©Gloria Killian

As a former law student, Gloria Killian was assigned to the prison law library, where she worked for 14 years providing legal assistance to other inmates. She worked extensively with battered women and developed specialized legal services for many different areas of the prison. After being incarcerated for 16 years, Killian's conviction was overturned on appeal. Once released, she started her own nonprofit organization, Action Committee for Women in Prison, whose mission is to advocate for the humane and compassionate treatment of incarcerated women and to work for the release of all women who are unjustly imprisoned.

THERE ARE A NUMBER OF TRAGIC STORIES of aging prisoners in the California correctional system who are ineligible for parole. One of the most touching is that of Helen Leheac, who at 88 years old was nearly blind and deaf, her mind enfeebled by Alzheimer's, and in the terminal stages of kidney failure. Helen had hoped to be released from prison and spend her last days in a transitional home for formerly incarcerated women.[1] But after she had served 19 years behind bars on a conspiracy-to-murder conviction, the parole board told her that she remained a risk to public safety if she were freed and denied her request for release.

On January 5, 2009, Helen died of pneumonia in a hospital near the Central California Women's Facility (CCWF) in Chowchilla, where she was confined. She was shackled at her waist and ankles, with two guards at her bedside.

Gloria Killian, a former inmate of the California Institution for Women (CIW) in Corona and now a strong prisoners' rights advocate, comments, "It's a terrible injustice, what's going on in those prisons. There's nothing worse than being sick and being in prison. These people are not a threat to society. They couldn't hurt a fly if they wanted to. And besides, it's too expensive to keep them incarcerated."

"The board gives us a release date, and the governor takes it away," said Jane Benson, 60, a prisoner of 22 years at CIW. She succeeded in persuading the parole board to free her the fourth time she came up for parole. But she said her luck ran out when her papers reached the governor's desk.

12

Special Prison Populations

AP Images/Rich Pedroncelli, file

LEARNING OBJECTIVES

- LO1 Describe the problems of inmates with a substance-involved history
- LO2 Recognize what challenges and problems sex offenders bring to the prison
- LO3 Name some of the issues terrorists present to the correctional system
- LO4 Explain the prison experience of HIV inmates
- LO5 Describe the world faced by chronic mentally ill inmates while they are in prison
- LO6 Explain the plight of elderly inmates while incarcerated and what is involved in their care
- LO7 Discuss the problems faced by illegal immigrants in U.S. prisons

PREVIEW OF KEY CONCEPTS

special offense inmates
special needs inmates
special population inmates
sex offenders
Megan's Law
terrorist
ticking bomb scenario
family detention centers

With tougher sentencing laws, it is projected that by 2030 there will be 33,000 geriatric inmates in California prisons alone, costing the state at least a $1 billion a year.[2] Elderly inmates provide unique management problems for staff. How is it possible to treat this special needs group in a manner that is compassionate and humane? It also illustrates how the prison population today is not a homogenous community but as diverse and varied as the nation itself. Inmates bring with them a myriad of social problems, and this chapter will consider a variety of inmate types, grouped in the following three categories: **special offense inmates**—inmates with substance abuse histories, sex offenders, and terrorists; **special needs inmates**—HIV inmates and inmates with chronic mental health issues; and **special population inmates**—elderly inmates and inmates who are illegal immigrants. Problems posed by each type to the correctional environment and to community settings when they are released are discussed in some detail, followed by a discussion of the programs that are being employed to help members of these subgroups adjust to the institution and to the community upon their release.

special offense inmates Inmates who are involved in substance abuse, are sex offenders, or are terrorists.

special needs inmates These include HIV inmates and inmates with chronic mental health issues.

special population inmates These include the elderly prisoner and the illegal immigrant inmate.

Mary Leftridge Byrd, a corrections professional for more than 30 years, served as superintendent of three correctional institutions housing women and men, and is currently the federal security director for the Transportation Security Administration (TSA) at Hartsfield-Jackson Atlanta International Airport. In Voices Across the Profession, she discusses what she liked about being a warden, including working with difficult or special populations, and what she feels she accomplished in her work in corrections.

SPECIAL OFFENSE INMATES

Special offense inmates are linked together because of their prior criminal/deviant behavior issues. Some are violent offenders, others are substance abusers, and some present problems to correctional administrators because they engage in multiple-offense patterns, such as violent drug-gang members, and others are domestic or international terrorists. Three special offense inmates are considered in this section: inmates with substance abuse histories, which includes such offenders as street-level drug dealers, drug traffickers, "mules" who carry drugs for others, and alcoholics whose crimes are directly related to drinking problems; the **sex offenders** group, which includes rapists and pedophiles; and terrorists.

sex offenders A variety of offenders including pedophiles and rapists.

Describe the problems of inmates with a substance-involved history LO1

Corrections and Substance-Involved Inmates

The problems of substance-involved inmates are certainly not a small matter: many offenders report that they were under the influence of drugs and alcohol when they committed crime.[3] Nearly 50 percent of inmates in federal prisons are drug offenders.[4] Nearly 30 percent of inmates in state prisons are serving time for drug offenses.[5] (See Exhibit 12.1 for drug abuse history of inmates in prison.)

PROBLEMS OF WORKING WITH SUBSTANCE-INVOLVED INMATES

Narcotics or alcohol can become a special challenge when an inmate comes into the prison addicted and may crash from a sudden withdrawal. A sudden withdrawal from alcohol, for example, can throw the inmate's system into shock and may cause cardiac arrest, kidney failure, or hallucinations. Another challenge of working with substance-abuse inmates is the cost of medical treatment for inmates dealing with substance abuse.

Some inmates, desperate to continue their substance-abusing lifestyle, will actually produce homemade alcohol within the institution. An alcohol-based contraband that is found in nearly every prison is called "prison hooch" or sometimes "rook," which is a concentrated form of alcohol and can be made in a variety of ways. Much of

VOICES ACROSS THE PROFESSION

When asked about my management philosophy—no matter what office I am leading—I need only six words: "Do justly, walk humbly, love mercy."

Mary Leftridge Byrd

Federal Security Director for the TSA at Hartsfield-Jackson International Airport and former prison warden

I have served as superintendent or warden of institutions that house mentally ill women and men who live in the same housing areas as those who have had long histories of drug abuse and addiction. I have also been involved with those who had histories of domestic violence, both as survivors and as perpetrators. Inmates could be elderly or very young and extraordinarily violent or extremely vulnerable. We had inmates who were living with HIV/AIDS. We always needed to remember that beyond the problems inmates bring to us, they were still daughters and sons, fathers and mothers, and relatives to people in the community, and we needed to treat them in a respectful way.

What did I like about being a warden? Where else could I have the opportunity to be involved in ensuring the provision of medical care along with the emotional and spiritual support often needed when someone is seriously or terminally ill? Where else could I have the opportunity to learn a lot about facilities, management, and physical plant maintenance? Where else could I have the opportunity to become active in a dynamic education system without certification? Where else would I have the ability to insist on hanging artwork in a public facility? Where else could I have the opportunity to be directly involved and accountable for the financial administration of a large organization? Where else could I have the opportunity to be involved with the culinary arts on such a large scale? Where else could I get involved in law enforcement as we were there? Think about our K-9 units, contraband interdiction efforts, investigations, sweeps and searches. Where else could I be involved in ministry? There is no question that my work is based on my own spirituality. For years I have believed I am called to do this. The longer I remain in the field, the more readily I acknowledge this calling, but my ministry is based more on behavior than through spoken words.

