects" to be first analyzed and subsequently "corrected" or "normalized" by the institution (Foucault 1977, pp. 184-185; pp.191-192). Author Joseph Galanek (2012) examines the cultural construction of mental illness in prisons, noting many problematic aspects of the diagnostic process. This process, he asserts, is a subjective one reliant on fixed categories of mental affliction that are ever-changing and highly contested. According to Galanek (2012), prison clinicians or psychiatric professionals attempt to render objective extremely subjective behaviors and experiences of the prisoners, compounding diagnostic uncertainties and limiting the scope of holistic understanding. Theorists such as Hoffmann (2014) note that limitations in our evolving understanding of mental health are inevitable, and necessarily affect treatment outcomes. In consideration of this valid criticism of the diagnosis and categorization of inmates, I will instead concentrate on the actual processes of administration of treatment (APA, 2013).

Beck and Maruschak (2001) reveal that 70% of American state adult correctional facilities reported their use of some sort of initial screening process or diagnostic assessment. According to this report, these state prisons use a separate diagnostic facility to identify inmates with mental disorders prior to their placement into the actual prison. However, there is very little information available regarding the type and quality of this screening process. In a comprehensive report on available health services in prisons, Chari et al. (2016) with the Bureau of Justice Statistics conducted a series of telephone interviews from respondents in 45 of the state Department of Corrections Offices. When asked about mental health screening procedures, respondents from all 45 states reported providing mental health screening to 'at least some' prisoners in the initial admission process. 31 states also revealed information about the minimum

qualifications of the health care workers charged with the administration of this diagnostic screening process. In 9 states, nurses administered screening; in 7, psychologists or psychiatrists did; specially trained correctional officers administered screening in one state, while "some other form" of licensed mental health care provider (e.g. masters level social workers) screened prisoners in 14 states (Chari et al., 2016). According to a 1994 survey of mental health evaluation in U.S. prisons by Metzner, Miller, and Kleinsasser (1994), both structured and subjective interview techniques, as well as a wide variety of tests, were reportedly being used in screening processes. The most commonly administered tests were the Minnesota Multiphasic Personality Inventory (MMPI-2),[11] the Bender-Gestalt,[12] Wide-Range Achievement Test (WRAT)[13] and the Revised Beta-2[14] (Bender, 1938; Kellogg & Morton, 1957; Jastak & Wilkinson, 1984; Butcher et al., 1990) Problematically, results of these tests were unlikely to illicit treatment; rather, they were more commonly used to determine inmate placement and classification for security purposes–that is, to house prisoners according to mental health status so as to best prevent inmate altercations. There was no information given regarding structured or subjective interview processes (Metzner et al., 1994).

This diverse array of test administrators and methods used indicates very little standardization or enacted requirements designating proper screening procedures or protocol. While in the 2016 survey, all states reported screening 'at least some' prisoners, no information was provided on how these prisoners–or how many–are selected (Chari et al., 2016). In addition, the qualifications of the individual administering the screening process are highly variable, along with the actual type of assessment being used. Furthermore, there are no methods in place to

[11] MMPI-2 is a written psychological assessment used for diagnosing mental health
[12] Bender-Gestalt is a psychological instrument used to assess visual-motor functioning and visual perception skills
[13] WRAT is a psychological assessment measuring reading, spelling and math skills
[14] Revised Beta-2 is a psychological assessment of nonverbal intellectual capacity

determine the universal effectiveness of these processes, and in particular regard to interviews, whether or not they prove to have high face validity[15]–if a reasonable level of agreement exists across all raters or assessors. To delve deeper into this issue, one must take a look at the standards in place to guide this process.

According to Metzner et al. (1994), these standards, or rather, recommendations to guide inmate evaluations, are principally provided by three non-governmental organizations: The National Commission on Correctional Health Care (NCCHC), the American Psychiatric Association (APA), and the American Public Health Association (APHA).

First, I will look at the standards provided by the NCCHC, an organization originally founded by the American Medical Association in the 1970s in response to reports of substandard health in American prisons. The NCCHC website proclaims its dedication to "improving the quality of health care in jails, prisons and juvenile confinement facilities," (NCCHC, 2018). It provides purchasable written guidance for prisons on all matters of inmate health and offers various programs of certification for prison health care professionals as well as facilities themselves. The particular NCCHC clause pertaining to mental health screening of prisoners is the standard E-05 Mental Health Screening and Evaluation. This standard–detailed in the *CorrectCare* Volume 32, Issue 1 of 2018–proclaims its intent to "ensure that the inmate's serious mental health needs, including those related to developmental disability and/or addictions, are identified." It requires that within 14 days, a mental health screening must be completed for all incoming prisoners that address certain indicators of mental health (not listed on the NCCHC website). It mandates that this diagnostic process should be administered by "qualified mental health professionals or mental health staff," a rather obtuse description that could include individuals with a variety of educational or professional backgrounds. Standard E-05 then

[15] Defined as whether or not a test measures what it is designed to measure

mandates that inmates with positive test results in this initial screening (indicative of a mental health issue) must then be referred to a "qualified mental health professionals" for further evaluation (NCCHC, 2018). To view the full recommendations for diagnostic evaluation, the extensive *CorrectCare* volume must be purchased. Correctional facilities that abide by the requirements of this volume can then apply to receive "accreditation"–an official acknowledgment of their adherence to the NCCHC Standards. This accreditation process is one of the main factors that sets the NCCHC apart from the APA and the APHA, which don't offer a similar service. Rather, the APHA states its public support of the NCCHC accreditation process and encourages prisons to apply (APHA, 2004).

While the NCCHC protocols may be helpful in guiding prison administrators and professionals, there is little information available regarding the actual type and number of American corrective institutions that attempt to follow them: one report by a correctional healthcare consultant of the organization suggests that over 500 facilities have been accredited in the U.S., "affecting the lives of over 500,000 prisoners," (Schramm, 2014). However, there is no specification of which facilities or states have completed the process, or more importantly, what measures are being used to quantify the actual effect of the NCCHC guidelines on prisoner lives and treatment.

One available report by researchers Gibson and Phillips (2016) surveyed NCCHC accredited facilities in an effort to analyze their actual compliance with the organization's standards. This study found a clear positive correlation between total admission and prisoner capacity of a prison (how many prisoners are admitted to and housed in the facility) and noncompliance with the NCCHC standards in section E–the section pertaining to inmate care and treatment. Since the standard regarding inmate mental health screening and evaluation (E-

05) is in this section, we can infer that larger, busier accredited prisons are less likely to effectively perform initial diagnostic assessments of mental health, thereby violating this standard. This report also confirms the general suspicion that simple accreditation itself does *not* ensure future adherence to NCCHC standards (Gibson & Phillips, 2016).

In sum, without more focused data on the prisons that adhere to the NCCHC recommendations, it is impossible to determine a) the location and type of facilities using the guidelines and b) if their use of these guidelines is effective. It should also be noted that even if the NCCHC is successful in evaluating and accrediting prisons on a mass scale, its specific protocols for initial mental health screening are somewhat ambiguous, at least according to the organization's website. In addition, even once a facility is accredited, there is a clear precedent for violating the NCCHC inmate care and treatment standards, especially by larger state prisons (Gibson & Phillips, 2016). In summary, the indeterminate nature of the NCCHC penetration and effectiveness points to the need for enforceable legislation mandating superior prison care, in place of private organizations which simply recommend it.

The American Psychiatric Association or APA is the second prominent organization that provides guidelines for mental healthcare in prisons (Metzner et al., 1994). The APA recently released a revised version of its *Psychiatric Services in Correctional Facilities*, first published in 1989. This book offers strategies for treatment as well as screening tools set in a legal and ethical context (American Psychiatric Association, 2018). Similar to the NCCHC, the APA recommends an initial diagnostic assessment of prisoners defined as "observation and structured inquiry" by "qualified mental health personnel," (Metzner et al., 1994). However, rather than the 14 days allowed by the NCCHC, the APA recommends screening within four hours of intake, in order to allow clinicians to assess the urgency of care needed and determine which prisoners should be

given priority. One published review of the APA guidelines by Adetunji (2017) highlighted a key shortfall in the organization's failure to mention the many limiting factors that may inhibit facilities' implementation of the actual recommendations, and how to properly address these factors. For example, Adetunji notes no mention of the acute shortage of correctional psychiatrists–a shortage that may severely impact the quality and scope of initial screening performed on prisoners. Unlike the NCCHC, the APA offers no accreditation (APA, 2018). Regardless, as a private organization, it cannot enforce adherence to its guidelines. Therefore, notwithstanding the actual validity or effectiveness of its recommendations, the APA's standards have a very limited ability to influence prisoner care.

