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2007

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Recommended Citation

Chapter 12

Specialized Detention and Correctional Facilities

by Christopher A. Mallett, Michael J. Williams, and Shawn C. Marsh

INTRODUCTION

Psychiatrists, psychologists, and other mental health professionals often find themselves working with children, youth, and adults involved in the justice system. Mental health issues are common among those contacting the justice system, with roughly two-thirds of juvenile and adult offenders meeting the criteria for at least one mental health disorder (Grisso, 2008; James & Glaze, 2006; Teplin et al., 2006). Depending on the severity of offending behavior or treatment needs, courts have the option of sending offenders to out-of-home placements. There is substantial variance in the types of placements available when an individual's behavior requires his or her removal from the community. For the purpose of this chapter, we focus on those placements that are in some form "secure," in that residents—either juvenile or adult—are prevented from leaving a facility either by staff or by physical barriers such as locked doors. Further, we limit our discussion to specialized placements rather than more common institutions such as jails or correctional facilities for adult male offenders. Specifically, the placements covered in this chapter include child and youth residential treatment facilities, juvenile detention and correctional facilities, juvenile sexual offender treatment facilities, women's prisons, and military detention and correctional institutions. For each of these specialized placements, we present their history and current philosophy; outline basic components of design, treatment services, and programming; and review the status of evidence-based practice.

CHILD AND YOUTH RESIDENTIAL TREATMENT FACILITIES

History

The English Poor Law of 1601 that was widely implemented in the Americas' colonies stated that parentless children, or parents deemed unable to provide care, would have their children cared for by the local community through apprenticeships (Lindsey & Stuart, 2009). Residential treatment facilities for children and youth eventually emerged with the orphanage movement of the nineteenth century. The gradual shift from community apprenticeships to institutional care was influenced by population and urban area growth, along with accompanying social stressors that found many families destitute. From the 1830s through the 1850s, institutions were established with a belief in charity to address some of these difficulties. These institutions included almshouses and workhouses for able-bodied poor adults and youth, houses of refuge for youthful delinquents, asylums for those with mental illnesses, residential schools for those with certain disabilities (blind, deaf, etc.), and orphanages (Mechanic, 2008). Often, these orphanages were populated with children whose fam-

ilies were encountering economic hardships, not children there because of family disruption or parental absence.

The Progressive Era, from the later 1800s through the 1930s, challenged the extensive use of these institutions and orphanages for children and youth, believing that in-home care was both more humane and would expend fewer local and state government funds. This period witnessed the establishment of the juvenile courts, the profession of social work to support the courts and other institutions, and the recognition of adolescence as a distinct development stage—all of which were influential in the elimination of child labor (Mallett, 2006; Sallee, 2004). This movement included the increased use of in-home care for children who formerly would be placed into orphanages, as well as the use of probation and parole for delinquent youth (Lindsey & Stuart, 2009).

Orphanages, though, continued to exist and increased capacity for the caretaking of children and youth. A key expansion point was the establishment of the "orphan trains," an initiative that relocated urban-dwelling children from economically distressed families to rural farm communities, often in western states. A majority of these rural families were Protestant, prompting an expansion of both Catholic and Jewish-supported orphanages on the East Coast that attempted to minimize the utilization of the orphan train relocations (Burson, 2001; Kamerman & Kahn, 1990). While the number of children in orphanages remained fairly stable from 1900 to the 1930s, after the passage of the Social Security Act (1935), support for poor children in single-parent families became available through the Aid to Dependent Children (ADC) Program, known today as the Temporary Assistance for Needy Families (TANF) Program. Some of the Social Security Act funds could be used to support children and youth in orphanages and other institutions but eventually were used to help with specialized youth problems or youth with disabilities (Lindsey & Stuart, 2009; Wolins & Piliavin, 1964).

By the 1960s, orphanages were replaced through the establishment of both the child welfare foster care system and residential treatment centers (RTC) for children and youth (Ferguson, 1961). The orphanage population subsequently decreased from 750,000 in 1920 to just 60,000 in 1960 (Pelton, 1989). By the 1970s, the child welfare system became the public entity responsible for investigating allegations of abuse or neglect and to determine the safest placement for the child. Because of these changes, the orphanage facilities, which originally tried to address a variety of social problems (e.g., dependence, crime, and physical and mental illness), were eventually remodeled to provide specialized care for children and youth, most of whom had severe emotional problems (Morton, 2009; Substance Abuse and Mental Health Services Administration, 2008a).

Today, RTCs provide services for children and youth from child welfare, juvenile justice, school districts, and other youth-supporting systems. There has also been a shift in funding, for RTCs receive almost all revenue from public sources—Medicaid for treatment, Title IV-E funding for out-of-home placements, and other grants for support services. These residential facilities primarily treat children and youth with serious emotional disturbances or severe behavioral handicaps. This population, with severe difficulties, numbers approximately one million children and youth in the United States, though only one-fourth are placed into residential treatment in any given year (Abt Associates, 2008; Substance Abuse and Mental Health Services Administration, 2008a, 2008b).

Philosophy

Residential treatment is a specific level of care distinguished by the services and setting. Its characteristics include a twenty-four-hour therapeutically planned behavioral health intervention; highly supervised and structured group living; an active learning environment where distinct and individualized therapies and adjunct treatment services are provided; diagnostic processes which address psychiatric, social, and educational needs; multidisciplinary teams of clinically licensed professionals (psychiatrists, psychologists, social workers, nurses, special education teachers, activity therapists, and others); and individualized assessment, treatment planning, and aftercare involving the child and family. The purpose of these activities is to help each child and youth master the adaptive skills necessary to return to, and function successfully in, his or her community—often in conjunction with intensive wraparound services (National Association for Children's Behavioral Health, 2008).

Design, Treatment, and Programming

As noted, RTCs provide intensive, multidisciplinary treatment for severely behaviorally and emotionally troubled youth, with treatments available to meet many varied youth needs, including mental health disorders, substance abuse issues, and co-occurring disorders. Most RTCs offer programming options that include medication management; individual and family psychiatric assessment; psychological testing; milieu therapy; individual, family, and group therapy; case management; and academic instruction. These services are offered within a variety of theoretical orientations, depending on the RTC—psychodynamic, cognitive-behavioral, psychoeducational, family systems, and an eclectic (mixed) approach (American Association of Children's Residential Treatment Centers, 2000). In addition, other services within a continuum of care model are available in assisting the transition from the RTC to the community, including supported housing, outpatient counseling, in-home treatment, therapeutic foster care, academic tutoring, and vocational training (Allen, Pires, & Brown, 2010; Lyman & Campbell, 1996).

Evidence-Based Practice

While a continuum of care approach has been found to be an important treatment schema in achieving positive youth and family outcomes (Stroul & Blau, 2008), there is still a need for improved RTC evaluations, including more frequent and rigorous studies with consistent measurements (Baker, Wulczyn, & Dale, 2005; Cornwall & Blood, 1998; Foltz, 2004; Lyons & Schaefer, 2000; McCurdy & McIntyre, 2004; Tripodi, 2009). Although treatment efficacy and research methodology barriers (e.g., limitations on control group designs) exist in determining for whom these facilities are best suited and how best these facilities should operate (Blanz & Schmidt, 2000), evidence to date is encouraging that RTCs serve to improve youth outcomes across domains of psychosocial functioning (Bettman & Jasperson, 2009; Leichtman, Leichtman, Barber, & Neese, 2001; Smith, Duffee, Steinke, Huang, & Larkin, 2008). In addition, youth with serious emotional difficulties are at high risk for suicidal

ideation and behaviors; RTCs are designed to serve the important function of keeping these youth safe (Hayes, 2009).