When asked about my management philosophy—no matter what office I am leading—I need only six words: "Do justly, walk humbly, love mercy." I am ever grateful to be on a journey that gives so much, especially the ever-present privilege to teach and the opportunity to learn.

EXHIBIT 12.1

Substance-Abusing Inmates and Criminal Activity in Prisons

A report by the National Center on Addiction and Substance Abuse (CASA) at Columbia University revealed that substance abuse inmates were involved in these inmate offenses:

- 78 percent of violent crimes
- 83 percent of property crimes
- 77 percent of public order, immigration or weapon offenses, and probation/parole violations

The CASA report also found that substance abuse inmates were:

- Four times likelier to receive income through illegal activity
- Twice as likely to have had at least one parent who abused alcohol or other drugs when they were children
- 41 percent likelier to have some family criminal history
- 20 percent less likely to have completed at least high school
- 20 percent likelier to be unemployed a month before incarceration

Source: Lauren Duran and Sulaiman Berg, *Behind Bars II: Substance Abuse and America's Prison Population*, the National Center on Addiction and Substance Abuse at Columbia University, press release, 2010, http://www.casacolumbia.org/newsroom/press-releases/2010-behind-bars-II (accessed July 2014).

the inmate world in some prisons focuses around the drug/alcohol economy—buying, using, selling, and bartering. Not surprisingly, violence invariably erupts from this economy. In the Correctional Life feature, a long-term Pennsylvania inmate tells how he has learned to do time. He also gives some information on how he sells drugs in prison.

PROGRAMS FOR SUBSTANCE-INVOLVED INMATES About 90 percent of all state and federal prisons in the United States offer some form of substance abuse counseling, and about one in eight inmates have participated in a substance abuse treatment program while incarcerated.[6] Alcoholics Anonymous (AA), Narcotics Anonymous (NA), and other drug programs are also conducted in prisons. Some programs are brought into the prisons by AA or NA members from the community. Others are conducted by staff members.[7]

Evaluations of drug treatment programs have determined that treatment services should be based on the following:

- A clear and consistent treatment philosophy
- An atmosphere of empathy and safety
- The recruitment and maintenance of committed, qualified treatment staff
- Clear and unambiguous rules of conduct
- The use of ex-offenders and ex-addicts as role models, staff, and volunteers
- The use of peer role models and peer pressure
- The provision of relapse prevention programs
- The establishment of continuity of care throughout custody and community aftercare
- The integration of treatment evaluations into the design of the program
- The maintenance of treatment program integrity, autonomy, flexibility, and openness[8]

There is evidence that prisoners assigned to prison-based drug treatment programs have better prison adjustment than those in the general population.[9] There is also evidence that drug-involved offenders are less likely to recidivate if they receive treatment behind prison walls.[10] Offenders who enter and complete in-prison residential treatment are less likely to experience new arrests and substance use during the first six months following release.[11] Nonetheless, despite this success, relatively few at-risk inmates receive treatment while incarcerated.[12] In the Evidence-Based Corrections feature, one of the more widely used and successful programs to treat substance-abusing inmates is discussed.

Recognize what challenges and problems sex offenders bring to the prison LO2

Sex Offenders

About 10 percent of prisoners in state prisons and 1 percent in federal facilities have been convicted of a sex offense. This number varies from one state to another.[13] In 2008, a Texas man named James Kevin Pope was sentenced to 40 life prison terms for sexually assaulting young girls over a two-year period. He received a life sentence for each sex assault conviction. At the request of prosecutors, Pope was sentenced to serve the sentences consecutively, adding up to 4,060 years behind bars; parole eligibility would begin in the year 3209.[14]

While Pope's sentence was extreme, increased prosecution and conviction, as well as longer and harsher sentences, have contributed significantly to increased numbers

EVIDENCE-BASED CORRECTIONS

Therapeutic Communities

Because substance abuse is superprevailing among correctional clients, some correctional facilities have been reformulated into therapeutic communities that apply a psychological, experimental learning process and rely on positive peer pressure within a highly structural environment. The therapeutic community (TC) for the treatment of drug abuse and addiction has existed for about 40 years. In general, TCs are drug-free residential settings that use treatment stages that reflect increased levels of personal and social responsibility. Peer influence, applied through a variety of group processes, is used to help individuals learn and assimilate social norms and develop more effective social skills.

TCs differ from other treatment approaches principally in their use of the community, comprising treatment staff with those in recovery, as key agents of change. This approach is often referred to as "community as method." TC members interact in structural and nonstructural ways to influence attitudes, perceptions, and behavior associated with drug use.

The community itself, including staff and program participants, becomes the primary method of change. They work together as members of a "family" in order to create a culture where community members confront each other's negative behavior and attitudes and establish an open, trusting, and safe environment. The TC approach then relies on mutual self-help. It also encourages personal disclosure rather than the isolation of the general prison culture.

In addition to the importance of the community as a primary agent of change, a second fundamental TC principle is "self-help," a process that ensures that the individual and treatment are the main contributors to the change process. Mutual self-help means that individuals also assume partial responsibility for the recovery of their peers, an important aspect of an individual's own treatment.

IS IT EFFECTIVE?

Treating substance-abuse inmates has proved difficult even with such highly touted programs as the therapeutic community. For three decades, the National Institute on Drug Abuse has conducted several large studies to advance scientific knowledge of the outcome of drug abuse treatment. These studies collected data from over 65,000 individuals submitted to publicly funded treatment agencies, including TCs and other types of program (i.e., methadone maintenance, outpatient drug abuse, short-term inpatient, and drug detoxification programs). Data were collected during the treatment stage and in a series of follow-ups that focused on outcomes that occurred 12 months and longer after treatment.

These studies found that participation in a TC was associated with several positive outcomes. For example, the Drug Abuse Treatment Outcome Study I (DATOS), the most recent long-term study of drug treatment outcomes, shows that those who successfully completed treatment in a TC had lower levels of cocaine, heroin, and alcohol use, criminal behavior, unemployment, and indicators of depression than they had before treatment.

Success rates for TC programs may be shaped by the way individual programs are administered and the effectiveness of treatment delivery. For example, there is evidence that those inmates who recently completed TC programs have significantly lower recidivism rates than non-attendees and are more likely to seek treatment once they return to the community. In addition when run successfully, TC programs seem effective in reducing rearrest and reincarceration rates.

FOR CRITICAL THINKING AND WRITING

1. Do you think that there could be a potential abuse of power in therapeutic communities? Do you trust that those in a position of respect will use their power in a positive way? After all, in TC programs peers take a significant role in the treatment process. TC programs depend upon people who may have addiction problems and personality deficits to help one another. Is there a problem with that approach?
2. TC program evaluations show that those who successfully completed treatment in a TC had lower levels of cocaine, heroin, and alcohol use, criminal behavior, unemployment, and indicators of depression than they had before treatment. Is that conclusive evidence of success? What important questions remain unanswered? Hint: Who determines what a successful completion means and how many people successfully complete the program?