The third primary organization providing standards for prisoner health care is the American Public Health Association or APHA (Metzner et al., 1994). The APHA takes perhaps the most definitive stance of the three organizations in its policy statement on the quality of treatment in the prison system, noting the gross inadequacy of healthcare in prisons and chiding the commonness of "unethical experimentation" within these facilities. The APHA outlines the duties of the organization's Task Force on Jails and Prisons, citing the necessity to establish a "uniform health code that will standardize medical care given throughout the prison system" that explicitly demarcates the responsibility "between medical and correctional personnel," (APHA, 1973). More clearly than the NCCHC or APA, the APHA poignantly criticizes the current treatment deficits of U.S. facilities and calls for a universal protocol applicable to all prisons. In 2003, the APHA released the third and most recent edition of its *Standards for Health Services in Correctional Institutions*, a comprehensive guide for healthcare in prisons. A review of this book by MedScape (2004) emphasizes its clarity and provision of detailed information, but it notes that the book is outdated in addressing many issues that have since rapidly evolved (e.g.

the effectiveness of certain treatment methods). Similar to the APA, the APHA itself does not offer any accreditation or certification options; instead, it encourages American corrective facilities to apply for accreditation from the NCCHC and proclaims its support for this concurrent organization (APHA, 2004). All in all, despite the strong convictions of the APHA and its attention to detail, its 2003 book of standards is inherently outdated and as a private organization, it lacks the ability to enforce its own recommendations.

After a comprehensive look at these standard-setting organizations, the need for legal enforcement becomes even more apparent. The accreditation process of the NCCHC represents a positive effort to incentivize and regulate prisoner health care but falls woefully short when it comes to enforcement. Concurrent organizations–the APA and APHA–publish extensive resources for prison administrators and planners but are similarly powerless to compel compliance with them. When it comes to diagnostic assessment, a wide variety of methodologies are used, with very little evidence as to the effectiveness of their implementation. Factors such as differential education or professional background of screening administrators, type of assessment used, and selection processes for choosing which prisoners to assess leave ample room for error and neglect. In Part II of this section, I will examine state prison mental health care processes that follow initial inmate screenings, attempting to unravel their prevalence and effectiveness, along with external factors that influence treatment type and quality.

PART II: COUNSELING AND DRUG THERAPY

Once the diagnostic assessment has occurred, and prisoners with mental illness have been apparently identified, some form of treatment–whether counseling or medication–should ensue. However, according to a Bureau of Justice Statistics by James and Glaze (2006), only 34% of state prisoners with an identified mental health issue received treatment during their

incarceration. This report found prescription and administration of a medication to be the most common form of treatment for state inmates, with about 27% of state prisoners who had a mental problem being given drugs[16] for treatment while in prison. However, only 73% of state prisons reported even practicing the distribution of psychotropic medications to prisoners. James and Glaze (2006) found that the same percentage of these facilities (71%) reported providing therapy or counseling by a trained professional; another Bureau of Justice Statistics report by Beck and Maruschak (2001) found that only 22% of state prisoners with an identified mental health problem reportedly received this form of treatment. Of course, these statistics are general averages, thus, the data fails to reflect the highly variable treatment protocols followed by different states (and prisons within those states). However, in sum, they paint a disturbing picture of a system that fails to meet even the bare minimum requirements for treatment and offers no methods of procedural evaluation or oversight. According to the findings of Beck and Maruschak (2001), one hundred and sixty-four state prisons provide no mental health treatment at all, and those that do are only treating about a third of their inmates with mental illness–even assuming that diagnostic measures are more or less effective at determining which inmates have a mental health problem. In addition, this report found that the other two-thirds of inmates identified as having psychological disorders are not being given *any* form of treatment, whether counseling or drug therapy (Beck & Maruschak, 2001).

Whether or not the treatment that *is* being administered is effective is yet another difficult question. The treatment categorizations utilized by the report above–drug therapy or counseling therapy–are much too broad to give a clear idea regarding the actual experiences of inmates

[16] Drugs defined as antidepressants, stimulants, sedatives, tranquilizers, or other antipsychotic drugs

(Beck & Maruschak, 2001). Drug therapy is an extremely subjective form of treatment, leading to distinct outcomes depending on the prescribing professional and the location of the prison facility, among other things. One qualitative study by Brown, Rogers, and Shaw (2009) sought to examine the experiences of psychotropic medication-reliant inmates upon entering prison, and the various challenges they were forced to cope with. These challenges included learning to survive without the benefit of a long-standing medication regimen, as the prison did not offer that type of medication or any similar alternative. In addition, even when prisons did provide medication, delays in receiving it were found to be extremely common and resulted in rapid deterioration of inmates' mental states. To further compound their distress, prisoners were not offered an opportunity to negotiate their prescription regimen or request alterations (Brown et al., 2009). This evidence lends a new, even bleaker perspective when examining the aforementioned statistic that just 27% of state prisoners who had a mental problem are given drugs while in prison (Beck & Maruschak, 2001). Even inmates that *are* receiving some form of medication are not likely to receive their preferred medication or to maintain a proper dosing schedule.

Unfortunately, the second categorization of treatment type–counseling or therapy administered by a trained professional–is equally as variable as drug therapy. Even disregarding the relative ambiguity of the term "a trained professional"–as used by James and Glaze (2006)–and assuming that individuals administering therapy in prisons are qualified and well-equipped to do so (an unrealistically optimistic assumption), there is an extremely wide variety of therapy schools and techniques, some proven to be much more effective than others. Author Carkhuff (1976) noted a phenomenon seemingly common in the fields of counseling and psychotherapy: many advocates of popular schools of therapy persist in their practice despite consistent failure to demonstrate that school's effectiveness. This phenomenon presents a puzzling problem,

especially in the field of inmate care. With virtually no data exposing the specific types of therapy being used by prison professionals, there is no way to investigate whether or not inmates are receiving a form of care that is proven effective.

In light of the variability and subjectivity of these treatment forms, the question once again arises: *who* is providing inmate care? Not merely at an individual level, but on a larger scale; in asking this question, the mass privatization of prison health care comes to the forefront of the discussion. State failure to provide adequate health care in prisons has coincided with the contracting of private companies to provide this care (Andrews, 2017). The contracting of care also serves to relieve the state of the burden of liability–passing this responsibility to the corporations and reducing state expenses considerably (Kutscher, 2013). In theory, this development could represent a positive direction for inmate care, providing access to resources and treatments that the state simply cannot provide. However, in practice, the billion-dollar corporations charged with treatment–Corizon, Wexford, CoreCivic, and GEO Group, namely–have been the subject of numerous and serious allegations of negligence and abuse (Cohn, 2015; Andrews, 2017; Gilson et al., 2017; Schwartzapfel, 2018). A glance into the financial dealings of the companies reveals unsavory conflicts with federal standards, as the responsibilities of private corporations to their shareholders encourage them to spend as little as possible to maximize profits. In the realm of healthcare, which is extremely costly to provide, this cutting of corners translates into neglect (Andrews, 2017). For example, CoreCivic has a demonstrated history of denying hospital access to inmates and punishing those who make repeated requests for care (Gilson et al., 2017). Corizon is facing multiple class action lawsuits and has been found guilty of negligence by a federal court. Numerous inmates in Illinois have filed complaints against

Wexford for denying treatment (Cohn, 2015; Schwartzapfel, 2018). While prisons riots and lawsuits have occurred as a result, there has been little in the way of change (Gilson et al., 2017).