Positive results have been found across a number of RTC treatment approaches including symptom reduction (Colson, Murphy, O'Malley, & Hyland, 1990; Lyons et al., 2001), improved family and social setting functioning (Hooper, Murphy, Devaney, & Hultman, 2000; Larzelere et al., 2001), and a better orientation to treatment (Mann-Feder, 1996). Improved youth outcomes have been correlated with increased family involvement and use of after-care programming, whereas extended placement in the RTC (more than two years) has been associated with poorer discharge outcomes (Leichtman et al., 2001; Smith et al., 2008). In a review of cognitive-behavioral therapy utilization within RTCs, youth antisocial behaviors decreased by 10 percent compared to youth who did not receive the therapy. In addition, other offered therapies (e.g., attention control, stress management training, and milieu groups) have been found equally effective, though less evidence is available with which to compare outcomes (Armelius & Andreassen, 2007).

RTCs with a primary focus on youth substance abuse treatment are also understudied, with methodological limitations similar to evaluations in other RTC settings. However, when evaluated, improvements have been found in both decreased youth substance dependency and addictions (Jainchill, Hawke, DeLeon, & Yagelka, 2000; Mock et al., 2001; Ralph & McMenany, 1996; Sealock, Gottfredson, & Gallagher, 1997; Vaughn & Howard, 2004). In addition, treatment model efficacy was found important in achieving decreased youth substance abuse (Orlando, Chan, & Moral, 2003).

JUVENILE DETENTION CENTERS/INCARCERATION FACILITIES

History

The concern for youth who engage in delinquent activities dates back to the Colonial Era. Early prevention and intervention efforts were focused on family control of these children and youth, in addition to the use of almshouses—locked one-room buildings where able-bodied poor and wayward youth were held when necessary (Grob, 1994). By the turn of the nineteenth century, with the impact of increased poverty, urban growth, and immigrant influxes, new facilities were established (Houses of Refuge) in major cities to help control juvenile delinquency (Krisberg, 2005). Houses of Refuge were the first institutions that provided separate facilities for youth, apart from adult criminals and workhouses, and that provided education along with reform efforts (Mennel, 1973). These facilities housed a broad array of children and youth in need including those who were delinquent, neglected, and/or dependent. The doctrine of *parens patriae* supported the Houses of Refuge's efforts through the belief that the state should act as benevolent legal parent when the family was no longer willing or able to serve the best interest of the child (Mallett, 2011b; Platt, 1969). This philosophy continued to guide the movement from these Houses of Refuge to the Child Savers Movement and the establishment of the juvenile courts.

The Child Savers Movement was focused on the difficulties of the urban poor at the end of the 1800s, trying to keep children and youth sheltered, fed, and—when pos-

sible—working (Hawes, 1971). This movement mirrored the "orphan train" activities in that vagrant and poor children were relocated to midwestern farm families to help "reform" them, though converting these children into inexpensive labor was often the primary result. As the Child Savers Movement lost favor, local governments began to take over the responsibility for juvenile delinquents, often through a combined private and public effort. These collaborations lead often to the establishment of reform schools, and—by the end of the 1800s—were almost completely publicly funded. Most reform schools were located in the northern and western states (Krisberg, 2005; Lawrence & Hemmens, 2008).

Reform schools at this time were criticized for lacking proactive efforts to change the behavior of juvenile delinquents and for only housing youth for long periods of time. The Progressive Era (1880–1920), a time of rational optimism, brought reforms to these schools and expanded the doctrine of *parens patriae*. This movement provided safeguards for children and youth who were charged with delinquency (including truancy and lack of supervision), with the state of Illinois establishing the first juvenile court in 1899. By 1925, forty-six of the existing forty-eight states at the time had established juvenile or specialized courts for children and youth (Coalition for Juvenile Justice, 1998; Krisberg, 2005).

In conjunction with the establishment of juvenile courts, the use of correctional facilities for delinquent youth expanded from the 1940s to the1960s. By the 1960s, a near majority of the youth brought before the juvenile courts were, at some point, held in a detention facility or correctional facility. This detained and incarcerated population totaled over 100,000 youth annually in the 1940s, rising to over 400,000 by the 1960s. Many of these facilities were substandard, and did not include rehabilitative services or medical care (President's Commission on Law Enforcement and Administration of Justice, 1967; Roberts, 2004).

Although juvenile courts were established as part of a reform effort to more humanely provide for the best interest of neglected, abused, and delinquent children (Binder, Geis, & Bruce, 1988; Sorrentino, 1975), their impact was relatively limited. The continued poor treatment of system-involved youth, and the perception that a social welfare approach was doing little to curb expanding juvenile crime, resulted in more focused attention on issues of due process. Critics at the time argued that the juvenile court could no longer justify its broad disposition powers and invasion of personal rights (i.e., due process) on humanitarian grounds. Youth were, in actuality, treated like adult criminals yet had none of the legal protections granted to adults (Binder et al., 1988; Scott & Grisso, 1997). Eventually, due process concerns came to the forefront of juvenile justice in the United States with the *Gault* decision (*In re Gault*, 1967), where youth were extended both the right to counsel and the opportunity to cross-examine sworn testimony.

The intent of *Gault* was to balance the broad powers of the juvenile court by providing legal protections to juveniles. However, the *Gault* decision also focused attention on similarities between the juvenile court and the adult court versus the differences in intent underlying the systems (Schwartz, 2001). While, in theory, still oriented toward rehabilitation, the new focus on due process resulted in the juvenile system orienting toward retribution as a means to address delinquency—the hallmark of the adult criminal justice system. This shift toward "adultification" and punishment, com-

bined with the influential but misunderstood message of "nothing works" (Martinson, 1974, 1979), set the stage for the next era of change in the juvenile justice system.

The late 1980s and early 1990s marked an aggressive swing toward societal protection as the primary goal in developing responses to crime (Scott & Grisso, 1997). Public opinion that juvenile crime was out of control, public concern about a largely fictional new class of juvenile "superpredators," and a growing public attitude that juvenile courts were soft on crime (Snyder & Sickmund, 1999) fueled critical changes in the juvenile justice system that exist through today. For example, state legislatures began passing increasingly punitive laws aimed at stemming juvenile crime, including laws that provided transfer and waiver protocols to move juveniles to the adult system for certain serious crimes. Accordingly, age became the determinant of culpability versus developmentally informed views of adolescence (Moffitt, 1993; Scott & Grisso, 1997). A view of juvenile offenders as "little adult criminals," a largely punitive orientation to social control, and reduced judicial discretion marked for many the end of the *parens patriae* doctrine in American juvenile justice (Binder et al., 1988).

In the 2000s, the rise of restorative justice, the emergence of positive youth development principles, improved understanding of brain development, and several landmark Supreme Court decisions (e.g., the juvenile death penalty abolishment and the concern over the sentence of juvenile life without parole) have helped move the juvenile justice system back toward a more social welfare orientation (Mallett, 2011a). As part of this shift—in combination with concerns regarding the iatrogenic effects of congregate care of juveniles (Dishion, McCord, & Poulin, 1999; Dodge, Dishion, & Landsford, 2006)—substantial effort has been placed in developing diversion opportunities for youthful offenders, alternatives to detention and incarceration, and more normative correctional placements that are smaller and geographically closer to the populations they serve (e.g., Missouri Model; Missouri Division of Youth Services, 2010).

