From David Jones, Ed., Humane Prisons. Oxford: Radcliffe Publishing, 2006.

How to Create Madness in Prison

Terry A. Kupers, M.D., M.S.P.

It's worth pausing for a moment to consider how we created as much madness as exists today in our prisons. Perhaps, after exploring how we arrived at this dreadful state of affairs, we can strive to reverse the process and foster sanity, at the same time developing humane and effective prisons.

In the era of mental asylums, when individuals suffering from serious mental illness were confined in large public psychiatric hospitals, institutional dynamics came under the spotlight. Erving Goffman, Thomas Scheff and other "sociologists of deviance" hypothesized that institutional dynamics had a big part in driving patients to regress into impotent and bizarre aggressive behaviours while clinicians were side-tracked into self-fulfilling biases in diagnostics. ([1] Goffman E ,1962 Scheff T , 1966) An example of their theory: A young man is brought to the asylum by family members who consider him "crazy," he protests loudly that he is not crazy and in fact it is the parents who want him locked up who are actually the crazy ones, the psychiatrist interprets his increasingly loud protests as signs of the very mental illness being ascribed to him, he is involuntarily admitted to the asylum, as he realizes he is being deprived of his freedom his protests become louder and more desperate, the staff take his emotional protests as further evidence confirming the diagnosis of psychosis, he is placed on a locked ward and deprived of most familiar means of expressing himself, he does something irrational such as throwing a chair through a window in order to express his outrage over being deprived of his

freedom, the staff are even more convinced of his "madness" and lock him in an isolation room with no clothes and no pens or writing materials, being even more incensed and more desperate to express himself he smears faeces on the wall of the isolation room and begins to write messages with his finger in the smears on the wall. Of course, Goffman and Scheff were very concerned about the self-fulfilling-prophecy aspect of the staff's diagnostic process, and they warned poignantly that incremental denial of freedom to individuals within "total institutions," whether they actually suffer from a bona fide mental illness or not, leads them inexorably to increasingly irrational and desperate attempts to maintain their dignity and express themselves.

Today, because of recent interconnected historical developments – including de-institutionalization, reduced resources for public mental health services and relatively less sympathy in criminal courts for defendants with psychiatric disabilities - serious mental illness is more likely acted out in prisons than in asylums.(Kupers, 1999) In fact, in the U.S.A., there are more people suffering from serious mental illness in the jails and prisons than there are in psychiatric hospitals. And the bizarre scenarios enacted in correctional settings today can make the "back wards" of 1940's asylums look tame in comparison.

Consider as an example the scenario where the disturbed/disruptive prisoner winds up in some form of punitive segregation, typically in a supermaximum security unit where he remains isolated and idle in his cell nearly 24 hours per day. In the context of near-total isolation and idleness, psychiatric symptoms emerge, even in previously healthy prisoners. For example, a prisoner may feel overwhelmed by a strange sense of anxiety. The walls may seem to be moving in on him (it is stunning how many prisoners in isolated confinement independently report this experience). He may begin to suffer from panic attacks wherein he cannot breathe and he thinks his heart is beating so fast he is going to die. Almost all prisoners in supermaximum security

units tell me that they have trouble focusing on any task, their memory is poor, they have trouble sleeping, they get very anxious, and they fear they will not be able to control their rage. The prisoner may find himself disobeying an order or inexplicably screaming at an officer, when really all he wants is for the officer to stop and interact with him a little longer than it takes for a food tray to be slid through the slot in his cell door. Many prisoners in isolated confinement report it is extremely difficult for them to contain their mounting rage, and they fear losing their temper with an officer and being given a ticket that will result in a longer term in punitive segregation.

Eventually, and often rather quickly, a prisoner's psychiatric condition deteriorates to the point where he inexplicably refuses to return his food tray, cuts himself or pastes paper over the small window in his solid metal cell door, causing security staff to trigger an emergency "take-down" or "cell extraction." In many cases where I have interviewed the prisoner after the extraction, he confides that voices he was hearing at the time commanded him to retain his tray, paper his window or harm himself.