When examining these issues, the standards set by the APA, the APHA, and the NCCHC once again come into play, with the accreditation processes of the NCCHC and the APA representing, in essence, the only formal methods of assessing (and approving) inmate mental health care in state prisons. Yet, according to a follow-up study on NCCHC accredited facilities, even these prisons demonstrated a clear tendency to violate the required standards post-accreditation (Gibson & Phillips, 2016). Therefore, examining the specific guidelines set out by these organizations is inherently flawed. Instead, what is needed is a new, universal treatment approach, funded and supported by legislation, with consequences for non-compliance by enforcement through the courts. While the lack of data regarding mental health treatment types and outcomes in prisons creates statistical uncertainty, the severe neglect that pervades the prison system renders these specific treatment details of secondary importance. Rather than a further analysis of our current methods, efforts should be focused on the immediate implementation of reform. While the path to achieving this reform is complex and difficult, with many political and legal obstacles, it appears the only viable course of action. In Part III below, I will outline these obstacles and the path that any reform effort would have to follow in order to succeed.

PART III: LEGAL FRAMEWORK AND FUNDING

In this chapter, I will discuss the various ways to effect the kind of change needed to ensure humane treatment of inmates with mental illness. First, we must consider the relationship between the prisoner and the politician, who share an intangible, yet undeniable connection rooted in their both belonging to American government institutions. Second, I will discuss the

impact of lawsuits brought against state governments and Departments of Correction for violation of the Eighth Amendment.

The politician is one cog in the machine of legislative bodies, whether at the county, state, or federal level. The prisoner is one of the millions held in the penal institution, also on either a county, state, or federal scale. The fundamental difference between these two is power: while the politician subjectively shapes lives, the prisoner's life is subjected to this shaping. The language of Foucault is recalled, as the politician represents an institution that is part of the larger system of disciplinary power, governing the lives of all individuals subjected to it. The penal institution is also part of this system, wielding its power with the intent to normalize (Foucault, 1977). The intrinsic connection between prison systems and legislative bodies–and therefore, the politicians and prisoners within these entities–cannot be understated. Given the tenets of Critical Race Theory (CRT) and structural determinism, these institutions' actions will be determined by the purpose of their creation–to serve the needs of those in power. By nature, both legislative bodies and criminal justice and prison systems will continue to reinforce patterns of oppression, and minorities and stigmatized groups will suffer the consequences. While true reversal of the destructive force of incarceration would require a complete dismantling and restructuring of the prison system, in absence of this radical change, the reform of mental health treatment in prisons could meaningfully mitigate the negative effects of the institution. Unfortunately, the intense politicization of American prisons, crime policy, and sentencing patterns make improvement practically nonexistent (Shannon & Uggen, 2012). To shift politicians' focus on improving prison care, public pressure must shift accordingly. Even more significantly, securing funding for a nationwide overhaul would likely require unprecedented

coordination of electorates, politicians, and nonprofit organizations dedicated to the cause; an unlikely event considering the structural and socio-political forces that contradict that goal.

However, the courts, as well as Congress, have made some efforts to affect change, albeit with mixed results. Culminating in the landmark case of *Estelle v. Gamble* forty years ago, the Eighth Amendment of the Constitution, which prohibits "cruel and unusual punishment," has been repeatedly interpreted by judges to ensure the provision of adequate medical care for U.S. prisoners (Estelle v. Gamble, 1976; Vanheuverzwyn, 2009). As a result, federal and state prison facilities are mandated to provide this care. However, correctional health care has remained sorely inadequate in the intervening years, with seemingly minimal effort to adhere to the established legal requirement (Andrews, 2017).

In 2002, the U.S. Congress requested the NCCHC to write an extensive report on inmate health care in American prisons, titled *The Health Status of Soon-To-Be-Released Inmates.* This proposal included details on the subpar conditions as well as specific strategies and recommendations to improve prisoner health care services. Despite the findings of this report, no concrete congressional action ensued following its completion (Wilper et al., 2009). It should be noted that thousands of bills are introduced in Congress each year, the vast majority declared 'dead on arrival.' According to non-profit organization Sunlight Foundation (2009), only 4% of bills introduced in Congress ever become law.

H.R.6764 is one of the most recent bills to attempt to improve prisoner care, introduced in Congress in September of 2018, with the proclaimed goal of amending title XIX of the Social Security Act to provide a consistent standard of health care to American prisoners (Kuster, 2018). In essence, this bill would repeal the Social Security Act's exclusion of prisoners from care, thereby giving inmates access to Medicaid. This access would allow states to be reimbursed

up to a percentage for care given to inmates outside prison walls, somewhat relieving their financial burden. In essence, the passage of this bill would serve to partially transfer responsibility for quality inmate care from states to the federal government (Andrews, 2017). This bill, which could potentially lead to vast improvement, is only in its introductory phase and statistically highly unlikely to ever become law (Sunlight Foundation, 2009).

While the submission of bills such as H.R.6764 provides evidence that at least some politicians are cognizant of the current treatment deficits in prisons, its mere introduction is not indicative of true progress. In many ways, the failure of legislatures and Congress to initiate real change appears to stem from this subject's political volatility. Due to the extremely expensive nature of health care and a general lack of public concern, politicians are encouraged to push this issue aside (Andrews, 2017). Compounding the problem, racialized "tough on crime" rhetoric is often an effective method of gaining political support (Shannon & Uggen, 2012).

With no foreseeable incentive for politicians to work on prison care reform, change (from this source) is not currently viable. Therefore, I would propose that targeted lawsuits–in particular, class action suits–may be the only method of effecting true and timely change. The legal complexity involved in taking these lawsuits before the federal courts require significant resources, resources often provided by organizations such as the American Civil Liberties Union (ACLU). While the ACLU has fought for improved prison conditions on many fronts, it has achieved only limited, incremental change, not widespread improvements for mental health care. (Lyman, 1999; Botkin, 2018; SPLC, 2018). In order to hold state prison systems accountable and ensure the federal government's proper enforcement of regulations, it is necessary to invoke the power of class action lawsuits filed in federal courts. Next, I will summarize several cases that have set the precedent for state prison reform in individual states.

In 2011, a federal judge issued a landmark order against the California prison system. In an unprecedented act of mass forgiveness, the state was ordered to release tens of thousands of prisoners housed in unconstitutionally harsh conditions. The lawsuit cited these conditions as creating a "criminogenic" environment, perpetuating cycles of recidivism (Williams, 2009; Johnson, 2011; Kuznia, 2016). It should be noted that the subsequent release of almost 30,000 low-level offenders from the state's prison system saved over $453 million and did not result in any rise in California's crime rate (Sundt, Salisbury, & Harmon, 2016).

More recently, in 2014, the Southern Poverty Law Center (SPLC) and the Alabama Disabilities Advocacy Program (ADAP) filed a lawsuit against the Alabama Department of Corrections (ADOC) with the goal of improving deplorable conditions in the state prison system. The lawsuit, detailed by the SPLC (2018) cited decades of insufficient funding and the understaffing of both correctional and mental health workers as key issues in need of addressing. Alabama legislators have requested $80 million in federal funds for prison health care, but researchers warn that this amount will barely cover expected increases, with nothing left over to remedy staff shortages or improve conditions. In 2017, a 302-page report was released by the U.S. District Court declaring the Alabama prison system's failure to abide by the Eighth Amendment's prohibition of cruel and unusual punishment. Evidentiary hearings were subsequently scheduled to determine exactly how the state will fix its constitutional violations (SPLC, 2018). In September of 2018, ADOC officials were threatened with contempt after their failure to comply with the federal court's ruling, which required recruitment and hiring of medical and mental health personnel. Further hearings are ongoing, as the ADOC struggles to comply (Chandler, 2018; WFSA, 2018).

While this lawsuit represents a legal success, it remains to be seen how and if the federal courts will ensure that Alabama prison systems adhere to the mandate. Meanwhile, class action lawsuits in Arizona have run into similar issues. Tens of thousands of inmates sued the private company charged with prison care–Corizon–for inadequate treatment and neglect (Jenkins, 2018). According to staff attorney Kendrick (2018) of the American Civil Liberties Union (ACLU), federal courts issued a scathing order in June of 2018 finding Arizona Department of Corrections officials in contempt for their ongoing failure to provide minimum levels of care. In particular, the presiding judge cited over 25 performance measures in the settlement that the prison system was "chronically and profoundly noncompliant with," including stipulations regarding the provision of psychotropic medications (Kendrick, 2018, p. 1). According to Kendrick, contempt is often used by courts as a last resort after severe noncompliance has occurred.