Although improvements have been made in reducing the use of detention and correctional institutions, they remain a common disposition of juvenile courts in the United States. In 2008, for example, over 340,000 youth were held in detention centers and over 100,000 in state correctional facilities; this population was disproportionately minority (40 percent) and male (80 percent) (Sickmund, 2008; Sickmund, Sladky, & Kang, 2010). Indeed, disproportionate minority contact (DMC) with these systems remains a substantial social concern despite decades of efforts to reduce overrepresentation based on race/ethnicity (e.g., see W. Haywood Burns Institute, 2009). Suicide—the most likely cause of death in detention and correctional placements—is another major concern, with 110 juvenile suicides occurring between 1995 and 1999 in secure confinement in the United States (Hayes, 2009).

Philosophy

Although juvenile detention and juvenile correction facilities share an incapacitation function, their missions are substantially different. Juvenile detention typically refers to short-term secure placement of youth awaiting disposition because of delinquent acts, and usually does not focus on rehabilitation of the offender. In contrast, juvenile correctional facilities are designed for longer-term secure placement of adju-

dicated youth, and they usually provide rehabilitative treatment for serious or chronic juvenile offenders. Historically, juvenile correctional facilities have been called "reform schools" or "training schools" and have served to isolate young offenders from society in order to provide rehabilitative services and to protect both the community and youth (Binder et al., 1988). Both juvenile detention and correctional facilities can vary in size, administration, and sophistication (e.g., services provided and accreditation). Basic minimums of appropriate operation of secure juvenile facilities are, in principle, guided largely by the core components of the Juvenile Justice and Delinquency Prevention Act (JJDPA). These components include deinstitutionalization of status offenders (e.g., not using secure placement for truants) and not jointly housing juvenile and adult offenders. States that do not comply with the core components of the JJDPA risk reduction in federal funding support. Organizations such as the American Correctional Association and the Council of Juvenile Correctional Administrators also have developed standards to guide practice in detention and correction facilities (e.g., see Performance Based Standards; PbS Learning Institute, 2011).

Drawing form the work of Lewin (1951) and Bandura (1986), Roush (1996) notes the following about institutional settings and the underlying philosophy of behavior change:

> Lewin's [classic] behavior formula is always at work . . . everything that a staff member does is an interaction and teaching influence . . . and the behavior (modeling) of each staff member has an observational learning effect. . . . Staff members are seen as the most powerful and important models in the detention and corrections environment. The more attractive the staff member, by any means of measurement, the more influential the message. (p. 139)

Design, Treatment, and Programming

Juvenile Detention. Juvenile detention facilities are typically designed to hold youth awaiting adjudication or disposition on delinquency charges. In many jurisdictions, they also serve as the point of intake and initial detention when youth are arrested by law enforcement. Recommended practice in determining admission to detention includes use of a validated Risk Assessment Instrument (RAI) such as the Massachusetts Youth Screen Instrument (MAYSI-2; Grisso, Barnum, Fletcher, Cauffman, & Peuschold, 2001) and the Youth Level of Service/Case Management Inventory (Y-LSI; Schmidt, Hoge, & Gomes, 2005). Many detention facilities also incorporate screenings for suicidal ideation, substance abuse, and other clinically important health and well-being issues at the point of intake, in order to match presenting needs and appropriate services (e.g., see Child Welfare Trauma Referral Tool by the National Child Traumatic Stress Network, 2008). Length of stay for juveniles in detention can vary substantially from a few hours for minor offenses to years in the case of complex waiver and transfer cases. Depending on the jurisdiction, detention facilities might be run by juvenile probation, county or state agencies, or private contractors.

Juvenile Corrections. On the continuum of responses to delinquency available within the modern juvenile justice system, placement in a juvenile correctional facility represents the most restrictive disposition for youth. Unfortunately, juvenile correctional facilities have a tarnished reputation in the United States, with reports of abusive conditions and poor outcomes commonplace across their history (Beck, Guerino, & Harrison, 2010; Binder et al., 1988; Miller, 1991; Sorrentino, 1975; Wooden, 2000). Although reform efforts are improving conditions and services in these facilities, many facilities remain dangerous warehouses for delinquent youth by emphasizing punishment and engaging in atheoretical, ineffective or even damaging practices (Gavazzi, 2006; Peterson-Badali & Koegl, 2002; Rhule, 2005; Schwartz, 2001; Styve, MacKenzie, Gover, & Mitchell, 2000).

Despite this criticism, some youth correction facilities employ programs based on guiding treatment models to encourage rehabilitation, including those grounded in social learning, reality therapy, transactional analysis, and positive peer culture approaches (Hoge, 2001; Stumphauzer, 1986). Specific treatment tools within these approaches commonly include behavior contracting, token economies, level systems, individual counseling, group counseling, education, and vocational training (Hoge, 2001).

Evidence-Based Practice

Detention Facilities Outcomes. Detention facilities are designed for youthful offenders who pose a high risk of reoffending and/or who may not appear for their juvenile court trial (Holman & Ziedenberg, 2006). In addition to serving as a facility for those who are safety and appearance risks, a shift toward holding nonviolent offenders has occurred over the past decade (Knoll & Sickmund, 2010). While concerned about reoffenses by these youth, there is a growing consensus by practitioners and researchers alike that detention—in the long run—is not meeting stated public safety objectives, and that the actual detention of youth may be part of the problem in terms of increased likelihood of future antisocial acts (Mallett & Stoddard-Dare, 2010). Specifically, detention placement has increasingly been found to have a causal impact on increased youth reoffending and recidivism (Justice Policy Institute, 2009; Soler, Shoenberg, Schindler, 2009). The experience of detention makes it more likely that detained youth will continue to engage in delinquent behavior, and it may increase the odds of recidivism (Holman & Ziedenberg, 2006). Detained youth are more likely than nondetained youth to further penetrate the juvenile justice system, with prior commitment being the most significant predictor of recidivism (Fendrich & Archer, 1998; Sheldon, 1999). Additionally, detention placement has been found to triple the chance of youth subsequently being incarcerated in a state facility (Office of State Courts Administrator, 2003).

Detaining youth also has a negative impact on juveniles' education, mental and physical well-being, and future employment opportunities (Forrest, Tambor, Riley, Ensminger, & Starfield, 2000; Males, Macallair, & Corcoran, 2006). Time spent in detention interrupts positive peer, family, and school relations, while often promoting a negative peer culture within the facilities (Dodge et al., 2006). Many detained youth

with special education needs fail to return to school, further eroding an important protective factor and complicating problems experienced by at-risk youth (Holman & Ziedenberg, 2006; Mears & Aron, 2003).

Incarceration Facility Outcomes. Youth incarceration facilities are less frequent placements for youthful offenders, but they are for more serious matters and entail longer dispositions for confinement. Even for these more serious offenders, though, the evidence of these facilities' effectiveness is at best minimal. Placement in these facilities either has no impact on youth rearrest or recidivism (Loughran et al., 2009; Winokur, Smith, Bontrager, & Blankenship, 2008) or increases the risk for youth rearrest or recidivism (Myner, Santman, Cappelletty, & Perlmutter, 1998). In many reviews, a large percentage of incarcerated youth reoffended within twenty-four to thirty months of their release (Petrosino, Guckenburg, & Turpin-Petrosino, 2010; Annie E. Casey Foundation, 2009). While incarcerated, many of these youth do not receive services that may assist in mitigating their prior offending behavior. As noted, services that may be rehabilitative include behavior contracting, token economies, level systems, individual counseling, group counseling, education, and vocational training.