The more vehemently correctional staff insist the disturbed prisoner return a food tray, come out of his cell or remove the paper from the cell door so they can see inside, the more passionately the disturbed prisoner shouts: "You're going to have to come in here and get it (or me)!" The officers go off and assemble an emergency team – several large officers in total body protective gear who, with a plastic shield, are responsible for doing cell extractions of rowdy or recalcitrant prisoners. The emergency team appears at the prisoner's cell door and the coordinator asks gruffly if the prisoner wants to return the food tray, or do they have to come in and get it? While a more rational prisoner would realize he had no chance of withstanding this kind of overwhelming force, the disturbed prisoner puts up his fists in mock boxing battle position and yells "Come on in, if you're tough enough!" The officers barge in all at once, each

being responsible for pushing the prisoner against the wall with the shield or grabbing one of his extremities. The prisoner is bruised and hurt, but when a nurse examines the shackled prisoner and asks about injuries he responds that they hardly scratched him.

This kind of "cell extraction," which occurs in some supermaximum security prisons as often as ten times per week and reminds one of the scenario sociologists of deviance described in 50's asylums, is not the only outbreak of madness within correctional institutions. Officers in facilities of all levels of security tend to yell at prisoners and tend to threaten prisoners with harsh reprisals if they do not obey orders quickly or thoroughly enough. Prisoners in whom anger has mounted because of the extremity of their situation typically respond in an angry tone, perhaps meeting swearing with swearing. Or they mutilate themselves repeatedly, or they smear faeces or throw excrement at staff. With each angry, bizarre act on the part of prisoners, correctional staff become more harsh and punitive, less interested in listening to the prisoners' expressed grievances, less concerned about prisoners' pain and suffering, and more quick to respond to the slightest provocation with overwhelming force.

The recipe for creating madness in our prisons is easy enough to explicate, one merely needs to identify the steps that were taken to reach the current state of affairs. Here is the recipe:

Begin by over-crowding the prisons with unprecedented numbers of drug-users and petty offenders, and make sentences longer across the board.

Dismantle many of the rehabilitation and education programs so prisoners are relatively idle.

Add to the mix a large number of prisoners suffering from serious mental illness.

Obstruct and restrict visiting, thus cutting prisoners off even more from the outside world.

Respond to the enlarging violence and psychosis by segregating a growing proportion of prisoners in isolative settings such as supermaximum security units.

Ignore the many traumas in the pre-incarceration histories of prisoners as well as traumas such as prison rape that take place inside the prisons.

Discount many cases of mental disorder as "malingering."

Label out-of-control prisoners "psychopaths."

Deny the "malingerers" and "psychopaths" mental health treatment and leave them warehoused in cells within supermaximum security units.

Watch the recidivism rate rise and proclaim the rise a reflection of a new breed of incorrigible criminals and "superpredators."

I will briefly discuss these successive steps to madness, starting with the massive prison crowding that began in the 1970's and continued to swell prison populations exponentially until, just after the new millennium, the prison and jail population in the USA climbed to over 2 million - and it keeps on growing. There was convincing research at the time that prison crowding caused increased rates of violence, psychiatric breakdown and suicide in correctional facilities. (Paulus, McCain and Cox , 1978, Thornbury & Call, 1983) One had only to tour a prison to understand how violence and madness were bred by the crowding. Consider the gymnasium that had to be converted to a dormitory with bunks for 200 prisoners. A prisoner cannot move more than a few feet away from a neighbour, and lines form at the pay telephones and the urinals. With tough men crowded into a small space and forced to wait in lines, altercations are practically inevitable.

The next prisoner in line begins to harass the prisoner on the phone, saying he's been on too long, the man on the phone turns and takes a swing at the other, and there's a fight. Of course, open expressions of rage and frequent eruptions of violence tend to push individuals prone to psychiatric breakdown over the edge. Often they become preferred victims of the violence. The more violence, the more madness, and the crowding exacerbates both.