Sources: National Institute of Drug Abuse Research Series, *Therapeutic Community*, http://www.drugabuse.gov/publications/research-reports/therapeutic-community (accessed July 2014); Sheldon X. Zhang, Robert E. L. Roberts, and Kathryn E. McCollier, "Therapeutic Community in a California Prison, Treatment Outcomes After 5 Years," *Crime and Delinquency* 37 (2011): 82; Mitchell Miller and Helen Miller, "Considering the Effectiveness of Drug Treatment Behind Bars, Findings from the South Carolina RSAT," *Justice Quarterly* 28 (2011): 70–86.

Megan's Law Named for Megan Kanka, a seven-year-old girl from New Jersey who was sexually assaulted and murdered in 1994 by a neighbor who, unknown to the victim's family, had been previously convicted for sex offenses against children. Megan's Laws are state and federal statutes that require convicted sex offenders to register with local police and to notify law enforcement authorities whenever they move to a new location. The statutes establish a notification process to provide information about sex offenders to law enforcement agencies and, when appropriate, to the public. The type of notification is based on an evaluation of the risk to the community from a particular offender.

of sex offenders in prisons. Other signs of the get-tough attitude toward sex offenders are laws permitting the indefinite confinement of rapists and child molesters who are viewed as too dangerous for release at the end of their court-imposed sentences. The state of Washington had the first such law, and Kansas, New Jersey, and Wisconsin have adopted similar laws.[15] With their release, these offenders, especially those convicted of offenses against children, are faced with **Megan's Law** and the National Sex Offender Registry. Megan's Law is mentioned in an Evidence-Based Corrections feature in Chapter 3, and in a TechnoCorrections feature Chapter 11, and is the legislation passed by New Jersey that is commonly called by this name. In 1996, Congress passed a tougher version of Megan's Law, which requires states to inform the public when a convicted sex offender considered a danger to the public is released from prison and settles in the neighborhood. States were required to establish a warning system by September 1997 or lose some federal anticrime funds. A National Sex Offender Registry became fully functional in 1999.

PROBLEMS OF WORKING WITH SEX OFFENDERS The child molester, or pedophile, has long had difficulty with prison adjustment. Other inmates, many of whom have families and children on the outside, want to set an example and convince child molesters that they will pay dearly for their crimes. In many prisons, unless pedophiles are placed in protective custody, they are likely to be sexually assaulted or even killed. Yet, in other prisons, prison classification has been successful in placing sex offenders in relatively safe environments; in these institutions, pedophiles are not harmed as they do their time.

Many studies have shown the recidivism rate of sex offenders to be relatively low, especially when compared to the recidivism rates of other types of offenders. While their recidivism rate is relatively low, released sex offenders are four times more likely to be rearrested for a sex crime than released non–sex offenders, most occurring in the first 12 months following their release from a state prison. Those with the most frequent pre-prison sex offending record, as measured by number of arrests, were the ones most likely to continue their sex offending career.[16] In Exhibit 12.2, Washington state's program for sex offenders is discussed in some detail.

Marvin Fong/Plain Dealer/Landov

Ariel Castro pauses while speaking before his sentencing with his attorneys Craig Weintraub, left, and Jaye Schlachet, right, in Cuyahoga County Common Pleas Court in Cleveland, Ohio, on July 26, 2013. Castro was sentenced to prison for life on hundreds of charges, including kidnapping, rape, and holding captive Amanda Berry, Gina DeJesus, and Michelle Knight for nearly a decade. One month into his sentence, he committed suicide.

CRITICAL THINKING

If you were a warden, what would you do to ensure protection for incarcerated sex offenders? Should they be treated and housed differently? LO2

CIVIL COMMITMENT FACILITIES Legislatures in some states have recently taken another step in controlling sexual offenders by passing laws that permit a diagnosis of sex offenders as sexually violent predators. When a person is convicted of a sex offense, he receives a penal sanction, usually a prison sentence. Once the inmate is nearing release, the state can file a petition to have the offender involuntarily and indefinitely committed to a mental institution or correctional facility that blends both a correctional facility and a mental institution. An evaluation by a mental health professional is required as well as a probable cause hearing to determine whether to label the offender a sexually violent predator. If he is so labeled, and following the completion of his prison sentence, the offender is confined to a mental health facility until judged by mental health professionals to no longer constitute a danger to the community. Sixteen states have now passed laws to involuntarily commit sexually violent predators.[17]

Under these civil commitment programs, almost 3,000 pedophiles, rapists, and other sex offenders are being held indefinitely in civil commitment facilities, secure institutions that provide mental health treatment. They cost taxpayers from four to eight times more than keeping offenders in prison. The U.S. Supreme Court has

EXHIBIT 12.2

Sex Offender Treatment in Prison

An estimated 95 percent of sex offenders sentenced to prison eventually return to the community. That makes the Twin Rivers Sex Offender Treatment Program for men at the Monroe Correctional Complex and a similar program at the Washington Correction Center for Women in Gig Harbor valuable tools in the struggle to help them become law-abiding citizens.

The Department of Corrections knows treatment is not a cure for sexual deviancy. Therefore, the Monroe program's three main goals are:

- Helping offenders learn to reduce and manage risk
- Providing information to help the department and its community partners monitor and manage offenders more effectively
- Evaluating and improving treatment

Treatment begins with comprehensive assessments that include psychological tests, clinical interviews, and other techniques designed to define treatment goals and strategies for each offender. Counselors study what has sparked past offenses and then help to define the attitudes, thinking, and behavior skills that are needed to reduce the likelihood of reoffending. Program participants receive individual and group therapy. Group sessions generally have 12 to 14 members and meet from 6 to 10 hours per day. Additional classes and sessions address sexual deviancy, life skills, and other topics.

Offenders vary widely in their motivation and commitment to change. Treatment is likely to be successful to the extent that offenders are able to:

- Recognize and understand the factors that contributed to their offense(s)
- Monitor themselves and their environment to detect changes indicating that their risk to reoffend is increasing
- Develop the skills necessary to intervene, manage, and reduce risky behavior
- Remain willing and able to apply monitoring and intervention skills in a timely and effective manner, including seeking outside assistance when necessary

Treatment priority is given to the highest-risk offenders. But lower-risk offenders may be admitted for such factors as the offender:

- Used a high level of violence when committing his or her crime
- Likely committed more offenses than his or her official record shows
- Expresses an intention to commit future sex offenses
- Engages in sexually aggressive behavior in prison
- Experiences thoughts and fantasies related to sexually abusive behavior and is bothered by them

Offenders can be terminated from treatment for assaults and fighting, sexual behavior, violating the confidentiality of others in the program, failing to make progress in treatment, or being placed in a high security category (such as maximum). Offenders are expected to continue receiving treatment for up to three years after leaving prison through aftercare programs available throughout the state. The Washington Corrections Center for Women in Gig Harbor offers similar treatment for approximately 10 of the 25 female sex offenders incarcerated there.

Source: Washington State Department of Corrections, "Sex Offender Treatment in Prison," http://www.doc.wa.gov/community/sexoffenders/prisontreatment.asp (accessed July 2014).

upheld the constitutionality of the laws, primarily because their aim is to furnish treatment if possible, not punish offenders twice for the same crime. The Supreme Court weighed in on this issue in 1997, in the case of *Kansas v. Hendricks*.[18] Leroy Hendricks was a repeat child molester. As the end of his prison sentence neared, state prosecutors became concerned that upon his release he would continue victimizing children. In accordance with Kansas's Sexually Violent Predator Act, they filed to have Hendricks civilly committed as soon as he was released from prison. Hendricks appealed, claiming that it violated the law against double jeopardy. The case eventually made it to the Supreme Court, which ruled that the Kansas act did not violate double jeopardy because it was a civil action and was designed to protect the safety of innocent people rather than punish an offender. The Court ruled that indefinite commitment was not equal to a life sentence because the prisoner-cum-patient is "permitted immediate release upon a showing that the individual is no longer dangerous or

FOR GROUP DISCUSSION

Is there a cure for sex offenders? Should sex offenders be treated as if they are ill? Discuss your views with the group, using Exhibit 12.2, "Sex Offender Treatment in Prison," as a basis for your discussion.