In addition to these examples, there have been multiple lawsuits across states (e.g. Texas, Ohio) that have ended in the requirement of federal oversight to ensure adherence to settlements (Lyman, 1999; Botkin, 2018). While this oversight has often resulted in improved conditions, a meaningful overhaul of medical and mental health care has not occurred. Based on this evidence, one can infer that many future lawsuits will be necessary to ensure meaningful, widespread change through federal enforcement. These lawsuits would occur on a state by state basis, which if successful, could lead to the adoption of some form of my treatment proposal. Realistically, one or several states would pioneer the implementation of the proposal. Once these state prison systems provided clear evidence of its success in reduced recidivism, reduced prison populations, and massive tax savings, other states would have an incentive to follow suit, especially when faced with intervention by the federal courts. Class action lawsuits would provide the basis for

enforcing reforms, while my proposal would provide a clear process for implementing improvements.

While lawsuits brought against state prison systems on the basis of Constitutional violations mandate improvements from an external source–namely, federal courts–another type of lawsuit may provide compelling internal motivation for states to invest in care. In a Prison Legal News article, Paul Wright (2001) details a relatively recent trend of jury verdicts holding states accountable for negligent supervision of parolees which might incentivize the implementation of a proposal such as the one outlined in Section V below. Washington State provides the most striking example of this phenomenon. Wright describes how, since the year 2000, Washington State has either settled out of court or been ordered to pay settlements amounting to upwards of $100 million for negligent supervision. In particular, these cases have occurred when parolees committed violent acts against innocent civilians upon release from prison. In many cases, these parolees suffered from a myriad of mental health problems (often in addition to co-curring substance use disorders) which were left untreated in the state prison system (Wright, 2001; Prison Legal News, 2003). One such case, *Joyce v. State of Washington Dept. of Corrections* (2003) involved parolee Vernon Valdez Stewart, who ran a red light while smoking marijuana, subsequently hitting a woman's car and killing her instantly. Stewart was found to have committed a multitude of parole violations that should have previously landed him in jail. In addition, although he had been diagnosed with bipolar disorder and severe psychosis, the Washington State prison system failed to provide any treatment for his mental illness during his incarceration. Lawyers argued that Stewart's crime (and the death of an innocent bystander) would likely have been preventable with effective treatment and supervision. In 2003, a jury returned a verdict awarding $22.4 million to the victim's family. While this verdict was later

overturned in 2006 on the basis of faulty jury instruction (and settled out of court for $6.5 million), the Washington Supreme Court upheld its decision that the state can, in fact, be held liable for negligent supervision (Prison Legal News, 2006). This is just one of many cases illustrating the trend of lawsuits holding states liable for their failures to a) properly monitor parolees and b) effectively address the mental health of inmates. This trend should serve to warn states that their penal system's failure to rehabilitate will ultimately lead to massive liability, providing clear motivation to improve mental health care in state prisons. I would argue that this method of suing states on the basis of negligent supervision may be the only method of providing internal motivation for change. Meanwhile, in absence of this motivation, the suing of states based on broader Constitutional violations (particularly concerning the Eighth Amendment) will externally mandate improvements.

However, aside from litigation, it is also worth mentioning a more idealistic solution to this problem–namely, the creation of a new federally funded government agency. To ensure states' compliance, I would propose that the federal government create and fund a new agency charged with overseeing states' adherence to court-mandated standards. This agency would hold the power to promulgate new standards and regulations enforceable by law, compelled in large part by successful lawsuits against state and federal governments based on their current failed systems. While this course of action is unlikely given the lack of political will outlined in previous sections, it is explored in Section V as an optimal if unrealistic resolution.

SUMMARY OF KEY ISSUES

Before moving to Section V, describing the specifics of my proposal, I will provide a brief review of the key issues revealed in my investigation into the current status of mental health treatment in state prisons, identifying several main areas that beg major reform.

Firstly, diagnostic assessment of prisoners is inconsistent and severely lacking. Beck and Maruschak (2001) found that only 70% of state prisons reported using some form of intake assessment. In a survey of 45 state prisons, Chari et al. (2016) found that prisons reported only screening 'some' inmates, with no information given on how many or the process of choosing which inmates to screen. Moreover, Chari et al. found the qualifications and training of prison officials charged with administrating the assessment were extremely variable and lacked any standardization. In addition, Metzner et al. (1994) found prison screening processes to be highly variable, with a wide variety of assessments used, often designed to measure different things. Most problematically, perhaps, they found that results from diagnostic assessments did not lead to treatment–rather, they were most often used to categorize and house inmates according to mental health.

When it then comes to mental health treatment, prisons appear to be similarly ill-equipped and ineffective. James and Glaze (2006), found that 34% of state inmates with an identified mental health problem received treatment while in prison, with 27% of these being administered prescription medication. To compound this problem, Brown et al. (2009) found that prison medication administration was often inconsistent and riddled with delays. Meanwhile, Beck and Maruschak (2001) reveal that just 22% of state prisoners with an identified mental health issue received any form of therapy or counseling. In addition, there is no data available regarding the type of counseling being given or its effectiveness. Contributing to and compounding these issues, the shortage of qualified prison mental health staff is also a dire problem.

The largest organizations providing guidelines for screening and treatment–the NCCHC, APA, AND APHA–are private, lacking any ability to enforce or effectively monitor prisons'

adherence to their recommended standards. Furthermore, an investigation into the political, legal, and financial precedent for reform reveals clear deficits in funding and political will. While the creation of a government agency designed specifically to oversee and fund a mental health treatment overhaul would represent an ideal solution, lawsuits against state governments and officials present a more realistic path towards reform. In the following section, I will outline my own proposal for evidence-based mental health diagnosis and treatment protocol in state U.S. prisons.

SECTION V: MY PROPOSAL

INTRODUCTION

In order to create a viable proposal, the key issues revealed in the previous section must be addressed. In particular, any effective proposal would have to entail some method of standardization designed to reduce costs, time, and effort while streamlining assessment, training, and treatment processes. First, this proposal must design a brief, inexpensive universal screening process. Second, it must provide an evidence-based, relatively uniform counseling or therapy treatment. The training of officials in administering this treatment must be uniform, cost-effective, and efficient. In addition, funding must be allocated to ensure the adequate and timely provision of prescription medication.

In order to facilitate these goals, the shortage of qualified mental health staff in prisons must be addressed, including the recruitment of qualified minorities, increased salaries, and improved training and employee support. To succeed, it is critical to demonstrate the economic and social benefits of significant reform. In sum, the financial cost of the proposal must be shown to be far outweighed by long-term savings it will accrue. In order to create a precedent for

these savings, the proposal would be first implemented in one or two states, in order to provide evidence for its effectiveness and cost savings. This evidence could then be used to financially motivate other states to follow suit. In the meantime, successful lawsuits will continue to provide a powerful incentive for state legislatures to consider the value of reform.

In the following section, I will outline a proposal for satisfying these requirements, beginning first with the exploration of an ideal financial solution in the form of a new federal agency. Then, I will address staffing needs, followed by universalized methods of diagnostic assessment. Lastly, I will present my proposal for mental health treatment of prisoners, emphasizing an evidence-based treatment type with clear precedent for success.

PART I: AN IDEAL SOLUTION

This section will serve to detail my recommendations concerning the creation of a federal agency to overhaul mental health care in state prisons. While this solution is unlikely to occur given a lack of political will and funding challenges, it is explored here as an idealistic answer to the systemic lack of mental health care in prisons.