The steady rise of prison crowding since the1980s has been driven by calls for "tougher sentences," especially in the context of a widely proclaimed "War on Drugs." More defendants are put behind bars for longer terms, and a growing number of new laws require incarceration for drug-use, drug-dealing, and a whole list of crimes associated with illegal drugs. (Garland, 2001)

As it turns out, the theory that led to incarcerating more drug-users was entirely foolhardy. Prison is not good for people with a substance-abuse problem. Studies show that those who enter prison with a drug problem will leave prison with the same drug problem. And, with budget cuts, the actual amount of substance abuse treatment in prison has been declining over the past two decades. Prisoners who are not provided intensive substance abuse treatment will not transcend their drug habit while incarcerated, but as many as 60% to 80% of those who complete an intensive drug treatment program in the community will be "clean and sober" after three years.(Mumola, 1997). What sense does it make to "violate" a drug-user's parole and send him or her back to prison because of a "dirty" urine on an unscheduled test? A reasonable alternative to incarceration, a drug treatment program in the community, would require a fraction of the expense to the state, and the diversion of people who commit low-level, drug-related crimes would vastly improve the crowding problem in the prisons. Yet, from the 1980's until the present, the sentences have grown longer, drug treatment programs have been cut, the rate of parole violation has climbed precipitously, and the recidivism rate has been rising.

The next miss-step was the dismantling of rehabilitation and education programs inside the prisons. A turning point occurred with the publication of Robert Martinson's 1974 essay, "What Works? — Questions and Answers About Prison Reform."(Martinson, 1974) Martinson ran some numbers and announced that rehabilitation programs have no positive effect on recidivism rates. This was the research that conservative pundits and politicians had been waiting for, and they made Martinson famous as they legislated a drastic turn from rehabilitation to harsher punishments. The article Martinson published in 1979 qualifying and recanting his rash overgeneralization never received the media attention that had been showered on his earlier castigation of rehabilitation.(Martinson, 1979)

In the 1979 article Martinson confessed there had been serious flaws in his 1974 methodology. He had tried correlating the presence of any kind of rehabilitation program in a prison with the overall recidivism rate, and found no significant correlation. In 1979 he argued that a better method would have been to correlate the availability of specific programs with the recidivism rates of prisoners whose needs were matched by those programs, and that this more nuanced research would clearly show that rehabilitation programs are effective to the extent they are directed at appropriately motivated and capable subpopulations of prisoners. But it was too late. The argument for longer sentences and harsher punishments had already come to dominate the public discussion about crime, and consequently very little notice was given to Martinson's recantation. With calls to "stop coddling" prisoners, prison education programs were slashed, weights were removed from the yards, the quality of prison food declined, prisoners were deprived of materials for arts and crafts, and so forth. Later in 1979, a dismayed Martinson took his own life. (Hallinan, 2001)

With crowding and the dismantling of rehabilitation and education programs, a wrong turn was taken in American penology, a tragic miss-step that has yet to be corrected and is causing irreparable harm. Frank Wood, the former Minnesota Commissioner of Corrections, commented: "When you take away television, when you take away weights, when you take away all forms of recreation, inmates react as normal people would. They become irritable. They become hostile. Hostility breeds violence, and violence breeds fear. And fear is the enemy of rehabilitation."(hallinan, 2001) There was a moment in the mid-1980s, when prison violence was totally out of control, when it would have been possible for corrections departments to admit they had made a mistake and to reverse the crowding while reinstating rehabilitation and education programs. But instead of taking the advice offered by Wood and many other experienced penologists, legislators and correctional administrators decided instead to "lock up" the prisoners they deemed troublemakers ("the worst of the worst"), and proceeded with increasingly shrill demands for absolute control inside the prison walls. The supermaximum security unit was born. Before exploring that development, I will turn to another disastrous miss-step in late twentieth century penology: the incarceration of a growing number of people suffering from serious mental illness.

The Federal Bureau of Prisons estimates that at least 283,000 prisoners have significant emotional problems and are in need of treatment.(Ditton, 1999) Reasons for the expanding prevalence of mental illness in correctional settings include the shortcomings of public mental health systems, the tendency for post-Hinckley (the man who attempted to assassinate President Reagan) criminal courts to give less weight to psychiatric testimony, harsher policies toward drug offenders including those with dual diagnoses (mental illness plus substance abuse), and the

growing tendency for local governments to incarcerate homeless people for a variety of minor crimes.