Name some of the issues terrorists present to the correctional system LO3

Web App 12.1

View the *60 Minutes* segment "Supermax: A Clean Version of Hell" (http://www.cbsnews.com/news/supermax-a-clean-version-of-hell/) about terrorists in supermax. Do you think terrorists belong in our prison system? Do they understand the deterrent effect? Is this simply a way to safely keep them away from the outside world? LO3

terrorists One who acts with premeditated and politically directed violence directed against noncombatants.

mentally impaired." After the decision Leroy Hendricks remained locked up at a cost of $185,000 a year—more than eight times the cost of a prison sentence in that state. When it was announced that he was moving to a group home in 2006, his transfer was protested by community residents. On April 28, 2006, the Kansas Supreme Court prevented the state from moving Hendricks out of a special treatment program for violent sexual predators to a group home in rural Leavenworth County.[19]

Terrorists in Prison

The Guantánamo Bay Naval Base detention camp is still in operation, though the number of inmates has been steadily declining. According to Human Rights Watch, as of August 2014, a total of 779 detainees have been held at the Guantánamo Bay facility since the September 11, 2001, attacks, 15 of them under age 18. Of the 779, roughly 600 have been released without charges; there are now about 149 detainees remaining. Of these, 78 are awaiting transfer home or to another country; 7 have been convicted in the military commissions after trial or plea bargain. Of the 149 detainees that remain at Guantánamo only six, Abd al-Rahim al-Nashiri, and the September 11, 2001 co-defendants, face any formal charges.[20]

In addition to Guantánamo, many convicted **terrorists** are now being housed in federal maximum-security prisons and are part of the general prison population. The United States Penitentiary Administrative Maximum Facility (ADX) in Florence, Colorado, the most secure supermax federal prison, holds many of the convicted terrorists, including Zacarias Moussaoui, who planned to be one of the 9/11 hijackers; Wadih El Hage, Osama bin Laden's former private secretary; and Ramzi Yousef, the leader of the first World Trade Center attack in 1993.[21]

When (and if) Guantánamo is closed down, its terrorist inmates will be transferred to traditional prisons in the United States or elsewhere. Correctional administrators will then have to decide how to control this special population: should they be given the same rights and privileges of other inmates or kept under much tighter control?

One major issue has been accusations that convicted terrorists held in maximum security prisons are able to freely communicate with the outside world, encouraging future terrorist attacks from their jail cells. Media news reports indicate that individuals convicted of committing terrorist acts against the United States have been allowed to recruit terrorists because the Federal Bureau of Prisons allows them very generous pen pal privileges. In one notorious incident, convicted terrorists were able to contact, from their prison in the United States, individuals in a Spanish terror cell, including Mohamed Achraf, who later allegedly led a plot to bomb Spain's National Court building in Madrid.[22]

MYTH A progressive, democratic society like the United States would never condone the physical torture of people being held in custody.

FACT While official U.S. government policy and doctrine are vehemently opposed to torture, the United States has condoned harsh interrogation techniques that combine physical and psychological tactics, including head slapping, waterboarding, and exposure to extreme cold.

Using Torture

One of the most controversial issues surrounding the treatment of suspected terrorists is the use of torture to gain information. While most people loathe the thought of torturing anyone, some experts argue that torture can sometimes be justified in what they call the **ticking bomb scenario**. Suppose the government found out that a captured terrorist knew the whereabouts of a dangerous explosive device that was set to go off and kill thousands of innocent people. Would it be permissible to engage in the use of torture on this single suspect if it would save the population of a city? Legal scholar Alan Dershowitz argues that torturing terrorists in custody can be justified under some circumstances, especially to prevent damaging terror attacks. To ensure that torture is not used capriciously, Dershowitz proposes the creation of a "torture warrant" that can only be issued by a judge in cases where (a) there is an absolute need to obtain immediate information in order to save lives and (b) there is probable cause that the suspect has such information and is unwilling to reveal it to law enforcement agents. The suspect would be given

ticking bomb scenario This scenario proposes that a dangerous explosive device is set to go off and kill thousands of people and, therefore, it might be necessary to take extreme measures, such as torture, on a subject to extract information from him or her.

EXHIBIT 12.3

Comparison of Special Offense Inmates

Inmate	Number in Prison	Treatment Access	Recidivism Rates
Substance-involved inmates	High percentage	About 1 in every 8 substance-abusing inmates receive adequate treatment	High rates of recidivism upon release
Sex offenders	About 10 percent in state prisons and 1 percent in federal prisons	Relatively few receive adequate treatment	Very low, 5 to 10 percent repeat their criminal offenses
Terrorists	1,100 or so spread over several prisons	N/A	Low for those who have been released from federal prisons

immunity from prosecution based on information elicited by the torture; it would only be to save lives. The warrant would limit the torture to nonlethal means, such as sterile needles being inserted beneath the nails to cause excruciating pain without endangering life.[23]

RARE RECIDIVISM In contrast with the record at Guantánamo, where the Defense Department says that about 25 percent of those released are suspected or known of subsequently joining militant groups, it appears extremely rare for federal inmates with past terrorist ties to plot violence following release. About 300 have been quietly released, and the government keeps a close eye on them. Before prisoners are released, FBI agents generally interview them, and probation officers track them for a number of years.[24] Exhibit 12.3 sets out a comparison of these special offense categories.

SPECIAL NEEDS INMATES

Special needs inmates include a variety of people with particular mental or physical conditions that require that they either be separated from the general prison population and/or receive unique treatment tailored to their particular circumstance. Inmates bring many physical health issues to the prison, including high rates of tuberculosis, hepatitis, and HIV, and these health issues have an effect on budgets, staff, and other inmates. In addition, as a group, inmates have high rates of chronic mental health issues, including depression, anxiety, and some psychosis.

Corrections and the HIV-Infected Inmate

LO4 Explain the prison experience of HIV inmates

Inmate populations include a high percentage of individuals in AIDS risk groups, particularly intravenous drug users.[25] However, the number of HIV-infected inmates has been on the decline.

- The rate of HIV/AIDS among state and federal prison inmates declined from 194 cases per 10,000 inmates in 2001 to 146 per 10,000 at year end 2010.
- Between 2001 and 2010, the average annual decline of 16 percent in the national AIDS mortality rate was similar to the decline in small (down 12 percent), medium (down 17 percent), and large (down 19 percent) state prison populations.
- AIDS-related deaths in state prisons declined from 89 in 2009 to 69 in 2010 among males, from 70 to 43 among black non-Hispanics, and from 87 to 60 among all state inmates age 35 or older.[26]

AP Images/Dave Martin

Inmates sit on their bunks in a dorm at Tutwiler Prison for Women in Wetumpka, Alabama. Alabama prison system's policy of keeping HIV-positive inmates segregated from other inmates was struck down as a violation of federal disabilities law. The state was given time to comply with the ruling.