Research on the efficacy of these interventions with youthful offenders, however, often centers on an assessment of main effects. This approach is likely too simplistic, given the complex array of treatment variables in correctional settings. For example, a main effects model might seek to show statistically significant changes in depression due to participation in a cognitive-behavioral–based group intervention (i.e., program factor). In doing so, however, the model might not account for interactions with worker demographics, change philosophy, and interpersonal styles that are likely associated with program climate and implementation (i.e., worker factor; Gordon, 1999a, 1999b; Mitchell, MacKenzie, Gover, & Styve, 2001; Marsh, Evans, & Williams, 2010; Moak & Wallace, 2000). The range of factors that should be considered to strengthen the correctional intervention research literature includes outcome, setting, worker, program, client, and process (Hoge, 2001). Meta-analyses that control for some of these intervention factors have produced support for *some* treatment approaches being effective for *some* populations in *some* settings (see, e.g., Antonowicz & Ross, 1994; Lipsey, 1992). Nonetheless, evidence suggests that programs in general should focus on modifying established criminogenic factors—such as substance abuse and lack of problem-solving skills—that are highly correlated with delinquent behavior (Latessa & Lowenkamp, 2006).

Some facilities that have designed these therapeutic components in a quality manner, and that offer them to high-risk juvenile offenders, have been able to effectively decrease recidivism rates (Armelius & Andreassen, 2007; Greenwood & Turner, 2009). The components that have been found to help decrease recidivism include counseling, skill building (anger management, social skills, etc.), restorative justice approaches, and combinations of these programs, which have a positive impact on youth both in correctional facilities and under community supervision (Lipsey, 2009). This means that juvenile offenders may be as effectively supervised outside the facility, avoiding the harm associated with detention or incarceration. Nonetheless, conditions and outcomes for youth placed in correctional facilities are notoriously poor, and

most juvenile justice professionals view these placements as an absolute "last resort" to be considered only when offending behavior is so egregious as to constitute substantial risk to community safety.

JUVENILE SEX OFFENDER FACILITIES

History

Abuse of children was recognized as a societal problem during the late 1800s, when maltreatment cases came to the attention of humanitarian organizations. By the 1940s, medical doctors began to document physical and sexual abuse cases, bringing this hidden problem to the concern among policymakers (Ryan, 1997). By the 1970s, legislation had passed establishing surveillance of the maltreatment of children and youth, including sexual abuse, coinciding with emerging standards of care. However, early results of the treatment of sexual abuse for adult offenders were disconcerting; most reoffended (Groth, 1977), leading to policies and efforts to identify these offenders in development during their teen years. The treatment field began working with younger sexual offenders, primarily through control and containment rather than interventive measures (Abel, Becker, & Mittelman, 1985). Consequently, by the 1980s, a juvenile sex offender had come to be defined as any youth who sexually abuses (Ryan, 1997).

The identification of sexually abusive youth expanded during the 1980s, as treatment and victim assistance programs were established. Treatment programs have numbered between 600 and 800 over the past three decades. Eighty percent of these treatment programs were community-based, and 25 percent of the remaining residential facility programs were located within locked juvenile court facilities (Freeman-Longo, Bird, Stevenson, & Fiske, 1995; Ryan, 1997; Zimring, 2004). This expansion of the identification of youth sexual offenders was also the result of an increased legal response, in that these providers learned that intervention at younger ages and holding youth accountable for their actions helped decrease recidivism (Speirs, 1989). During this aggressive societal protection era, the term "juvenile sex offender" became common nomenclature.

Today, over one-third of sexual offenders of minors known to police are juveniles (approximately 90,000 annually). The offender is most likely male (over 90 percent), and either between the ages of 12 and 14 or 17 and 18. These offenders account for only 3 percent of all juvenile offenders, and 7 percent of all serious juvenile offenders (Federal Bureau of Investigation, 2010; Finkelhor, Ormrod, & Chaffin, 2009), though the rate of juveniles arrested for sex offenses has remained stable over the past two decades (Zimring, 2004). However, because of the lack of general youth population surveys, outside clinical samples, prevalence rates for the number of juvenile sexual offenders are unavailable. In 2007, nearly 3,500 adjudicated juvenile offenders with sexual assault listed as their most serious crime were committed to locked facilities in the United States (Sickmund, Sladky, Kang, & Puzzanchera, 2011). It is not clear, however, how many secure facilities currently offer specialized, evidence-based sexual offender treatment for juveniles.

Philosophy

Despite common public perception (Letourneau & Miner, 2005), juvenile sexual offenders have a relatively low rate of recidivism after completing treatment, often less than 10 percent (Caldwell, 2010; Finkelhor et al., 2009; Reitzel & Carbonell, 2006; Worling, Littlejohn, & Bookalam, 2010). Treatment of juvenile sexual offenders is a specialized area of practice, and interventions can span several years. Ideally, these efforts involve the family, are significantly structured, include evidence-based treatment alternatives, and offer substantial aftercare/safety planning (Association for the Treatment of Sexual Abusers, 2006; Righthand & Welch, 2001).

Design, Treatment, and Programming

There has been, and still exists, disagreement on whether facilities to treat juvenile sexual offenders should separate these offenders from other juvenile offending populations. Although most facilities segregate the sexual offending population from other offenders for treatment and supervision, this model may not be more effective than a comingled juvenile offender setting. This may be because most sexual offending youth also have other delinquent offense histories (often drug, theft, and/or assault charges; Snyder & Sickmund, 2006). There are other important considerations when making facility design decisions, including the treatment philosophy (group vs. individual modality), safety of the youth and staff, efficacy, recidivism outcomes, and fiscal constraints (Righthand & Welch, 2001).

When juvenile sexual offenders are congregated for treatment in separate units within larger correctional facilities, this reflects specialized treatment needs, and–in some cases–recognition of perpetration and victimization issues associated with the comingling of populations. Treatment often focuses on addressing thinking errors, understanding offense cycles, victim empathy development, sexual education, and safety planning/relapse prevention. These treatments are offered through a variety of modalities, including individual therapy, group work, milieu therapy, and a combination of these approaches (Center for Sex Offender Management, 2006; Hunter & Longo, 2004). It is strongly recommended that these locked facilities be part of a continuum of care that is available to the youth as treatment progresses: a continuum that includes training schools, residential group homes, day treatment (partial hospitalization) programs, outpatient services, and psycho-educational programs (Bengis, 1997; National Adolescent Perpetrator Network, 1993).

Evidence-Based Practice

Youth who commit sexual offenses do so for a variety of reasons—some out of sexual curiosity, some because of impulsivity or poor judgment, and some with a pattern of offending (Center for Sex Offender Management, 1999; Chaffin, 2006). Understanding why these juveniles offend is an important part both of the assessment and treatment planning process, and—ultimately—in improving the youth's ability to desist from these behaviors. Although evidence to date is expanding on what treatment types and modalities are most effective with this youth population, there is general

agreement that limited applicable research is available. Investigations of the effectiveness of these interventions are important and necessary for improved future decision making (Chaffin, 2006; Fanniff & Becker, 2006; Walker, McGovern, Poey, & .Otis, 2004).