As previously discussed, the attempt to relieve the financial burden on states through the privatization of prison health care appears a failed experiment (Kutscher, 2013; Cohn, 2015; Andrews, 2017). The efforts of well-intended, non-governmental organizations have had limited real-world, measurable results (Gibson & Phillips, 2016). To remedy this situation, I propose the creation of a federal administrative agency with the explicit mandate of overhauling mental health care in state prisons. This agency would be charged with overseeing and disseminating federal funds to state prisons that implement the provisions of my proposal, amended with the benefits of newer research developments. This agency would be a regulatory body with limited powers delegated by Congress under the delegation doctrine, which requires clear and adequate

standards to guide the agency (U.S. Legal, 2016). Creation of the agency would require enabling legislation passed by Congress, bestowing powers of rulemaking and adjudication. Rulemaking is a process (codified in the Administrative Procedure Act of 1946) that establishes legal standards for government agencies to change, create, or eliminate regulations enforceable by law. According to the Department of Justice (2015), this process requires that the agency publish a "notice of proposed rulemaking" and allow time for the public to voice their opinion during a "notice and comment" period. Under these standards, the agency would have the authority to create and impose new rules and regulations that further its mission. The power of adjudication would give the agency the ability to resolve public and private disputes that may arise as a result of its actions (DOJ, 2015).

My proposed new federal agency, established under the Administrative Procedure Act, would be charged with creating a program to distribute funds and monitor the prison facilities receiving funding, ensuring that prisons follow its guidelines and use the funding as designed to improve mental health services. Specifically, mental health care improvement would be measured through a three-pronged analysis of 1) the facility's administration of the enumerated diagnostic screening procedures 2) its training in and use of Cognitive Behavioral Therapy (CBT) for treatment of psychological disorders, and 3) its provision of prescription medication as needed. To facilitate the implementation of this proposal, prisons would also need to address existing mental health staffing shortages. The federal agency would complete annual analyses of progress by collecting data from each facility receiving funding, reserving the power to revoke or reallocate funds as needed to promote successful care. Funding would serve as an effective incentive for state prison systems to buy-in and take the dramatic steps needed to improve their mental health treatment programs.

My proposal recognizes that effective provision of mental health care is extremely costly, complicated by the constraints of a prison setting, and politically unpopular. An overhaul of our current system would be a slow and challenging process, with varying degrees of success on a state-by-state basis. While lawsuits will continue to be the primary motivation for change, an ideal solution would consist of creating a new federal agency, adequately funded to facilitate oversight and enforcement. While fraught with challenges, it would be the most effective means to ensure that our state prison systems finally abide by the Constitutional right to medical care.

In the next sections, I will describe the actual content of my treatment proposal, concentrating on the importance of increased staffing and uniform, evidence-based screening and treatment practices.

PART II: STAFFING

The staffing of mental health personnel in prisons presents yet another complex dilemma. On a federal level, only 57% of the Bureau of Prisons (BOP) full time correctional psychiatric positions are filled nationwide. Many facilities fall far short of the BOP's already minimal standard of one mental health professional per 500 prisoners (Evaluation and Inspections Division 17-05, 2017). When it comes to states, the situation appears similarly dire, although less comprehensive information is available due to lack of a unified system. In one case mentioned in the previous section (SPLC and ACLU v. ADOC), a judge in Alabama recently ruled the actions of the Alabama Department of Corrections (ADOC) unconstitutional, ordering the prison overseer to hire more staff. Months later, ADOC officials are being threatened with contempt after returning to court with only a fraction of the required positions filled (Chandler, 2018). Arizona State prisons have been slapped with federal oversight and threatened with million

dollar fines due to similarly unconstitutional conditions, the judge citing a lack of mental health and medical personnel as a crucial contributing factor (Schwartzapfel, 2018).

Recent inmate riots in Missouri prisons have been attributed directly to a lack of prison staff (Haldiman, 2018). Acute shortages of mental health staff are the rule, rather than the exception, in American prisons (Davidson, 2017). One Inspector General report sought to explain the difficulty of recruiting and retaining prison medical staff by citing the superior benefits and pay offered by private companies (Evaluation and Inspections Division 16-05, 2016). Another report by Lambert et al. (2011) analyzed literature focused on the burnout of correctional staff and found several additional factors that may contribute to the increased burnout rates of prison employees. These factors included perceived dangerousness of the job, role conflict, role overload, role ambiguity, among others. One of the key findings of this report is that social support–from supervisors, administrators, and co-workers–can effectively shield staff from burnout. Frequent job feedback was also negatively correlated with job burnout (Lambert et al., 2011).

Without adequate qualified mental health staffing, no overhaul of mental health care in prisons will succeed. Steps must be taken to address this shortage before the widespread implementation of a new treatment program. In order to best do so, I would propose the delegation of federal funding by my proposed agency to various state prisons on the condition the money be used exclusively to recruit and pay new mental health staff. Benefits and salaries must rival those offered by private companies. Staff must also be sought from a range of socio-economic and cultural-ethnic backgrounds, to better serve the high percentage of minority and underprivileged populations within the prison system. Based on findings by Lambert et al. (2011), prisons can mitigate the high burnout rate of employees through increased support

services, decreased role ambiguity, and the hiring of more employees to reduce work overload. In addition, frequent feedback sessions between supervisors and subordinates must be implemented to increase clarity of expectations, thereby reducing strain and increasing morale (Lambert et al., 2011).

In the next sections, I will detail treatment initiatives with proven effectiveness and destined to succeed once prisons have been adequately equipped with qualified personnel.

PART III: ASSESSING MENTAL HEALTH OF PRISONERS

Before treatment can occur, prisoners with a mental health problem must first be identified. As previously discussed, there is no universal diagnostic method being utilized in prisons; rather, a wide variety and combination of various tools are used. While the gold standard for diagnostic assessment is the Structured Clinical Interview for DSM Disorders (SCID), this assessment is, unfortunately, time-intensive, costly, and necessitates intensive training for its administration. For these reasons, the SCID and similar structured interview tests are not currently practical for use in the prison setting (First et al., 1996). Therefore, I propose the use of two standardized self-report tests to uniformly screen inmate mental health and minimize the subjective influence of variably trained prison assessors.

It should be noted that the two recommended diagnostic tests depend on the current categorization of mental disorders by the previously mentioned DSM, which are highly contested and ever-evolving (Hoffmann, 2014). This fact leaves much to be desired in the way of diagnosis and renders any written test imperfect by nature. However, given the current shortage of mental health professionals working in prisons, and the innate subjectivity of each professional assessor, I would argue that the use of standardized self-report tests is preferable to individual, interview-based assessments (Adetunji, 2017). In addition, the subsequent use of Cognitive Behavioral

Therapy (CBT) as a core treatment method (in conjunction with prescription medication) renders specific diagnostic categorization less important than a general indication of mental health. Because CBT treats root symptoms of mental dysfunction without relying heavily on official DSM categories, screening procedures need only identify inmates who may benefit from further evaluation and treatment (Hoffmann, 2014). I would propose that this quality of CBT also mitigates concerns regarding the lack of scientific validity of psychiatric conceptions (such as that expressed by Foucault, Kant, and Symonds) by focusing on concrete symptoms as opposed to rigid categories or diagnostic conceptualizations (Symonds, 1991; Goodwin, 2015; Gutting & Oksala, 2018). From a sociological-philosophical standpoint, minimizing the subjectivity of the assessor and the reliance of treatment on diagnostic categories will facilitate the identification of those in need, lead to superior treatment outcomes, and reduce the impact of stigmatization. However, diagnostic assessments and CBT still operate within the confines of the institution of psychiatry, and it is important to recognize their potential use as normalizing forces in prisons and society.

In order to maximize the efficiency and minimize the costs of diagnostic assessment, I propose that the tests used be easily accessible, free, and relatively brief (with less than 50 individual items). In addition, they must have established reliability and validity and be relevant for the most common mental health problems or disorders. A 2016 review of diagnostic measures–with the purpose of promoting evidence-based practice in mental health care–identified 29 adult assessments that fit the above criteria. Of these assessments, just two can be effectively used as diagnostic and screening tools that measure overall mental health (Beidas et al., 2015). The first of these is the *National Institutes of Health Patient Reported Outcomes Measurement Information System* (NIH PROMIS). The NIH PROMIS is a database with self-

report measures that assess symptoms across four key domains: global, physical, mental, and social health (NIH PROMIS, 2013). The domain of mental health would be particularly valuable in determining a future course of treatment, assessing such items as anxiety, depression, anger, and substance use. These measures were found to have concurrent validity with measures used by the Center for Epidemiological Studies and the Mood and Anxiety Symptom Questionnaire (MASQ) (Beidas et al., 2015). This test, while far from comprehensive, would provide a fast and free method of identifying inmates with psychological dysfunction. This identification is key in that it would separate inmates with a mental health problem from those without, and determine which prisoners warrant further evaluation, diagnosis, and treatment.