The fact that a growing proportion of prisoners suffer from serious mental illness has not led to proportional enrichment of the mental health treatment capacities of the prisons. There is a tendency to focus precious mental health resources on those who suffer from an obvious "major mental illness," including Schizophrenia, Bipolar Disorder and severe Depression. While prisoners suffering from these conditions deserve comprehensive mental health services (which they are unlikely to receive, given current budget constraints – their treatment is often limited to cell-confinement with psychiatric medications), other disorders can cause as much suffering and disability, including anxiety, phobia, obsessive-compulsive disorder and post-traumatic stress disorder (PTSD). PTSD is especially important, since we know that prisoners, on average, have suffered from a lifetime of severe traumas, including the domestic violence they witnessed or fell victim to as children, the violence and deaths they saw on the streets and the violence they experienced as adults prior to incarceration.(Kupers, 2005) Then, as convicts, they experience new traumas, including beatings, sexual assaults and time in solitary confinement. Because of inadequacies in correctional mental health programs, oft-traumatized prisoners receive woefully inadequate treatment for PTSD and depression. All of this compounds the problem of crowding, of course, and exacerbates the madness.

Then, added to the mix, there are attempts by departments of corrections to limit and restrict visiting. This can take the form of shortened hours for visiting, requiring family members to wait in long lines to see their loved ones. It can take the form of increasingly intrusive searches, which cause humiliated family members and friends to visit less often. It can take the form of severe restrictions on mail and packages from home. Or it can take the form of punishing

prisoners who violate prison rules with loss of visitation – a practice that clearly violates international human rights standards. These obstacles to visitation, combined with the fact that prisons are usually built far from the big cities where most prisoners' families reside, have the overall effect of decreasing the number and quality of prison visits. Since research clearly demonstrates that prisoners who are able to sustain quality contact with loved ones over the length of a prison term are much more likely than others to succeed at "going straight" after they are released,(Holt, Miller, 1976) these obstacles to quality contact with friends and family tend to increase the general level of madness within the prisons.

Then, in crowded facilities where rehabilitation programs are sparse and prisoners are relatively idle, the worst traumas and abuses are reserved for prisoners suffering from mental illness. It is not difficult to figure out the reasons for this unfortunate dynamic. Consider the prison rapist's options in selecting a potential victim. He wants to choose his victim well, the wrong choice might lead to lethal retaliation. If he rapes a gang member, or even a prisoner with friends, he would be forever vulnerable to deadly retaliation. But if he selects a prisoner with significant mental illness, a loner who would not likely have friends who might retaliate, he is more likely to get away with the rape and avoid retaliation. Thus prisoners with serious mental illness, especially if they are not provided a relatively safe and therapeutic treatment program, are prone to victimization by other prisoners.(Human Rights Watch, 2001) In women's prisons, rape and sexual assaults are more often perpetrated by male staff, but women who have experienced earlier traumas and those suffering from mental illness are likewise singled out for victimization.(Human Rights Watch 1996) And of course the repeated traumas they are forced to endure in prison make prisoners' mental disorders and their prognoses far more dire.

By the 1980's, when the rate of violence was clearly rising precipitously in the prisons and there were too many disruptive prisoners suffering from serious mental illness, the response on the part of the corrections system to the resulting violence and chaos was to vilify the "worst of the worst" among prisoners, the ones presumably responsible for much of the violence, and lock them up in near-total isolation.(King 1999) The supermaximum security prison, where prisoners are almost entirely isolated and idle in their cells just about all of the time, was designed to diminish prison violence. There is ample evidence that long-term cell-confinement with almost no social interactions and no meaningful activities has very destructive psychological effects, including but not limited to worsening mental disorders and extraordinarily high rates of suicide (Grassian, Friedman, 1986, Hodgkin, Cote,1991) And newer research suggests that the turn toward supermaximum/isolated confinement for a growing proportion of prisoners is not reducing the violence inside prisons.(Briggs, Sundt, Castellano, 2003)

Individuals in long-term segregated prison housing tend to develop psychiatric symptoms, if not full-blown decompensation, and they universally report the build-up of uncontrollable rage. Of course, even as departments of correction rely ever more on supermaximum security and other forms of punitive 23-hours-per-day cell confinement, only about six to ten percent of entire prison populations are in segregation at any given time. But a much greater percentage of prisoners spend time in segregation during their prison term, and the presence of harsh segregation units within a prison or prison system has a chilling effect on the entire population.