There are a number of comprehensive components to delivering effective treatment to juvenile sexual offenders. First, a full assessment of the youth's needs, risk factors, and history is critical, which will guide an individualized and developmentally appropriate plan of treatment. Second, the individualized treatment planning should be reviewed and revised on a regular basis and should thoroughly outline specific treatment needs, intervention protocols, and benchmarks for assessing progress in treatment. Third, treatment should be provided in the least restrictive environment necessary for community safety. Fourth, documented progress reports should discuss measured, objective, and demonstrated youth change. Fifth, treatment length for many youth may need to be long term (Center for Sex Offender Management, 2006; National Adolescent Perpetrator Network, 1993; Righthand & Welch, 2001), though, more recent evidence has found that some short-term interventions were effective at reducing reoffending rates (Caldwell, 2010).

In secure facilities, treatment should be comprehensive, holistic, and intensive, including daily group work to encourage social skills development, weekly group therapy on treatment-specific topics, family therapy, parent and guardian groups, and individual therapy (Avalon Associates, 1986). Content areas that are important in youth treatment include sex education, values clarification, empathy training, decision-making skills, impulse control, victimization experiences, family difficulties, and coexisting problem areas such as substance abuse, mental health disorders, and developmental disabilities (Becker & Hunter, 1997; Hunter & Figueredo, 1999; Worling, 2004). It is important to note that programs built on adult treatment models—that typically focus on cognitive distortion, deviant sexual arousal, and anger management—are not appropriate for juveniles, because of their different risks, better responses to treatment, lower recidivism rates, and developmental differences (Association for the Treatment of Sexual Abusers, 2003; Letourneau & Miner, 2005). There is evidence that youth in secure facilities benefit from a systematic reward program model, the use of cognitive-behavioral approaches, and a clear focus on relapse prevention and safety planning (Lee & Olender, 1992; Righthand & Welch, 2001).

WOMEN'S PRISONS

History

The first all-female reformatory opened in Indiana in 1873, and operated with the stated goal of turning the women into "good housewives" (Belknap, 2010; Sharp, 2003). Although the modern justice system holds less sexist and more contemporary goals for incarcerating women, it also has experienced a steady growth in prisons for women: by 1990 the United States had 71 female-only facilities, and by 1995 that number had jumped to 104 (Sharp, 2003). Not surprisingly, the growth of dedicated prisons for women has been accompanied by an explosion in incarceration rates for women. Specifically, the incarceration rate for men in 2008 was about eight times the

rate it was in 1970, whereas women's incarceration rate in 2008 was twenty times what it was in 1970 (Sabol, West, & Cooper, 2009). Even with this increase in imprisoned females, incarceration rates for males in the United States, at the end of 2009, were still fourteen times that of females, at 949 per 100,000 compared to 67 per 100,000, respectively (West, Sabol, & Greenman, 2010). Nonetheless, in 2009, nearly 113,500 women were incarcerated in state or federal correctional facilities in the United States, representing an annual average increase of 2.6 percent in the female incarceration rate over the decade (West et al., 2010). Data also indicate substantial disparity in incarceration rates within the female offender population, with 1 in 703 black females imprisoned, compared to one in 1,356 Hispanic females, and 1 in 1,987 white females (West et al., 2010).

Philosophy

The vast majority of offenses committed by women are either property related or other nonviolent offenses. In this respect, females are not generally considered a threat to public safety and thus do not require high-level prison security (Moloney, van den Bergh, & Moller, 2009). Many criminal justice professionals agree that "few women pose a risk to public safety and should be supervised in the community, which is less costly and more effective" (Reichert, Adams, & Bostwick, 2010, p. v). Despite their generally less serious offense profiles, and relatively limited risk to public safety, it remains that a certain population of female offenders will require incarceration. The purpose of incarceration is not only incapacitation, retribution, punishment, and deterrence but also rehabilitation. To achieve rehabilitation, prison programs must provide offenders meaningful opportunities for personal development, skill enhancement, and reintegration support. Most prison programs, however, are based on the needs of male offenders, and they lack the necessary supports and services specific to the needs of female offenders in terms of physical and mental health, relational and vocational skill development, and family/social reintegration (Bartels & Gaffney, 2011). In seeking to develop a gender-responsive justice system, "risk classification and sentencing policies and practices [also] should systematically consider public safety risks, individual assets to family and community, and health and human service needs to determine a proper criminal sentence" (Reichert et al., 2010, p. v). In other words, classification systems for determining dispositions and placements for female offenders need to be different than those used with male offenders.

Although prison programming for female offenders has, by and large, traditionally mirrored what is offered for males, the United States and other industrialized countries have made progress toward designing and implementing gender-specific prisons and correctional programs. Modern prisons are increasingly responsive to the unique stressors and needs of female offenders, which often include demands associated with pregnancy, birth, and childrearing; broad disadvantages related to poverty and less access to resources; higher relational needs; and susceptibility to victimization and exploitation within correctional facilities. Substance abuse in this population also is prevalent with an estimated 40–60 percent of female inmates in federal or state prisons dependent on or abusing drugs at time of incarceration—a risk factor strongly associated with the likelihood of recidivism (Mumola & Karberg, 2006; Tripodi,

Bledsoe, Kim, & Bender, 2011). Further, female offenders often have substantial trauma histories (Moloney et al., 2009). For example, compared to community samples, incarcerated women were more likely to report a history of childhood sexual or physical abuse (Zlotnick, 1997), with 50–90 percent of incarcerated women—depending on the data collection method—reporting a history of lifetime sexual and/or physical abuse (Zust, 2009). For mental health professionals working with these populations, it is important to note that direct violence experienced by an individual has the strongest association with post-traumatic stress disorder (PTSD) symptoms (i.e., avoidance, reexperiencing, and hypervigilance; American Psychiatric Association, 2000). Furthermore, the pathways by which these symptoms develop appear to be different for women than for men (Komarovskaya, Loper, Warren, & Jackson, 2011). This constellation of gender-specific needs and stressors, coupled with an improved understanding of associated developmental impacts, is shaping the preferred design, treatment, and programming of modern prisons for female offenders.

Design, Treatment, and Programming

Researchers such as Ellis, McFadden, and Colaric (2008) note that simply separating female offenders from male offenders is not the same as comprehensive gender-specific programming. Rather, "gender-specific programming reinforces 'femaleness' as a positive identity with inherent strengths" (Ellis et al., 2008, p. 202). The literature on female offenders has become more consistent over the last decade about recommended practice for designing prisons and prison programs for women. Recommended programs often include components to meet women's varied and complex needs, by focusing on issues that include housing, parenting, relationships, trauma recovery, financial management, independent living, legal advice, physical and mental health issues, drug and alcohol counseling, and reintegration into the community (i.e., network development within the local community; Bartels & Gaffney, 2011).

Facility design is a critical component in designing gender-responsive programs. Several countries, including Australia and the United States, have proposed minimum standards of good architectural practice in designing prisons for female offenders. Consistent recommendations include the use of cottage-style accommodations that are mother and child friendly (e.g., indoor play areas or outside playgrounds) and incorporate features associated with well-being such as natural light, space, privacy, and access to the outdoors with such greenery as grass and trees (Bartels & Gaffney, 2011). Within these well-designed facilities, recommended practice includes employing female, senior staff in key positions and ensuring that both female and male staff receive special training in the areas of the unique needs of female prisoners, gender sensitivity, sexual misconduct, and discrimination issues (United Nations Office on Drugs and Crime, 2008). Further, prison officials should recognize women's greater concern with interpersonal relationships and expression of emotions and work to ensure that all staff are skilled in active listening, possess the patience to thoroughly explain rules and expectations, demonstrate awareness of emotional and relational dynamics, and have the capacity to respond firmly, fairly, and consistently when working with female offenders (Ellis et al., 2008).