In addition to the NIH PROMIS, one other screening tool was found to have an adequate agreement between its results and the diagnoses of independent mental health professionals. This test, *Patient Health Questionnaires*, assesses symptoms of common mental health problems and can be used both as a screening assessment and to determine symptom change over time (Beidas et al., 2015). Like the NIH PROMIS, this test is not synonymous with a professional diagnosis, however, it can serve as a sorting tool that identifies inmates who require further evaluation and treatment.

The use of these two assessments is preferable to current diagnostic methods in that they are fast, inexpensive, have adequate to high reliability and concurrent validity, and require little to no training to administer. In contrast, the current methods used are highly variable, sometimes costly, and can require trained mental health professionals to administer. These factors may combine to result in the lack of diagnostic practice in today's prisons: in the year 2000, only 70% of American state prison facilities reported their use of any diagnostic tool, and in a 2016 report, Department of Corrections Officials in 45 states reported screening only 'some' prisoners upon

intake (Beck & Maruschak, 2001; Chari et al., 2016). The mass standardization of diagnostic assessment using the above two self-report tools would promote the widespread screening of prisoners and reduce the temptation for prison officials to cut corners in this domain. It would also dramatically reduce costs of the diagnostic stage of the process, a critical advantage in 'selling' the program to legislatures and state prison systems.

PART IV: EVIDENCE-BASED TREATMENT

After the above diagnostic tools have been used to determine which prisoners need further evaluation and treatment, the second two prongs of the three-pronged approach come into play (James & Glaze, 2006). The first of these is drug therapy, or the administration of psychotropic medications. This particular part of the treatment process would ideally require specific legislation to be put in place by a federal agency, mandating prisons to provide the same types of medications that are available to the general public and requiring prison officials to continue the treatment regimens of newly admitted inmates. These mandates would address two of the primary problems associated with prescription medication in prison: 1) the lack of sufficient and varied medication available and 2) the abrupt termination of newly admitted prisoners' medication regimens. This legislation would also necessitate funding designated for the express purpose of providing psychotropic drugs to inmates, and the hiring of mental health professionals qualified to prescribe and administer these medications.

When it comes to the last prong of the three-pronged approach–counseling or therapy administered by a trained professional–one particular form of treatment emerges as the most proven effective method: Cognitive Behavioral Therapy (CBT). CBT has its roots in behaviorism, created through the amalgamation of behaviorist and cognitive schools of thought. According to the Center for Substance Abuse and Treatment (1999), CBT combines behaviorist

concepts of classical conditioning and operant learning with cognitive social learning theory's emphasis on cognitive beliefs, schemas, and attributions. Hoffmann et al. (2012) describe how, pioneered by founders Aaron Beck and Albert Ellis, CBT holds that maladaptive cognitive functions (e.g. 'schemas' about the world, future, and self) can lead to chronic emotional distress and behavioral problems. According to the tenets of CBT, cognition and behavior are mutually dependent forces, and misalignment of either can lead to perpetual cycles of dysfunction. The basic purpose of CBT is to directly alter the maladaptive functions that give rise to negative thoughts, thereby reducing emotional distress and breaking cycles of problematic thinking and behavior (Hoffmann et al., 2012). In an article on mindfulness, Cayoun and Elbourne (2018) describe how CBT differs from traditional "talk therapies" (e.g. psychoanalysis) in its focus on skill-building through specific strategies, exercises, and "homework." Patients are taught to change both cognitive outcomes through behavioral exercises, and behavioral outcomes through cognitive exercises, each reinforcing the other. These exercises–such as the practice of mindfulness[17]–are key to CBT's success (Cayoun & Elbourne, 2018).

Furthermore, one of the main advantages of CBT is that it is not constrained by the contested and somewhat arbitrary diagnostic categories of the DSM; rather than administering treatment based on these categories, it treats the individual symptoms of patients–regardless of official labels (Hoffmann, 2014). Therefore, the use of CBT also minimizes the need for correct and specific diagnostic assessment upon intake of prisoners. Moreover, this quality of CBT is extremely important in reducing concerns regarding the subjectivity and non-neutrality of psychiatry as an institution. During the process of CBT, patients self-identify which symptoms they want to address, working in tandem with administrators of treatment to create a custom plan

[17] mindfulness in CBT is defined as non-reactive, non-judgemental experience of the present moment. It can involve meditation and breathing exercises

of care (Hoffmann, 2014). Essentially, rather than making one-sided diagnoses identifying a patient's behavior as deviant from social norms, CBT operates based on input from patients themselves. While still working under the umbrella of psychiatry, CBT's disregard for formal diagnostic categorization and patient-centric treatment style greatly mitigates psychiatry's propensity to act as a mechanism of social control.

An overview of evidence-based mental health treatment consistently points to CBT as the most effective form of treatment, with a remarkable ability to reduce recidivism in criminal offenders. One meta-analysis of 58 studies on the efficacy of CBT in treating prisoners found exceptional results. According to this review, the "consistency and magnitude" of the effects demonstrated from the research studies examined leave little doubt that CBT is "capable of producing significant reductions in the recidivism of even high-risk offenders," (Lipsey, Landenberger, & Wilson, 2007, pp. 23). These findings are consistent with those of earlier studies that sought to determine the principles of correctional treatment. In a 2002 article, researchers found that the use of a cognitive-behavioral-therapeutic approach was extremely effective for high-risk offenders when therapists specifically targeted criminogenic thought patterns (Bonta, 2002). Another CBT-based prison program in England was proven by several studies to significantly reduce participants' recidivism rates (Friendship et al., 2003; Sadlier, 2010). Based on these studies, it seems that further research to quantify CBT's positive impact is largely unnecessary. However, while these results hold great promise for the use of CBT in a prison setting, Lipsey et al. (2007) note that more research is needed to determine the ideal conditions under which it should be conducted.

The lack of data available on the quality of therapy currently provided to prisoners leads to the conclusion that it is not standardized or uniform in its type or provision. I propose that

CBT become the new standard for therapeutic care in state prisons–ideally overseen by the aforementioned government agency–with online training programs created and distributed to train mental health professionals in its use. While there remains a lot left to be discovered about CBT, the preliminary results from numerous studies examining its efficacy are extremely promising (Bonta, 2002; Friendship et al., 2003; Lipsey et al., 2007)

Furthermore, in addition to treating mental dysfunction alone, CBT has been shown to effectively treat co-curring substance abuse (Courbasson, Nishikawa, & Shapira, 2011; Haller et al., 2016). If successful, its use in prisons would lead to the integration of mental health and substance abuse treatment, promoting a holistic approach to inmate care (Hyatt, 2013). When examining mental health treatment in prisons, the connection between mental health and substance abuse cannot be ignored: the percentage of imprisoned individuals who meet the DSM IV criteria for drug dependence or substance abuse is well over 50% (Binswanger, Krueger, & Steiner, 2009). However, treatment estimates suggest that as few as 15% of inmates in need of treatment for substance abuse actually receive it (Belenko & Peugh, 2005). Rates of comorbidity of substance abuse and mental illness are high–potentially due to a combination of both personal or environmental risk factors and a tendency to self-medicate in the absence of effective treatment (Dumont et al., 2012). According to James and Glaze (2006), approximately 74% of inmates in State prisons and 64% of inmates in federal prison identified as having a mental health problem also met the criteria for a substance abuse or dependence disorder. In addition, about a third of inmates with a mental health problem were determined to have been using drugs or alcohol at the time they committed their offense (James & Glaze, 2006). The positive effects of CBT may be compounded by its ability to simultaneously address co-curring disorders: studies investigating its effects on patients with comorbid psychological and substance use

disorders found that CBT led to the significant reduction of both substance use and dysfunctional thoughts and behaviors (Courbasson et al., 2011; Haller et al., 2016).