A disproportionate number of prisoners with serious mental illness wind up in punitive segregation. For some, it is a matter of their mental illness leading to irrational acts and rule violations; for others it is a matter of losing control of their emotions and getting into altercations;

and for others it is a matter of breaking down only after being consigned to segregation for a lengthy period of time. I am often asked whether prisoners with serious mental illness are selectively sent to punitive segregation, or do the harsh conditions of isolation and idleness cause psychiatric decompensation in a vulnerable sub-population of prisoners. Of course, both mechanisms are in play. The result is that whenever I tour a supermaximum security facility in preparation for testimony in class action litigation about harsh conditions of confinement or the adequacy of mental health services, I discover a very large proportion of prisoners confined therein to be exhibiting the signs and symptoms of serious mental illness.

Of course, the presence of prisoners with serious mental illness in supermaximum and other segregation units heightens the noise level and the overall chaos. Prisoners who are not suffering from serious mental illness tell me it is extremely difficult to sleep in a unit where several prisoners with serious mental illness are up all night shouting and crying. And when a prisoner with serious mental illness flings excrement at an officer and the cell extraction team comes on the unit and sprays mace on that disturbed/disruptive individual, the prisoners in neighbouring cells experience the effects of the mace that wafts into their cells even though they have done nothing to provoke an assault by the guards. In other words, the disproportionate placement of prisoners with serious mental illness in supermaximum security units tends to exacerbate the general level of pandemonium.

Then, the same conditions that worsen psychiatric disorders make treatment problematic. Psychotropic medications are not very effective when the patient is confined to a cell. The clinician has little if any opportunity to develop a therapeutic relationship or even educate the patient about the illness and the need for medications, and there are no group therapies nor psychiatric rehabilitation programs. Yet this is precisely the situation in many jails and prisons.

In supermaximum security units the psychiatrist might even be forced to interview prisoners at their cell doors with absolutely no confidentiality.

The failure of prisoners suffering from serious mental illness to respond positively to the minimal mental health treatments available in segregation settings (typically psychiatric medications with cell-confinement) is often blamed on their "badness," or their psychopathy. Alternatively, their exacerbated mental illness and shockingly frequent attempts at self-harm are dismissed as inauthentic or "malingered."

Meanwhile the frustrated staff, who cannot figure out how to improve the situation, suffer massive burn-out and become all the more insensitive to the plight of their wards(Maslach, Leiter, 1997). They find themselves losing control of their tempers and resorting to ever more harsh and punitive measures in a desperate attempt to control an impossible situation. Then, in response to the harshness and seemingly arbitrary and disrespectful actions by security staff, prisoners become more disturbed, more enraged, and capable of even more bizarre actions such as flinging excrement at staff or repeatedly mutilating themselves. The bottom line is that we seem to have reproduced some of the worst aspects of an earlier époque's snake pit mental asylums in the isolation units of our modern prisons.

Is this kind of madness an inevitable aspect of prison life? If that were the case, there would really be little reason to think about what kinds of changes in the way prisons are run might diminish the madness. Or does a significant proportion of the madness arise from miss-management of the prisons? If so, the situation could be improved – i.e., better management would lead to less madness. To the extent correctional and mental health professionals throw up their hands and proclaim that the troublesome prisoners are incorrigible, there is no improving the

situation. The most that can be accomplished is isolation of the trouble-makers – but that really does not solve the problem, because eventually most of them will be released from prison and, without any treatment or rehabilitation, they will pose a huge menace. The next step in this cynical, failed strategy is to change the laws to permit indeterminate civil (psychiatric) hospital commitment following completion of a determinate prison term. That strategy is being pursued in many states today, but the result is that the forensic psychiatric hospitals are becoming crowded and the madness bred of prison miss-management is beginning to infest the mental health facilities.