PROBLEMS OF WORKING WITH HIV INMATES HIV inmates are now integrated with the general population in all state prison systems. Working with this population raises a number of questions: Should patients with AIDS be hospitalized, segregated, or paroled? Should officers be notified when an inmate tests positive? How about notifying past or prospective sexual partners? Does educating inmates about safe sex and needle hygiene imply that the state condones sexual behavior and drug use in prison? Does this education obligate prison officials to provide the means for prisoners to practice safe sex and good needle hygiene while imprisoned? Another issue is that in view of the HIPPA health privacy act, there is a prohibition of sharing HIV status of offenders with line officers and the implications of this problem for corrections staff.

PROGRAMS FOR HIV/AIDS INMATES Prison programs increasingly are informing inmates about the risk of unsafe sex and drug abuse. Prison personnel tend to be extremely cautious about contact with and treating inmates with HIV/AIDS. Nonetheless, a number of programs and initiatives have been created. Several states (including Vermont and Mississippi) and local jurisdictions (such as New York City, San Francisco, Philadelphia, and Washington, D.C.) are providing condoms to inmates, while others make bleach available to inmates to disinfect needles. The Centers for Disease Control and Prevention (CDC) is attempting to promote programs for HIV- and AIDS-infected inmates.[27]

- The CDC funds state and local health departments and community-based organizations to provide enhanced HIV testing and other HIV prevention services in a wide range of settings, including prisons and jails.
- It published HIV testing guidance for correctional facilities.
- It funded the evaluation of a program for which voluntary opt-out HIV rapid screening was integrated into the medical intake process at a large county jail in Atlanta with high HIV prevalence. The CDC is helping develop a best practices/model protocol for U.S. jails to implement HIV screening and other medical services during the medical assessment at intake. Persons with HIV will be linked to care and treatment.
- CDC supports Project START, an HIV, STI, and hepatitis prevention program for young men leaving prison. The intervention has been successful in reducing HIV risk behaviors of young men after release from custody, at a cost comparable to other HIV prevention programs. The CDC provides resources and training to providers through the Diffusion of Effective Behavioral Interventions project.
- Through a CDC-funded demonstration project, researchers are trying to decrease risky sexual behaviors among incarcerated adolescent black youth and adult black men at the Atlanta City Detention Center before the inmates return to their communities. Peer educators interview inmates about sexual practices and barriers to adopting HIV risk-reduction behaviors.[28]

Under the Corrections Demonstration Project, four state grantees (California, Florida, New Jersey, and New York) have created HIV prevention/peer education programs within correctional institutions. These services include weekly new inmate orientation to describe the available HIV prevention services (New Jersey) and prerelease health education sessions for inmates who are returning to the community (California).

Three of the state jurisdictions, California, New Jersey, and New York, are offering peer educator training to both HIV-positive and HIV-negative inmates. These programs hope to build associations with correctional officials and medical staff and to implement the needed services in prisons without placing a burden on correctional budgets.

Some prison systems have worked with outside agencies to help HIV/AIDS inmates adjust to prison life and prepare for reentry. In San Quentin prison in California, Centerforce, a private nonprofit institution, has been training inmates as peer HIV educators. Twice a year, volunteers are solicited to receive the comprehensive peer education training and then to work as peer educators within the prison. About 40 peer educators are trained each year. Centerforce personnel conduct focus groups to assess the service needs of inmates living with HIV, and to get feedback from them about primary prevention programs at the prison. Peer educators provide individual support for inmates newly diagnosed in prison and for HIV-positive inmates who have not been previously incarcerated. Centerforce has developed a two-week, eight-session health promotion intervention for HIV-positive inmates preparing to be released from prison. The sessions include such topics as self-esteem, health maintenance, community resources, stress management, substance use, legal issues, and barriers to care after release as well as a resource fair to introduce community service providers. In addition, peer educators conduct one-to-one sessions to help inmates learn techniques to prevent them from acquiring or transmitting HIV after release from prison. During these sessions, an individual's HIV risk is assessed, an individualized risk-reduction plan is created, and referrals are given. Sessions are conducted within two weeks of release from prison.[29]

CRITICAL THINKING

How much of the health care costs should taxpayers have to pay for those that are terminally ill? Is it appropriate to release those ill inmates in order for the state to save money? LO4

Corrections and Chronic Mentally Ill Inmates

LO5 Describe the world faced by chronic mentally ill inmates while they are in prison

According to national surveys, more than half of all prison and jail inmates (56 percent of state prisoners, 45 percent of federal prisoners, and 64 percent of local jail inmates) have a mental health problem. See Exhibit 12.4 for data on inmates who reported symptoms of a mental disorder.

PROBLEMS OF WORKING WITH CHRONIC MENTAL HEALTH INMATES

Prisoners with chronic mental health problems typically have had behavioral problems before incarceration and many get involved in substance abuse. An estimated 61 percent of state prisoners and 44 percent of jail inmates who have a mental health problem had a current or past violent offense. About a quarter of both state prisoners (25 percent) and jail inmates (26 percent) had served three or more prior sentences

EXHIBIT 12.4

Inmates Who Reported Symptoms of a Mental Disorder

- 54 percent of local jail inmates had symptoms of mania, 30 percent major depression, and 24 percent psychotic disorder, such as delusions or hallucinations.
- 43 percent of state prisoners had symptoms of mania, 23 percent major depression, and 15 percent psychotic disorder.
- 35 percent of federal prisoners had symptoms of mania, 16 percent major depression, and 10 percent psychotic disorder.

Female inmates have higher rates of mental health problems than male inmates—in state prisons, 73 percent of females and 55 percent of males; in federal prisons, 61 percent of females and 44 percent of males; and in local jails, 75 percent of females and 63 percent of males.

Source: Doris J. James and Lauren E. Glaze, *Mental Health Problems of Prison and Jail Inmates* (Washington, DC: Bureau of Justice Statistics Special Report, 2006), p. 1.

AP Images/TroyMaben

A mentally ill inmate (right) talks to members of the mental health treatment team, (from left) psych technician Anthony Ramos, social worker Lee Penchansky, and psychologist Dr. Charlene Green inside the Idaho Maximum Security Institution near Boise, Idaho. The inmate is one of many of Idaho's mentally ill sent to the prison for treatment because there are no other adequate facilities. He is too sick to be treated as an outpatient and too dangerous for lower-level security hospitals.

before incarceration. Inmates with a mental health problem also had high rates of substance dependence or abuse in the year before their admission:

- 74 percent of state prisoners and 76 percent of local jail inmates were dependent on or abusing drugs or alcohol.
- 37 percent of state prisoners and 34 percent of jail inmates said they had used drugs at the time of their offense.
- 13 percent of state prisoners and 12 percent of jail inmates had used methamphetamines in the month before their offense.

In addition, these inmates bring other problems to the prison setting. About a quarter of both state prisoners and jail inmates with mental problems also report past physical or sexual abuse. About one in three state prisoners with mental health problems, one in four federal prisoners, and one in six jail inmates had received mental health treatment since admission. Taking a prescribed medication was the most common type of treatment—27 percent in state prisons, 19 percent in federal prisons, and 15 percent in local jails.[30]

Because inmates with chronic mental health problems present such a challenge for correctional administrators, efforts have been made to develop screening instruments to identify and classify them in an efficient manner. These instruments are discussed in Exhibit 12.5.