Gender-responsive prison programs also should include procedures and protocols specific to the health needs of females. Management of physical and mental health in women's prisons includes relevant and timely health screening (e.g., breast exams), ensuring that the nutritional needs of pregnant and lactating women are met, providing health promotion programs (e.g., smoking cessation), health education, and support for transitioning to community health care upon release (Bartels & Gaffney, 2011; Clarke et al., 2006). As part of these targeted and timely health management practices, it is critical that officials develop comprehensive policies relating to women's obstetric care, pregnancy, childbirth, miscarriage, breastfeeding, and child care (Bartels & Gaffney). Even with well-designed gender-specific programs, health care continues to be a challenging correctional issue, and female offenders remain a vulnerable population with complex medical needs that can tax correctional care systems (Buell, 2009). For example, Clarke et al. (2006) found that nearly one-half of women in correctional institutions had a sexually transmitted diseases, and over 80 percent of pregnancies in this population were unplanned as a result of inconsistent use of birth control and multiple partners.

Perhaps the most vexing issues facing prison professionals working with female offenders are pregnancy, birth, and childrearing. Although the developmental literature emphasizes the importance of bonding and attachment between mother and child, promoting such bonding within a prison presents complex logistical and ethical issues. For example, is the well-being of the child—in terms of bonding and attachment—best served while living within the limited freedom and highly structured environment of a prison? In contrast, do the mental and physical hardships on the mother and child, resulting from separation, provide a core rationale to allow childrearing within prisons? Considering that the mother is the most common, primary caregiver, some professionals argue that if the child can remain safely with the mother—at least during the early phases of development—then programs should allow and encourage such arrangements. The practicalities of prison life, however, can make childrearing within facilities extremely difficult to accomplish safely and effectively. Accordingly, informed gender-specific prison programs often seek to find a middle ground around mother-child contact—such as allowing an initial bonding period after birth or during infanthood followed by opportunities for extended visits and routine contact with outside caregivers as the child matures.

Guidelines for developmentally appropriate and gender-responsive programs for mothers in prison, and their children, include the *Children of Prisoners: Draft Framework for Decision Making to Take Account of the Best Interests of the Child* (Mason-White, 2010). In particular, positive developments in Denmark, Germany, New Zealand, Northern Ireland, and Spain are noted in these guidelines, and the following requirements for effective parent-child programs are discussed: relationship building through visitation classes; strong communication ties with children; regular child contact; peer support from other inmates in similar situations; collaboration with the primary caregiver; and the commitment and cooperation of corrections staff. Innovative measures to promote women's relationships with their nonresident family, for example, include policies and procedures that enable teleconferencing, Skyping™, mother-child reading programs; the option for nonresident children to stay with their mothers for extended periods such as weekends and school holidays; and the provision of child care for women with resident children to enable them to undertake edu-

cation, employment, and treatment programs (Bartels & Gaffney, 2011).

Similar to these recommendations, the U.S. National Institute of Correction (NIC), in the document *Gender-Responsive Strategies: Research, Practice and Guiding Principles for Women Offenders* (Bloom, Owen, Covington, & Raeder, 2002) set forth key principles for creating a gender-responsive corrections system. Those principles include acknowledging that gender "makes a difference"; developing policies, practices, and programs that are relational focused and that promote healthy connections between children, family, significant others, and the community; providing women with opportunities to improve their socioeconomic conditions; and establishing a system of community supervision and reentry, with comprehensive, coordinated, and collaborative services. According to the National Institute of Corrections (2002), "investments in gender-responsive policy and procedures [will likely produce] long-term dividends for the criminal justice system and the community, as well as for women offenders and their families" (p. 4).

As McCampell (2005) notes, acknowledging that gender makes a difference allows administrators to reevaluate policies and procedures with the goal of improving the entire prison's operation by more effectively managing female inmates. Informing this gender-responsive approach, Richie (2009) compiled a report based on qualitative data related to incarcerated women's reentry experiences, to enhance the knowledge and understanding of gender-related issues in the field of criminology and criminal justice. Through analysis of firsthand accounts, a review of the relevant literature, and an evaluation of gender-related and culturally specific issues, a need was determined for the following: a greater number of programs/avenues to assist women exiting prison in gaining access to safe, secure, and affordable housing; greater access to child advocacy and family reunification groups/services; increased access to educational institutions and meaningful employment; and effective programs to address mental health issues, general health, substance abuse and stress management. Similar research suggests that former female prisoners stress the importance of family support upon release, a supportive network that includes a positive relationship with their supervising parole officer, and post-release services such as assistance with employment and housing (Cobbina, 2010).

Evidence-Based Practice

Although improvements have been made in developing gender-specific prison programs that reflect current understanding of gender differences in a broad sense, limited research has been conducted on this population in terms of generating robust evidence-based practice and outcome assessments. One of the few studies specific to this population found that substance abuse treatment programs are a promising approach both to reducing recidivism and to improving women's well-being (Tripodi et al., 2011). Evidence suggests that *Seeking Safety*, a cognitive-behavioral treatment for trauma and substance abuse, is an effective intervention with incarcerated females (Substance Abuse and Mental Health Administration, 2006). Further, to reduce depression—a risk factor associated with recidivism in women—cognitive-behavioral therapy has received support (Zust, 2009). Additional research that directly examines interventions with this population, in all domains of design and treatment, is clearly necessary.

A critical consideration for practice in any correctional system—but perhaps particularly in working with female offenders, given their high prevalence of adverse experiences—is the need for trauma-informed systems of care. Exposure to trauma and its subsequent impact on humans is a substantial public health concern. Trauma-informed systems of care recognize the biological, psychological, and social impacts that trauma—particularly complex trauma—has on individuals (e.g., see Buffington, Dierkhising, & Marsh, 2010). For example, trauma-informed systems actively adjust practice to reduce the potential for traumatic reminders. Further, these systems are sensitive to the complexities underlying both avoidance behaviors and hypervigilance that can accompany traumatic exposures that are often misinterpreted as antisocial or disruptive behaviors which, in context, served a necessary function for the individual. Accordingly, screening and assessment protocols that move beyond behavioral observation are critical for limiting misdiagnosis and ensuring proper matching of therapeutic interventions.

The preferred approaches in working with trauma are the cognitive-behavioral therapies. These require specialized training in helping clients develop a trauma narrative, develop self-soothing skills, and optimize coping strategies that encourage reconnection to important social support networks (see, e.g., Kaplan & Sadock, 1996). Developing these systems of care not only sets the foundation for better outcomes for female offenders but represents both a notable step forward in understanding the complexities of human behavior and experience and the most compassionate approach to helping vulnerable people in physical and mental pain.