While evidence clearly points to the untapped potential of CBT in healing prisoners and ultimately reducing recidivism rates, translating this knowledge to prison practice is no easy task. Training program models for cognitive behavioral therapy that are cost-effective and flexible are lacking in the field of psychotherapy, and a clear model for implementing CBT training needs to be developed, ideally under the direction of a federal agency. Substantial federal funding would be needed to both develop and oversee the use of such programs. However, web-based technology is a promising platform that has the potential to reduce costs dramatically by revolutionizing training programs across the public sector. The development of a succinct, comprehensive, and clear online training program for the use of CBT in a prison setting to treat psychological and substance use disorders could streamline the training process and greatly reduce the need for personnel and facility space. While funding would be needed to support the creation of the program software itself and install compatible technology (i.e. computers or tablets) into state prisons, physical distribution and implementation of the training program would be much less costly than the in-person, analog process. A study by Curran et al. (2015) pioneered the translation of in-person, manual CBT training to an internet training program focused on treatment for co-morbid depression and substance use disorders. Researchers heading this project created a detailed, interactive, self-paced training program that counselors completed in 12 to 16 hours. While overall results were positive, one key limitation became clear: trainees were not afforded substantive time during the workday to complete the training protocol, resulting in the fragmentation of the training process (Curran et al., 2015). The findings of this

study point to the need for designated training hours for mental health employees in State prisons, with the express purpose of completing online training programs for CBT.

While the implementation of these training programs and overall transformation of treatment would be costly, the enormous financial benefits associated with healing persons with mental illness and co-curring substance use disorders, thereby reducing recidivism rates and overall societal costs, would greatly outweigh these expenses. In the following section, I will provide evidence for this assertion and enumerate the many potential benefits of overhauling mental health care in state prisons today.

SECTION VI: BENEFITS OF IMPROVED TREATMENT IN STATE PRISONS

Aside from the obvious ethical and legal motivations, there are substantial economic and socio-cultural reasons to improve mental health care in prisons. Beyond simply transforming the lives of prisoners, overhauling treatment in state prisons would reap benefits for society as a whole. In this section, I will begin by outlining the financial and socio-economic incentives for implementing my proposal, focusing on potential savings in prison costs and societal benefits of improving overall mental health. In addition, I will reiterate the threat of legal action and liabilities incurred by the current treatment deficit, outlining internal and external motivations for states' reform of prison care. While I recognize the current lack of political will and funding associated with this goal, I will also briefly restate the desirability of federal agency oversight as part of an ideal solution. Next, I will attempt to orient this proposal in a larger social context, highlighting its place within institutions of social control. Lastly, I will address its potential role in breaking the repetitive cycle that characterizes society's treatment individuals with mental illness.

While it is impossible to accurately predict the overall reduction of recidivism rates that would occur as a result of improved care (as defined by the above proposal), studies on Cognitive Behavioral Therapy indicate a massive untapped potential (Bonta, 2002; Friendship et al., 2003; Lipsey et al., 2007). The prison system often acts as a revolving door for prisoners with mental health issues and treating these issues would likely lead to massive reductions in state costs (Baillargeon et al., 2009). The large-scale housing of prisoners is extremely expensive, with the average cost of each inmate in state prisons measured at $33,274 per year in the year 2015. A study that surveyed 45 states found total prison spending to amount to over $42 billion per year (Vera Institute, 2018). Furthermore, prisons have reported costs of housing inmates with mental illness to be tens of thousands of dollars more than the costs of housing those without (Gottschlich & Cetnar, 2002; Bender, 2003; Miller & Fantz, 2007). If CBT interventions were successfully implemented in prisons to stop the revolving door of recidivism, massive savings would follow. Substance abuse also comes into play: according to the National Association of State Mental Health Directors, societal costs of untreated substance abusers are over ten times those of treatment itself–the average cost of treating a substance-addicted individual is $1,346 vs. $17,300 if left untreated. Based on these estimates, the widespread treatment of often co-curring substance abuse and use disorders in prison (through CBT) could accumulate enormous economic benefits (Glover et al., 2012).

Aside from these benefits, the high turnover rates of American prison populations–along with their sheer magnitude–present a substantial opportunity to address public health needs. According to Wilper et al. (2009), the vast majority of prisoners are eventually released, and public health as a whole cannot be seen as isolated from prison health; indeed, prison health services should be seen as an extension of community public health systems. The effective

treatment of prisoners would translate into sweeping improvements of overall public mental health (Wilper et al., 2009). These improvements, in turn, would have widespread economic and social rewards, as many individuals previously suffering from psychological dysfunction would be able to enter the workforce and contribute to their communities. Additional massive cost reductions could occur: Insel (2008) describes how the economic costs of mental disorders are not capturable in standard economic analyses; rather, they accrue "indirect" costs. These indirect costs build through reductions in labor supply and educational attainment, along with increases in public income support payments and welfare. Homelessness and incarceration are, of course, great contributors. A five-month study by Kessler et al. (2008) examining losses in earnings of individuals with mental illness found a mean reduction in earnings of $16,306 per year in comparison to their mentally healthy counterparts. Extrapolating from these results, Kessler et al. were able to estimate annual earning losses upwards of $193.2 billion. Insel (2008) notes that this numerical estimate, while seemingly excessive, is actually a rather conservative one; this survey did not include any incarcerated, institutionalized, or homeless individuals, nor did it include any suffering from schizophrenia or autism (both associated with serious debilitating effects).

In addition to these indirect costs, Insel (2008) outlines the ways in which untreated mental disorders create direct medical costs in the form of medical complications. He notes the high rates of emergency room care and pulmonary disease–individuals with serious mental illness smoke 44% of all cigarettes in the United States. Early mortality is also associated with mental illness, with estimated losses of 13 to 32 years. These factors combine to create incalculable losses in America's GDP, notwithstanding their massively negative social-communal impact. Insel (2008) notes the emotional and financial burdens experienced by the

family members of individuals with mental illness, an immeasurable societal expense. Just as damaging is the emotional and financial burden thrust upon the millions of families of incarcerated individuals; author Hairston (2003) notes that the majority of imprisoned men and women are parents of dependent children, emphasizing the high costs of placing these children in foster care. The provision of welfare assistance to inmate's families is also extremely costly. Hairston also touches on the role of incarceration in perpetuating intergenerational crime, putting children at risk and promoting criminogenic activity by removing their breadwinning parents. Based on these assertions, significant reductions in recidivism and ultimately, incarceration rates as a whole could reduce government expenditures and have an extremely positive impact on the families and communities of inmates as well as inmates themselves.

In addition, given demographics of prison populations, effective treatment could potentially help rectify racial and socioeconomic disparities. From a Critical Race Theory (CRT) structural determinist perspective, prison as an institution is inherently racist and perpetuates economic and social disparities along racial lines (Davis, 2010). Medical care systems appear similarly discriminatory: research has revealed clear gaps in access to mental health care and substance use treatment experienced by ethnic minorities (Wells et al., 2001). While providing adequate mental health treatment to prisoners would not change this reality, it would provide an opportunity to address mental health problems that occur as a result of environmental and structural risk factors. In essence, effective treatment could reduce disparities by healing incarcerated groups often excluded from care.

While the findings outlined above provide powerful evidence of the potential socio-economic benefits of improved prison care, the up-front costs of overhauling treatment discourage states from acting. The sociological concept of "social capital" as defined by Portes

(2000) may also play a role, as prisoner populations lack the social power necessary to influence politicians and legislatures. Although improved care would have many indirect benefits reaching far beyond the lives of prisoners, prisoners appear to be the direct beneficiaries of a reform effort. As disenfranchised individuals who are often members of marginalized groups, inmates lack the social, political, and economic influence to attract the funding necessary for meaningful reform (Pattillo, Weiman, & Western, 2006). Analysis in Part II of Section II, a historical overview of mental health treatment revealed that even when public outcry results in humanitarian reform efforts, funding often fails to materialize, and reform ultimately falls short. Throughout Section IV, I described how even the most prominent organizations working to improve the conditions of mental health care (and general healthcare) in American prisons, NCCHC, APA, and APHA, lack the power to truly reform (APHA, 2004; APA, 2018; NCCHC, 2018). In addition to these, a multitude of other nonprofit organizations have dedicated time and resources to shine a light on this cause (Community Oriented Correctional Health Services, 2018; The Center for Prisoner Health and Human Rights, 2018; Prison Activist Resource Center, n.d.). Despite their valiant efforts, abysmal conditions persist. Therefore, other avenues of reform must be pursued.