EXHIBIT 12.5

Mental Health Screening Tools

Considering the significant problems posed by mentally ill inmates, it is important for correctional administrators to develop tools to quickly identify inmates who are in need of special services. Most clinical evaluations are time consuming and expensive, so a brief but effective screening is available. Researchers funded by the National Institute of Justice have created and tested two mental health screening tools and found that they are likely to work well in correctional settings: the Correctional Mental Health Screen (CMHS) and the Brief Jail Mental Health Screen (BMHS).[31]

CMHS

- The CMHS uses separate questionnaires for men and women. The version for women (CMHS-W) consists of eight yes/no questions and the version for men (CMHS-M) contains twelve yes/no questions about content and lifetime indications of serious mental disorders. Six questions regarding symptoms in the inmate's history of mental illness are the same on both questionnaires: the remaining questions are unique to each gender. Some of the questions are:
- Have you ever had worries you just can't get rid of?
- Some people feel that their mood changes frequently—as if they spend every day on an emotional roller coaster. Does this sound like you?
- Do you get annoyed when friends or family complain about their problems? Or do people complain that you are not sympathetic to their problems?
- Have you ever felt like you didn't have any feelings, or felt distant or cut off from other people or from your surroundings?
- Has there ever been a time when you felt so irritable that you found yourself shouting at people or starting fights or arguments? Do you often get in trouble at work or with friends because you act excited at first but then lose interest in projects and don't follow through?
- Do you tend to hold grudges or give people the silent treatment for days at a time?

Each screen takes about three to five minutes to administer. It is recommended that male inmates who answer yes to six or more questions and female inmates who answer yes to five or more questions be referred for further evaluation.

(continued)

BHMS

The BHMS has eight yes/no questions, takes about two to three minutes and requires minimum training to administer. It asks six questions about current mental disorders plus two questions about history of hospitalization and medication for mental or emotional problems. Inmates who answer yes to two or more questions about current symptoms or answer yes to either of the other two questions are referred for further evaluation. Corrections classification officers, intake staff, or nursing staff can administer the screen.

Validation test results show that these tests are effective instruments that can be used to identify depression, anxiety, PTSD, some personality disorders, and the presence of any undetected mental health problems.

Sources: Michael Martin, Ian Colman, Alexander Simpson, and Kwame McKenzie, "Mental Health Screening Tools in Correctional Institutions: A Systematic Review," *BMC Psychiatry* 13 (2013), http://www.ncbi.nlm.nih.gov/pubmed/24168162 (accessed July 2014); Andrew L. Goldberg and Brian R. Higgins, *Brief Mental Health Screening for Corrections Intake*, http://www.ncjrs.gov/pdffiles1/nij/215592.pdf (accessed July 2014); National Institute of Justice, *Mental Health Screens for Corrections*, May 7, 2007, http://www.ncjrs.gov/pdffiles1/nij/216152.pdf (accessed July 2014).

PROGRAMS FOR PRISONERS WITH CHRONIC MENTAL HEALTH ISSUES How did the population of mentally ill inmates get so large? In the 1960s, the government began closing state-run hospitals due to budget cuts and court orders forbidding the institutionalization of mentally ill people unless they received proper treatment. As a result, the number of people hospitalized for mental illness has significantly declined. Fifty years ago, the United States had nearly 600,000 state hospital beds for people suffering from mental illness; today, that number has dwindled to 40,000. Many wound up on the street and in the courts. Many Americans receive mental health treatment in prisons and jails rather than hospitals or treatment centers. New York City's Rikers Island jail alone holds thousands of mentally ill inmates at any given time.

MYTH One reason why male inmates are more violent and dangerous than female inmates is because males have a higher rate of mental illness.

FACT The rate of mental illness among females in prison is actually higher than males. Almost three-quarters of women in prison suffer from mental illness.

While the number of inmates with mental health problems is significant, treatment has been less than adequate and services for mentally ill inmates have been highly criticized. This has prompted advocacy groups to file lawsuits and lobby legislatures to promote relief for the mentally ill inmate. One reason is the charge that mentally ill inmates have been the subject of brutality by correctional officers. One case involving guards at the Rikers Island facility in New York was captured on a video where correctional officers can be seen scrapping with an inmate at his cell's threshold, then pushing their way inside. They spent about three minutes there—they threw the inmate to the floor and repeatedly kicked and punched him in the head and torso. A minute later, a captain entered the cell and was heard by a nearby inmate discussing how to handle the situation; Corrections Department rules permit officers to enter an inmate's cell only when there is an immediate threat, such as a suicide attempt. The video then shows the captain heading to a jail clinic, where she fashions a noose out of the inmate's pants, twisting the legs and tying them together in a loop. Shortly before this incident occurred, another inmate, a mentally ill Marine Corps veteran, died in an overheated cell, while another died after being locked in a cell for seven days, naked and covered in feces.[32]

Exhibit 12.6 sets out the treatment access and postrelease success of special needs inmates.

CRITICAL THINKING

Do the mentally ill belong in our prisons? Is there another place for them to go? If they commit a crime, should the focus be on punishment or treatment? LO5

EXHIBIT 12.6

Comparison of Special Needs Inmates

Inmate	Number in Prison	Treatment Access	Recidivism Rates
HIV-infected	No national data	Providing medical care and some psychological counseling	Postrelease success is typical of the average inmate
Chronic mental health issues	About half of inmates have mental health problems	Usually medication and some direct intervention when crisis situations take place	High recidivism rates when returned to the community

AP Images/Jennifer Simonian

Minnesota Department of Corrections Sgt. Carl Bennett, center, takes part in a role-playing exercise to convince a schizophrenic offender to come out of his cell during crisis intervention training at the Minnesota Correctional Facility in Stillwater. The training is intended to help employees defuse potentially violent situations and avoid use of force with inmates who have mental health issues.

SPECIAL POPULATION INMATES

The third type of unique inmate is those in special populations, whose status creates problems for prison administrators. The elderly prisoner and the illegal immigrant inmate are two forms of special population inmates.

Corrections and the Elderly Inmate

Today there are more than 120,000 inmates aged 50 and over in state or federal prisons, more than twice as many as a decade earlier.[33] The aging of the prison population has come about from longer sentences resulting from the get-tough-on-crime measures that impose truth-in-sentencing, mandatory sentences, and three-strikes laws, and an increasing number of older people convicted of sex crimes and murder.[34] This number is sure to rise: the U.S. population aged 65 and older is estimated to grow from 35 million in 2000 to 78 million in 2050, and the number of those aged 85 and older will increase from 4 million to 31 million.[35] By some estimates, by the year 2030 one-third of the U.S. prison population will be geriatric.[36]

Explain the plight of elderly inmates while incarcerated and what is involved in their care — LO6

There are different adjustment rates for elderly prisoners. The longer the amount of time remaining to be served, the harder it usually is for the elderly person to deal with confinement. Background factors, such as level of education and marital status, can also affect the adjustment of the elderly. Some inmates, especially those imprisoned early in life, are more institutionally dependent than others. Some have higher morale and are more involved in programs and prison life than others. There is the problem that in many prisons there is little programming or specialized treatment geared for elderly inmates.[37]