MILITARY DETENTION CENTERS

History

Established by Congress in 1873, and placed into operation in 1875, three renovated stone warehouses became the first U.S. military detention facility, which was also the first U.S. penitentiary under federal control (Schmitt, 2003; U.S. Army Combined Arms Center, 2008). Later named the U.S. Disciplinary Barracks, and nicknamed "the castle," that facility, and its operational philosophy, were the beginnings of a tradition in military corrections aimed at rehabilitating "errant soldiers" (Brodsky & Eggleston, 1970, p. 23). In contrast to the punitive orientation of state and local prisons of the time, which permitted flogging, branding, and meals of bread and water, the U.S. Disciplinary Barracks instituted the first correctee vocational training program, whereby correctees were employed in making shoes, boots, and other leather goods (Haasenritter, 2008). From its onset, the U.S. military correctional system recognized that confinement is its own punishment, and that the correctional system has a responsibility to aid correctees in becoming responsible, self-sufficient members of society (Leeson, 1997; Purcell & Peck, 2008).

In 1968, at a location known as the Army Correctional Training Facility, the United States correctional system instituted what was been described as the first "boot camp" or "shock incarceration" correctional program (Haasenritter, 2008). Although such programming was both short-lived and therapeutically misguided, its primary mission remains at the heart of military corrections: to return military correctees to duty or civilian life (unless precluded by a life sentence), to improve their vocational prospects,

and to enhance both their social support and their coping strategies through training and treatment. Such programming has evolved to include a specialized facility for women and specialized treatment programs for sex offenders (Haasenritter, 2008).

From its modest beginning with the 200-inmate capacity "castle," the U.S. military correctional system has grown to include sixty-four facilities, in a three-tiered system (Haasenritter, 2008; Schmitt, 2003). Level-one confinement facilities, typically, are used for both pretrial and short-term posttrial confinement of ninety days or less (Department of the Army, 2006). If necessary, these facilities may house correctees for up to one year, and they offer administrative support and limited counseling services for military correctees. Level-two facilities, referred to as "regional corrections facilities" (RCFs), or (in naval parlance) "brigs," can also provide local pretrial confinement, in addition to the following:

> Multifaceted correctional treatment programs, vocational and military training, administrative support, basic educational opportunity, employment, selected mental health programs, custodial control, and training to prepare military correctees for return to duty, if determined suitable, or to civilian society as a productive citizen. (Department of the Army, 2006, § 2-2.b; Haasenritter, 2003)

Level three is comprised of only one facility, the only maximum security facility in the Department of Defense: the U.S. Disciplinary Barracks (USDB) at Ft. Leavenworth, Kansas (U.S. Army Combined Arms Center, 2008). However, this facility no longer resembles the three stone warehouses of its predecessor. In 2002, the 127-year-old "castle" was retired. Less than two miles from the previous site, the new USDB was placed in service. A "state-of-the-art" 515-bed facility, in 1988, it was the first U.S. military detention center to earn accreditation from the American Correctional Association (ACA). It has been continuously accredited ever since by meeting, or exceeding, more than 500 standards that cover administration, management, training, physical infrastructure, institutional services, and correctee programs (U.S. Army Combined Arms Center, 2008). This facility is intended for long-term incarceration of military personnel of all services, and is the only Army Correctional System (ACS) facility authorized to permanently incarcerate death-sentenced correctees (Department of the Army, 2006). In addition to long-term confinement, the USDB is committed to providing rehabilitative services similar, in both kind and degree, to its level-two counterparts (Schmitt, 2003; U.S. Army Combined Arms Center, 2008).

As military correctional facilities have undergone change, so too have the types of crimes most often charged to military personnel. Military personnel are subject both to civilian law and to the Uniform Code of Military Justice, which—in accord with the NATO Status of Forces Agreement—gives the military jurisdiction over military personnel for the vast majority of criminal offenses (Jackson, 2008). Until the 1970s, most military correctees were convicted of alcohol-related and/or military-specific offenses such as desertion or disobedience. However, in the 1970s, an increasing trend in the prevalence of violent offenses began. Presently, the majority of offenses by service personnel are either drug-related or crimes against persons (e.g., assault) (Haasenritter, 2008). Additionally, U.S. confinement facilities have expanded to detain

foreign and nonmilitary personnel, including those accused of terrorism (Department of the Army, 2006). This section of the chapter, intended to address treatment programming for the majority of personnel detained in U.S. military facilities, will not address nascent programs of so-called terrorist deradicalization. Instead, this section focuses the remainder of its discussion on the correctional philosophy, treatment programming, and evidence-based practices intended to serve those who served their nation: U.S. military personnel.

Philosophy

The Department of Defense is explicit that the "overriding purpose of correctional custody is correction, not punishment" (Department of the Army, 2006, § 15-5). Consequently, harassment, unauthorized exercises, and demeaning treatment are prohibited (Purcell & Peck, 2008).

The rehabilitative focus of U.S. military corrections is highlighted in the motto of the USDB, which reads "Our Mission, Your Future," and the objectives of the system are codified in Army regulations to:

• Provide a safe and secure environment for the incarceration of military offenders.

• Protect the community from offenders.

• Prepare military correctees for their release whether return to duty or civilian status with the prospect of becoming productive soldiers/citizens by conforming to military or civilian environments (Department of the Army, 2006, § 1-6; U.S. Army Combined Arms Center, 2008).

As part of the operational philosophy of treating military correctees neither as incorrigibles nor as outcasts but as errant soldiers, correctees maintain the full status of soldiers (Department of the Army, 2006). As such, correctees wear the service uniform appropriate to their assigned duties, and they render salutes when appropriate (Department of the Army, 2006). In keeping with its mission to release eligible correctees in ways that optimize their chances of successful reintegration, parole is granted (typically) only if correctees provide satisfactory evidence that they (1) will be engaged in a reputable business, occupation, or educational institution, and (2) have a valid offer for housing. This requirement can be waived if correctees provide "cogent reasons" for such a waiver (Department of the Army, 2006, § 8-13).

Design, Treatment, and Programming

In accord with the philosophy that the purpose of correctional custody is correction rather than punishment, military correctees are afforded mental health programs, employment, education, training, and welfare activities (Department of the Army, 2006). However, correctees may be precluded from such activities due to medical, disciplinary, or other reasons deemed appropriate by the facility commander (Department of the Army, 2006). Additionally, activities afforded to correctees are not to be either less arduous or more generous than those for nonincarcerated military per-

sonnel (Department of the Army, 2006). Within that spectrum of services, mental health professionals are considered "essential ingredients" who provide ongoing mental health treatment and social work, which includes offense-specific programming such as treatment for substance abuse, violence, and sex offenses (Department of the Army, 2006, § 7-1; Johnston, 2003).

Intake Screening. Within two weeks of their arrival, correctees are screened by mental health professionals (Department of the Army, 2006). Correctees identified for abuse of drugs and/or alcohol are given additional assessments to determine their treatment needs in those domains (Department of the Army, 2006). At anytime, if correctees are identified at risk for suicide, they are placed under continuous observation (Department of the Army, 2006). In cases where correctees' treatment needs are assessed to be beyond those for which the military correctional system can provide, both pretrial and posttrial correctees may be transferred to a civilian, federal correctional facility (Department of the Army, 2006).

Correctee Counseling. Counseling is an integral part of U.S. military corrections, though no right is conferred to correctees regarding participation in given treatment programs (Department of the Army, 2006). When granted, at least, counseling services are available for immediate problem-solving and crisis intervention (Department of the Army, 2006). Additionally, level-two (regional) facilities, and the level-three facility (the USDB), offer—at least—the following services: (1) chemical abuse counseling; (2) anger management counseling; (3) stress management training; (4) adjunct therapy programs (i.e., Alcoholics Anonymous and Narcotics Anonymous); and (5) training regarding the impact of crimes on victims. As mentioned, specialized programs also are available to treat substance abuse, violence, and sex offenses (Department of the Army, 2006; Johnston, 2003).