A better plan would be to admit that mistakes have been made and that corrective action is needed. We need to reverse each step in the recipe I have delineated for creating madness in the prisons. And the process can be reversed. At the risk of appearing overly simplistic, I can offer a very schematic outline of that reversal here:

Crowding can be reversed by effective utilization of diversion programs and re-designing sentencing guidelines. Mental health courts and Drug Courts are requiring treatment in the community as an alternative to incarceration. Many other forms of diversion are possible. The trend toward harsher sentences can be ameliorated in rational ways to provide the kind of community treatment and rehabilitation that is needed by many of the individuals who currently populate our prisons. Of course, to accomplish this huge goal, social policies and priorities need to be re-examined. Homelessness contributes to high incarceration rates, as does unemployment. The social safety net that has been incrementally dismantled for decades needs to be strengthened and glaring social inequities need to be addressed.

Rehabilitation and education programs in the prisons must be re-instated and greatly expanded. It's simply not fair, and not accurate, to cut the programs that might help prisoners "go straight" and then blame the prisoners for their failure to do so without benefit of the needed programs.

Individuals suffering from serious mental illness in the community must be provided not only quality treatment in the public sector, they also need supported housing, help finding work, and so forth. If this plan were effected, far fewer of them would find their way into the jails and prisons. But there will still be prisoners suffering from serious mental illness, and they need quality mental health treatment within penal institutions.

Departments of Correction must support visitation in every way that makes sense. Instead of cutting down on the hours for visits and making visitors submit to humiliating searches, Departments of Correction should set up free transportation for families and encourage conjugal/family visits and even home leave for prisoners who do not pose a significant security risk.

Instead of segregating problematic prisoners in supermaximum security units, a richer collaboration between security and treatment staff is needed wherein the more problematic the prisoner the more creative the staff becomes in effecting a management and treatment strategy tailored to help that prisoner transcend his or her problematic behaviours. Of course, implicit in this notion is the requirement that staff treat prisoners with respect at all times, and take their problems and their pains seriously.(Gilligan, 2001)

A lot of attention needs to be paid to the traumas of a prisoner's life – those that occurred prior to incarceration and those that occur inside prison. Given the omnipresence of trauma in prisoners' lives, education about and treatment for PTSD needs to be readily available. The

harshness of prison life needs to be ameliorated, and more intensive efforts need to be made to prevent sexual assault and other forms of violence in the prisons.

While "malingering" does occur in prison, staff need to understand its roots in the severe deprivations prisoners experience. Before questioning whether a prisoner is really hearing bona fide voices, or is really intent on committing suicide, staff need to ask themselves what has driven the prisoner to the point of contemplating his or her own demise, or what pain is causing him or her to exaggerate symptoms. In other words, to the extent malingering is an issue, it is a symptom that requires attention.

Attention to antisocial personality disorder and psychopathy can be useful in helping shape individualized therapeutic interventions. But to the extent the diagnosis of an "Axis II Disorder" or psychopathy leads clinicians to give up on helping a dysfunctional prisoner, that diagnosis needs to be downplayed while a more effective intervention is sought. In other words, we need to stop blaming the victim's innate "badness" for failed interventions, and we need to try harder.

Mental health treatment services need to be expanded significantly. We must work on finding places other than jails and prisons for individuals suffering from serious mental illness, but in the meanwhile those who find their way into the prisons need to be provided adequate care. They must not be consigned to isolation in punitive segregation units, rather they require comprehensive treatment in settings that maximize their safety and their motivation to comply with treatment.

When recidivism rates rise, and when a growing number of parolees are "violated" and returned to prison, instead of blaming the prisoners for their incorrigibility, we need to interpret the trend as a failure of our prisons to "correct," and we need to seek better ways to manage the

prisons, and better interventions to help prisoners learn what they need to learn in order to succeed as members of the community after they are released.