PROBLEMS OF WORKING WITH THE ELDERLY INMATE The elderly prisoner is vulnerable to victimization and requires special attention when it comes to medical treatment, housing, nutrition, and institutional activities. The care of the elderly is extremely expensive. For example, the average cost of housing an inmate over 60 is $70,000 a year, which is about three times the average cost for other prisoners. To cope with this problem, some states have developed a number of strategies to mitigate the rising cost of caring for prisoners, including increased use of telemedicine and the outsourcing of medical services to state universities and other providers. A small number of states have made limited use of Medicaid to help finance rising prison health care costs. The potential benefits of Medicaid financing will increase substantially as the Affordable Care Act takes effect, but only in states that expand their programs. One problem: currently, most state Medicaid programs cover very few childless adults, a population that makes up the bulk of the prison population. In most cases, only pregnant women and disabled inmates are eligible for Medicaid. By expanding Medicaid to all adults with incomes up to 138 percent of the federal poverty line ($11,490 for an individual), virtually everyone who is incarcerated will qualify for the federal-state program. The federal government will pay 100 percent of costs for newly eligible adults from 2014 through 2016 and gradually decrease its share to 90 percent by 2020.[38]

Inmates over 50 are also more likely to have health and mental health problems than noninstitutionalized Americans because they often come from poor backgrounds, have a greater likelihood of drug and alcohol abuse, and have more restricted access to health care.[39]

THINKING LIKE A CORRECTIONS PROFESSIONAL

The warden calls you and other lieutenants together and tells you that prison suicides have become a major problem. There have been three so far this month, and the current year has the highest number of suicides in the history of the prison.

As the senior correctional supervisor, he wants you to chair a team to study this problem and make recommendations that will reduce the incidents of suicides. What will you do—first, second, and third? Are prison suicides something that can be reduced through management procedures?

Some elderly prisoners find prison physically difficult to manage. One study of 120 female prisoners aged 55 or older in a California prison found that 69 percent of the women reported that at least one prison activity of daily living was very difficult to perform. These women also had higher rates of hypertension, asthma or other lung disease, and arthritis.[40] Another study found that nearly 40 percent of state inmates 55 and older have a recent history of mental health problems or disorders.[41]

Ronald H. Aday and others have reported that older prisoners need more orderly conditions, safety precautions, emotional feedback, and familial support than younger prisoners. They are particularly uncomfortable in crowded conditions, tend to prefer small groups, and want time alone.[42]

One of the problems of working with elderly prisoners is that increasing numbers of these prisoners have violent records or are sex offenders. One study conducted in the Deerfield Correctional Center in Virginia, which includes a large population of geriatric inmates, found that 75 percent had violent records and nearly 30 percent were sex offenders.[43] This record means that while the elderly demand special care, high security measures still must be maintained.[44]

AP Images/Rob Carr

Martha Staggs, 68, listens to a question during an interview at the Julia Tutwiler Prison for Women in Wetumpka, Alabama. Staggs, who was convicted of murdering her husband in 2003, was diagnosed with colon cancer and after surgery the cancer spread to her liver. Her chemotherapy and medical bills total more than $67,000 a year. The cost of elderly or infirm inmates to Alabama's underfunded, overcrowded prison system has prompted several lawmakers to support a bill that would expedite parole dates for those prisoners. Is there any point in keeping someone like Staggs behind bars or would an elderly inmate such as her be better off being treated in the community?

Corrections and the Illegal Immigrant

Few issues create as much controversy as immigration and crime. Concerns over the effects of immigration have existed for a long time, and bans against criminal aliens represented some of the earliest restrictions on immigration in the United States.[45] More recently, policies adopted in the mid-1990s have greatly expanded the scope of acts for which noncitizens may be expelled from the United States. Even so, calls to curtail immigration, especially illegal immigration, appeal to public fears about immigrants' involvement in criminal activities.[46]

Ironically, concern about the criminal activity of immigrants is rampant despite growing evidence that they actually have very low crime rates. According to "Crime, Corrections, and California: What Does Immigration Have to Do with It?"—a report released by the Public Policy Institute of California—immigrants are far less likely than the average U.S. native to commit crime in California.[47] Significantly lower rates of incarceration and institutionalization among foreign-born adults suggest that long-standing fears of immigration as a threat to public safety are unjustified. See Exhibit 12.7 for the key findings.

The findings are striking because immigrants in California are more likely to be young and male and to have low levels of education—all characteristics associated with higher rates of crime and incarceration. Yet the report shows that institutionalization rates of young male immigrants with less than a high school diploma are extremely low, particularly when compared with U.S.-born men with low levels of education. The low rates of criminal involvement by immigrants may be due in part to current U.S. immigration policy, which screens immigrants for criminal history and assigns extra penalties to noncitizens who commit crime.[48]

CRITICAL THINKING

Is there a deterrent effect to keeping the elderly behind bars? Should they be subject to compassionate release? LO6

LO7 Discuss the problems faced by illegal immigrants in U.S. prisons

MYTH Most people are released from prison and there are relatively few elderly inmates.

FACT Today, there are more than 120,000 inmates aged 50 and over in state or federal prisons, more than twice as many as a decade earlier.

EXHIBIT 12.7

Key Findings About Immigrants

- People born outside the United States make up about 35 percent of California's adult population but represent only about 17 percent of the state prison population.
- U.S.-born adult men are incarcerated in state prisons at rates up to 3.3 times higher than foreign-born men.
- Among men aged 18 to 40—the age group most likely to commit crime—those born in the United States are 10 times more likely than immigrants to be in county jail or state prison.
- Noncitizen men from Mexico aged 18 to 40—a group disproportionately likely to have entered the United States illegally—are more than 8 times less likely than U.S.-born men in the same age group to be in a correctional setting (0.48 percent versus 4.2 percent).

Source: Kristin F. Butcher and Anne Morrison Piehl, "Immigration Has Little To Do with California Crime" press release, Public Policy Institute of California, February 25, 2008. Reprinted by permission of Public Policy Institute of California, http://www.ppic.org/main/publication.asp?i=776 (accessed July 2014).

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Illegal immigrants are an emerging correctional population. The Willacy Detention Center in Raymondville, Texas, is used by the U.S. Immigration and Customs Enforcement (ICE) agency to keep illegal immigrants in detention before they are deported. On December 18, 2008, 116 Salvadoran nationals—83 men and 33 women—were woken up at 4 A.M. and transported in buses under strict surveillance to be flown back to El Salvador. Here, prison guards at the Willacy facility frisk female detainees before embarking for the airport.

Despite the evidence indicating that both legal and illegal immigrants are less crime prone than native-born Americans, John Hagan and Alberto Palloni have found that the public's fear of illegal immigrants leads to higher levels of detention among Hispanic immigrants who actually break the law. Their findings suggest that Hispanics may suffer an increased burden at the pretrial release stage, because of both racism and anti-immigrant attitudes.[49] Stephen Demuth and Darrell Steffensmeier's analysis of this issue found conclusive evidence that anti-immigrant attitudes may contribute to the over-detention of immigrants who do break the law.[50]

PROBLEMS ILLEGAL IMMIGRANTS BRING TO THE PRISON Illegal immigrants have a number of unique problems that must be addressed by correctional administrators. They may be recruited into ethnically compatible gangs. They frequently have difficulty in communicating with staff because their ability to use English is limited. Consequently, the growing number of non–English-speaking inmates requires that correctional staff become bilingual. If needs are not met, prison unrest may result.