Correctee Employment. Unless restricted for medical or disciplinary reasons, correctees, typically, are employed forty hours per week on work deemed both constructive and beneficial toward advancing correctees' postrelease employment prospects (Department of the Army, 2006). Such employment can include agriculture, maintenance, or manufacturing of clothing, equipment, or other products used by federal agencies (Department of the Army, 2006). Additionally, correctees may be allowed to participate in work-release programs if doing so is deemed conducive to improving their attitude, motivation, self-discipline, and employment skills (Department of the Army, 2006). Although some work-release programs provide employment on a volunteer basis, correctees may be compensated for their work at the prevailing minimum wage (Department of the Army, 2006).

Vocational Training and Education. Within available resources, all correctees are tested, at the earliest opportunity, to assess their levels of education and mechanical aptitudes (Department of the Army, 2006). Furthermore, correctees are given a brief presentation of the academic and vocational opportunities available to them, and training programs are recommended that are suited to correctees' abilities (Department of the Army, 2006).

Resources permitting, both vocational training and academic courses are available

for correctees (Department of the Army, 2006). Vocational training is intended to improve correctees' postrelease employment prospects and can include both classroom and practical instruction (Department of the Army, 2006). As with work-release programs, correctees may be compensated for work that results from their vocational training (Department of the Army, 2006).

In addition to vocational training, educational programming consists (at least) of the following:

- Communication skills;

- General education;

- Basic academic skills;

- GED preparation;

- Special education;

- Postsecondary education;

- Other education programs, as dictated by the needs of the prison population. (Department of the Army, 2006, § 5-9)

However, postsecondary education is available only if it can be arranged at no cost to the government (Department of the Army, 2006). Correctees, who desire to participate in academic and/or vocational programs, have equal opportunity, regardless of physical, mental, emotional, and/or learning disabilities (Department of the Army, 2006). To ensure that instructional standards are met, every three years the academic programs undergo reassessment (Department of the Army, 2006).

Correctee Welfare Activities. Correctees are afforded both leisure-time activities In addition, library services are offered that include (at least) a reference collection and acquisition of other materials to meet the needs of both correctees and staff (Department of the Army, 2006). Resources permitting, physical recreation facilities must also be made available (Department of the Army, 2006).

Prerelease Program. Prerelease training is intended to prepare correctees for their return either to duty or to civilian life (Department of the Army, 2006). Such training emphasizes both toleration of frustrations and motivation to succeed in their new environments (Department of the Army, 2006). The training also includes practical lessons on topics such as resume preparation, checkbook maintenance, and military benefits (Department of the Army, 2006).

Evidence-Based Practice

Currently, there is scant research regarding U.S. military corrections that would meet generally accepted scientific standards for evidence-based practice (McLearen & Magaletta, 2011). For example, although it is known that cognitive-behavioral therapy (CBT) is employed within all three of the military's specialized facilities for the treatment of sex offenders, to date, there are no published findings regarding the effi-

cacy of this program (Heller, 2008; McLearen & Magaletta, 2011). Additionally, moral reconation therapy (MRT) has been employed in treating military correctees' criminal thinking. However, the single study of this program, with a sample of only thirty-five correctees, reported mixed results (Herndon, 2008).

This is not to suggest that U.S. military corrections do not have standards. To the contrary, many U.S. correctional facilities, including the USDB, are fully accredited by the ACA (U.S. Army Combined Arms Center, 2008). As mentioned, to receive accreditation, facilities must satisfy more than 500 criteria, and several U.S. military correctional facilities have received perfect scores for several continuous audit cycles (Haasenritter, 2008). Nevertheless, such standards represent what might be considered recommended practice, or common practice, but are not necessarily practices that have been subjected to scientific scrutiny.

Although the needs of military correctees do not necessarily differ from those of their nonmilitary counterparts, McLearen and Magaletta (2011) suggest that treatment of traumatic brain injury (TBI) might be an especially pressing need for military correctees who have experienced combat. Therefore, this discussion continues by focusing on evidence-based practices for treating TBI in prison contexts.

Correctees afflicted with TBI may demonstrate its effects through their motor abilities, cognitions, and moods (Department of Health and Human Services, 2007; Magaletta, Diamond, McLearen, & Denney, 2010). Of particular importance in correctional settings is that TBI is linked to increases in correctees' physical aggression and/or threats of violence (Brooks, Campsie, Symington, Beattie, & McKinlay, 1986). Additionally, correctees' impulse control might be diminished as a result of TBI (Young, Justice, & Erdberg, 2004). Furthermore, TBI is linked to mental illness, such that up to 80 percent of those with TBI are afflicted by a mental illness, including especially high rates of anxiety, depression, and psychosis (Hibbard, Uysal, Kepler, Bogdany, & Silver, 1998; Koponen et al., 2002).

Of course, TBI is problematic for anyone affected by it. However, given the emphasis placed on both order and discipline in correctional environments, TBI can be especially problematic for correctees insofar as it impairs their ability to conform to the demands placed on them (McLearen & Magaletta, 2011). McLearen and Magaletta recommend that mental health professionals should manage cases of TBI in at least two ways: at intake, and during interventions. Regarding intake, because those with TBI may appear similar to other correctees, both medical and mental health professionals should work collaboratively in developing procedures to identify cases of TBI (Fowles, 1988; Magaletta et al., 2010). Screening for TBI should be conducted by qualified medical or mental health professionals, who should consider using a validated screening instrument such as the Traumatic Brain Injury Questionnaire (Diamond, Harzke, Magaletta, Cummins, & Frankowski, 2007; McLearen & Magaletta, 2011). Upon diagnosis, if possible, correctees with TBI should be placed in mental health treatment programs specifically tailored to treat it through CBT (McLearen & Magaletta, 2011).

Although unqualified staff should not conduct screenings for TBI, McLearen and Magaletta (2011) consider training, in both the terminology and deficits related to TBI, to be essential for all staff who come in contact with correctees. Such training should include tips for addressing TBI deficits, including recognition of correctees' defiance as a possible indicator of TBI. Furthermore, staff training should emphasize

a collaborative/consultative relationship between custodial staff and mental health staff (McLearen & Magaletta). Considering that most, if not all, facilities within the United States military correctional system are required to conduct a minimum of 40 hours of annual in-service training for its personnel, incorporating training on TBI should not pose an undue burden to the system's operation (Department of the Army, 2006). By properly addressing TBI among U.S. military correctees, all three of the aforementioned overarching goals, stated in Army regulations AR 190-47, will be advanced. Specifically, the correctional environment will be safer and more secure. Eligible correctees will be better prepared for return to duty or civilian status, with the prospect of becoming productive soldiers and citizens, and the community will be better protected (Department of the Army, 2006).

CONCLUSION

Providing timely and effective psychiatric care in secure residential, detention, and correctional settings for special populations presents unique challenges for mental health professionals. Although the safety and security of both staff and offenders in these institutions are of primary importance, opportunities exist within even the most structured settings to develop thoughtful and targeted programming for offenders. Quality programming consistently involves sensitivity to age, gender, and culture; an emphasis on skill development and education; an appreciation for the benefits of social support; awareness of the prevalence of substance abuse, trauma, and mental illness in offender populations; and a commitment to comprehensive reentry planning and development of meaningful support networks in the community. Developing programs that incorporate these components is an important effort to help reduce recidivism, save money, and ultimately minimize human suffering.

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