In Part I of Section V: My Proposal, I outlined the ideal creation of a federal agency and corresponding funding to incentivize and oversee the states' adoption of this proposal. However, a lack of political will combined with general funding deficits unfortunately render the creation of this agency an unlikely outcome (Shannon & Uggen, 2012). A review of more realistic avenues of reform point to lawsuits as being the most effective method of propelling change in state prison systems (Wright, 2001; Prison Legal News, 2003; Chandler, 2018; Jenkins, 2018; WFSA, 2018; SPLC, 2018; Botkin, 2018). In particular, two distinct types of lawsuits seem to be

most compelling catalysts. The first of these lawsuits are those pursued against state officials and Department of Corrections in federal court for violation of the Constitutional rights of prisoners. The Eighth Amendment's proscription of "cruel and unusual punishment" lies at the center of these cases (outlined in Part III of Section IV) resulting in verdicts mandating reform (DOJ, 2015; Kuznia, 2016; SPLC, 2018). When this reform has failed to occur, state prison officials have been held in contempt (Kendrick, 2018). These cases–although not providing an immediate or easy solution–provide powerful external motivation for reform. Another type of lawsuit, exemplified in the courts of Washington State, may provide states with an even more powerful financial incentive to improve prison mental health treatment. These lawsuits target state government and officials for negligent supervision of parolees, holding prison systems accountable for their failures to not only monitor prisoners but give them proper mental health care (Wright, 2001). Holding states financially liable for their failures to supervise and treat may act as sufficient encouragement to reform prison treatment in an effort to prevent future liability. In the absence of the political will necessary to fund a federal agency and corresponding program to overhaul mental healthcare in state prisons, lawsuits will continue to be the most effective means of ensuring meaningful change. In addition, the implementation of my proposal (or one like it) in individual states may act as a catalyst, providing evidence of the financial benefits associated with improving care. Once these economic outcomes are clearly presented, it may provide powerful motivation for other states to follow suit.

While understanding legal avenues for change is imperative in facilitating the adoption of this proposal or any like it, blindly pursuing reform without acknowledging power structures at play would ultimately be a futile pursuit. Therefore, the following paragraph will address my proposal's place within larger institutions of social control.

Prison systems and psychiatry, understood in this analysis as powerful normalizing forces in society, converge at the center of this discussion (Foucault, 1977; Symonds, 1991). A proposal (like this one) specifically focusing on mental health treatment in prison systems will, if implemented, inevitably become part of the overall system of disciplinary power. As Foucault (1977) states in *Discipline and Punish*, the primary function of this disciplinary power is to correct deviance from social norms. Both institutions of psychiatry and prisons identify and punish deviant behavior on the basis of social constructs. This realization presents a powerful criticism of my proposal: while working within the framework of these institutions, it may be extremely difficult to effectively treat without reinforcing imbalances of power through the observation and punishment of deviance. However, the key goal of my proposal is to stop cycles of institutionalization, ultimately reducing incarceration rates through massive reductions in recidivism. By necessity, this proposal must work within prison and psychiatric institutions in order to create its desired impact, an impact that would ultimately reduce the power of normalization experienced by incarcerated individuals and society as a whole.

SUMMARY AND CONCLUSION

As long as American prison systems remain the primary vehicle for the punishment of illegally deviant behavior, mental health treatment in these prisons will remain a huge and presently unsolved social problem. The goal of this proposal was to address this problem through a system of standardized, cost-effective, and evidence-based treatment, providing a viable method of overhauling prison care.

This proposal does not seek to invalidate current efforts to not only reform but dismantle the prison system on the basis of its criminalization of the poor, minorities, and individuals with

mental illness. According to Sudbury (2015), anti-prison activists are gaining momentum towards the goal of reversing America's over-reliance on incarceration. Used to placate dominant classes by glossing over deep-rooted social problems, American prisons actually deepen social, racial and economic inequities (Sudbury, 2015). While the implementation of the proposal outlined in this paper could serve to significantly improve the mental health of society as a whole, it would necessarily fail to remedy the overall injustices perpetrated by the Prison Industrial Complex (PIC), a term coined by Eric Schlosser (1998) and used by modern prison abolitionists to describe the intersecting interests of government and industry through mechanisms of surveillance, policing and imprisonment (Sudbury, 2015; Critical Resistance, 2018). I would argue that the PIC is essentially a modern term used to embody Foucault's system of disciplinary power, including institutions of psychiatry and prisons as I have discussed in this paper. Growing awareness of the destructive and overwhelming impact of the PIC represents a positive effort to not only reform but to fundamentally alter the American penal system. From a Critical Race Theory perspective, prison as an institution was borne of racist origins, designed to serve dominant classes, and will thus continue to reinforce patterns of oppression despite reform efforts that may occur. Therefore, the ultimate dismantling of this institution will be necessary to abolish the racist and classist punishment of American citizens (Davis, 2010). In sum, while my proposal is designed to reform and improve prison mental health care, it does not negate these dismantling efforts; rather, it may provide temporary relief in the years leading up to more systemic change.

To conclude this section, I will address my proposal's role in breaking the pattern that characterizes society's treatment of individuals with mental illness. This pattern, explored in Part II of Section II, consists largely of neglect, institutionalization, and abuse, followed by exposure

of poor conditions and proceeded by reform efforts that ultimately fail due to dwindling interest and a lack of sufficient funds. Following the movement of deinstitutionalization in the latter decades of the twentieth century, the promised community-based treatment approach failed to receive adequate funding and attention (Gijswijt-Hofstra, 2005). Individuals with mental disorders were left to their own devices with little community or state support, falling into patterns of homelessness and incarceration (Bassuk & Gerson, 1978). Modern-day prisons then replaced mental asylums, now the primary institutions used to sequester individuals with psychological dysfunction (Penrose, 1939; Palermo et al., 1991). In order to provide complete justification for the implementation of my proposal, I must explain why and how it will break this destructive pattern and meaningfully change the pattern of neglect, institutionalization, and failed reform.

My proposal, in effect, aims to address the one key component consistently absent in the repetitive pattern described above. This component is effective, evidence-based mental health treatment. The well-intended but confused evolution of psychiatry has but recently begun to focus on evidence-based treatment, synthesizing behaviorist and cognitive-social learning ideologies to create a truly impactful means of addressing mental illness–Cognitive Behavioral Therapy (Bonta, 2002; Friendship et al., 2003; Lipsey et al., 2007). The creation and systematic testing of this therapeutic method provide a novel opportunity to treat mental illness on a universal, effective scale. In addition, the advent of online, digital training models presents the promise of efficiently training mental health professionals with extremely low distribution and administration costs that is unique to the twenty-first century (Curran et al., 2015). Meanwhile, recent trends of states being held legally accountable for violating prisoners' Constitutional rights and negligently supervising parolees provides newfound motivation for states to reform

prison mental health care. This proposal represents the possibility of true intervention and treatment, with the power to stop the cycle in its tracks. If individuals with mental disorders were given effective support and treatment, destructive behaviors would be greatly reduced. Patterns of neglect, abuse, and failed reform could be slowed and eventually broken, as treated individuals reintegrate into society, reconnecting with their communities and providing new economic and social contributions. In sum, the implementation of my proposal could reap incalculable benefits on an individual and societal scale, resulting in massive reductions in social and economic costs (Insel, 2008; Kessler et al., 2008; Baillargeon et al., 2009). The profound interconnectedness of the penal system and societal well-being as a whole provides a critical lesson: to heal prisoners is to heal America (Wilper et al., 2009).

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