Web App 12.2
Use your favorite Internet search engine to look up Arizona's controversial immigration law SB 1070. Do you think this legislation would have an impact on the number of illegal immigrants we find in our prisons? LO7

family detention centers Minimum-security residential facilities that provide schooling for children, recreational activities, and access to religious services.

PROGRAMS FOR ILLEGAL IMMIGRANTS The Bureau of Immigration and Customs Enforcement (ICE)—the federal agency that has jurisdiction over immigrant detention—is now in the process of creating **family detention centers**, minimum-security residential facilities that would house entire families and provide schooling for children, recreational activities, and access to religious services.

This concept has been condemned by human rights groups and immigrant rights organizations as punitive and unnecessary, but immigration authorities embrace it as a deterrent against families crossing the border as a group and to ensure that immigrants show up for their court hearings and leave the country when ordered deported. Illegal immigrants who commit criminal offenses typically are required to be punished for these offenses, such as being sent to prison and doing their time, before they are subjected to being deported.

When family detention centers began operations, correctional administrators immediately faced protests and lawsuits charging that the children were living in substandard conditions. Children were given hospital scrubs to wear, forbidden to have toys, and

allowed only one hour of recreation per day. After a legal settlement, children are now allowed to wear pajamas, move freely around the center, and bring toys into their rooms. There also have been changes made to the facility, including adding individual bathrooms, adding murals, and replacing metal doors.[51]

While the family detention center has been controversial, so too have the working conditions in the detention center. In 2014, at least 60,000 immigrants worked in the federal government's nationwide detention centers—a number that is greater than the work force of any other single employer in the country. What is at issue is the wages: 13 cents an hour, a number that saves the government and the private companies $40 million or more a year by allowing them to avoid paying outside contractors the $7.25 federal minimum wage. Some immigrants held at county jails do not receive a wage and are paid with sodas or candy bars for providing services like meal preparation for other government institutions. The compensation at detention centers is set under guidelines created in 1950 and which have not been changed since; courts have upheld the dollar-a-day compensation. So on any given day, about 5,500 detainees work for $1, in programs run by the federal government and private companies.[52]

washingtonindependent.com

The increased collaboration between the Department of Homeland Security (DHS) and local law enforcement has resulted in large numbers of detained illegal immigrants being held in local jails. Here, illegal immigrants are held at a detention facility in Phoenix, Arizona. Confusion often reigns when local jails go beyond handling regular local criminal matters to holding civil detainees for federal agencies. Questions of custody and responsibility involve both federal and state agencies, and inmates may be charged with both criminal and civil proceedings involving different legal rights.

Michael H. Fogel

CAREERS IN CORRECTIONS

Michael H. Fogel
Forensic Psychologist

"Forensic psychologists are employed in a variety of settings, including correctional facilities, psychiatric hospitals, and court clinics. I am a professor in the Department of Forensic Psychology at The Chicago School of Professional Psychology (TCSPP), and I maintain an independent practice in forensic psychology. At TCSPP, I teach courses for students seeking a master's degree in forensic psychology or a doctoral degree in clinical forensic psychology. In my private practice, I conduct psychological evaluations concerning psycholegal issues. I might be asked by a prosecuting or criminal defense attorney to assess a defendant's competence to stand trial, mental state at the time of the offense, or risk to commit a future act of violence. With each referral question, there are generally accepted standards of practice that guide how I complete the evaluation. One governing guideline is to perform an unbiased and impartial evaluation regardless of the side that retains me and the adversarial nature of the legal system. Indeed, a forensic psychologist is akin to a teacher. Instead of instructing a classroom of students, he or she is educating judges and juries via a written report and/or expert witness testimony about the findings of their evaluation."

"A typical evaluation will include a review of relevant records (e.g., police reports, school records, mental health records), interviews with the defendant, interviews with collateral informants (e.g., family members, witnesses, treatment providers), and the administration of psychological tests and/or forensic assessment instruments. After the evaluation is complete and an opinion has been reached, I will discuss my findings with the prosecuting or criminal defense attorney who retained my services, and will usually be asked to write a report, which will detail my findings and the data upon which they are based. Most often, my reports will stand on their own and expert witness testimony is not required; however, the extent to which an expert is called to testify varies greatly by jurisdiction and the nature of the evaluation."

See Chapter 15 for more detailed information on careers in corrections.

SUMMARY

LO1 Describe the problems of inmates with a substance-involved history

Inmates with a substance-involved history, especially drug-addicted inmates, need treatment while incarcerated and, at the same time, they pose particular challenges to maintaining a lawful environment if they are involved in drug use and trafficking to other inmates.

LO2 Recognize what challenges and problems sex offenders bring to the prison

Sex offenders are more numerous in prison than in the past. The major categories of sex offenders are the rapist and the child molester. It is the child molester who traditionally has had a difficult time in the prison environment, but improved classification in some states has resulted in sex offenders being safer than they have been in the past. Some sex offenders face civil commitment when they are released from prison.

LO3 Name some of the issues terrorists present to the correctional system

Terrorists are presently housed in the Guantánamo Bay facility and in federal facilities on the mainland. Relatively few are housed in Guantánamo and many of these are scheduled to be transferred or released. Only a handful have actually been convicted of crimes. When (and if) Guantánamo is closed down, its terrorist inmates will be transferred to traditional prisons. One major issue has been accusations that convicted terrorists held in maximum security prisons are able to freely communicate with the outside world, encouraging future terrorist attacks from their jail cells.

LO4 Explain the prison experience of HIV inmates

HIV inmates are now integrated in the general population. However, many problems and issues remain to be settled. Should patients with AIDS be hospitalized? Should officers be notified when an inmate tests positive? Does educating inmates about safe sex and needle hygiene imply that the state condones sexual behavior and drug use in prison?

LO5 Describe the world faced by chronic mentally ill inmates while they are in prison

Chronic mentally ill inmates are also highly represented in prison populations. It has been found that half or more of inmates in today's prisons have some form of mental health problem, and with some inmates their behavior is so extreme that they need psychiatric intervention and medication. They face ridicule, harassment, and the possibility of various forms of victimization from other inmates and very little in terms of programs and other means, other than medication, to help them cope with prison life.

LO6 Explain the plight of elderly inmates while incarcerated and what is involved in their care

Elderly inmates are extremely costly to care for, both in maintaining their physical well-being and in providing for them during the final days of their lives. One of the tasks of prison staff is to protect them from exploitative inmates. The management and care of these inmates require proper programming, a safe environment, and a sensitive and concerned staff.

LO7 Discuss the problems faced by illegal immigrants in U.S. prisons

Illegal immigrants are another special population in prison settings. Even though illegal immigrants do pose problems, such as when they become involved in a violent prison gang, they ordinarily present little difficulty during the time they are detained. Their biggest problem is being exploited as cheap prison labor: a dollar a day!

CRITICAL THINKING QUESTIONS

1. Is there a better way to handle vulnerable inmates than to put them in the prison population or to isolate them in protective custody?
2. What should the role of correctional staff be with inmates who are dying?
3. Which group of inmates discussed in this chapter do you think poses the greatest problem for staff?
4. Which group of inmates discussed in this chapter do you think has the greatest problem with prison life?
5. Does the fact that privately run detention facilities pay the illegal immigrants they house a dollar a day make you reconsider the concept of running a correctional facility for profit?

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