Of course, what I am outlining here in very abstract terms is what has been tried, and proven effective, for example in the groundbreaking work of Hans Toch with "disturbed/disruptive" prisoners,(Toch, Adams, 2002) and at Grendon Prison in the United Kingdom.(Jones, 2004, Morris 2004) The ingredients of humane prisons must include staff's constantly expressed respect for prisoners and their predicament; constant stress on communication between staff and their wards as well as among staff and among prisoners; skilled interventions by security staff as well as vocational trainers, teachers, and medical and mental health clinicians; and very importantly, a kind of perseverance and resilience that permits staff and prisoners to rebound from the inevitable mishaps and failures along the way to ending the madness and building a truly corrective prison system.

References

Briggs CS, Sundt JL and Castellano TC (2003) The Effect of Supermaximum Security Prisons on Aggregate Levels of Institutional Violence. Criminology, 41, 4, 301-336

Ditton PM (1999) Mental Health and Treatment of Inmates and Probationers. *Bureau of Justice Statistics Special Report.* U.S. Department of Justice, Washington, D.C.

Garland D (2001) The Culture of Control: crime and social order in contemporary society. University of Chicago Press, Chicago.

Gilligan J (2001) *Preventing Violence*. Thames & Hudson, London.

Goffman E (1962) *Asylums: essays on the social situation of mental patients and other inmates.* Aldine, Chicago

Grassian S. & N. Friedman (1986) "Effects of sensory deprivation in psychiatric seclusion and solitary confinement, *International Journal of Law and Psychiatry*, 8, 49-65.

Hallinan J (2001) *Going Up the River: travels in a prison nation*. Random House, New York.

Hodgins S and Cote G (1991) The Mental Health of Penitentiary Inmates in Isolation. *Canadian Journal of Criminology,* 175-182.

Holt N and Miller D (1976) Explorations in Inmate-Family Relationships. Research Report No. 46, California Department of Corrections, Sacramento, California.

Human Rights Watch (1996) All Too Familiar: sexual abuse of women in U.S. state prisons. Human Rights Watch, New York.

Human Rights Watch (2001) No Escape: male rape in U.S. prisons. Human Rights Watch, New York.

Jones, D (Ed.) (2004) *Working with Dangerous People*. Radcliffe Medical Press: Oxford.

(King, 1999).

Kupers T (1999) *Prison Madness: the mental health crisis behind bars and what we must do about it.* Jossey-Bass/Wiley, San Francisco.

Kupers T (2005) Posttraumatic Stress Disorder (PTSD) in Prisoners, in *Managing Special Populations in Jails and Prisons,* (ed. Stan Stojkovic) Civic Research Institute, Kingston, New Jersey

Martinson R (1974) What Works?: questions and answers about prison reform. *Public Interest*, 3, 5, 22-54.

Martinson R (1979) New Findings, New Views: a note of caution regarding sentencing reform. *Hofstra Law Review*, 7,2,243-258.

Maslach C and Leiter MP (1997) *The Truth About Burnout: how organizations cause personal stress and what to do about it.* Jossey-Bass, San Francisco.

Morris M (2004) *Dangerous and Severe – Process, Programme and Person: Grendon's work.* Jessica Kingsley, London.

Mumola C (1997) Substance Abuse and Treatment, State and Federal Prisoners, 1997. Bureau of Justice Statistics Special Report, U. S. Department of Justice, NCJ 172871, Washington, D.C.

Paulus PB, McCain G and Cox VC (1978) Death Rates, Psychiatric Commitments, Blood Pressure, and Perceived Crowding as a Function of Institutional Crowding. *Environmental Psychology and Nonverbal Behavior*, 3, 107-117.

Scheff T (1966) *Being Mentally Ill.* Aldine, Chicago

Thornberry T and Call J (1983) Constitutional Challenges to Prison Overcrowding: the scientific evidence of harmful effects. *Hastings Law Journal*, 35, 313-353.

Toch H and Adams K (2002) *Acting Out: maladaptive behavior in confinement.* American Psychological Association, Washington, D.C.