The book is divided into four sections plus a foreword by Gary Schoener, MEq, an introduction, appendices, and a short index. Part One describes the nature and scope of the problem; Part Two examines reporting, fallout, and recovery; Part Three addresses rehabilitation; and Part Four reviews prevention. As a group, the appendices are labeled Empirical Research: Appendix A is titled "Personal and Interpersonal Characteristics of Transgressors"; and Appendix B describes "A Rorschach Investigation," involving testing of sexual boundary transgressors.

At the outset, the author identifies several goals for this work: to dispel myths, to acknowledge the potential universality of loving gone awry, to move away from the excessively punitive view toward perpetrators on the basis of "this couldn't happen to me," to explore the possibilities for rehabilitation of the largest group of perpetrators (nonpsychopathic male therapists in crisis), and to limn the steps needed to promote openness and safety in the therapeutic arena.

The primarily empirical chapters in Part One provide a sweeping and detailed review of the relevant literature on the topic from a variety of viewpoints. This review coalesces in a composite case study of a typical violation by a middle-aged male therapist in a state of personal isolation who becomes involved with a female patient. An extensive description of his treatment is detailed in a later chapter. Other content includes a highly useful discussion of the precursors to misconduct and the facilitating conditions and personality dynamics in the therapist and patient. Subsequent chapters provide sophisticated analyses of the multiple factors in the patient and therapist that lead to misconduct, including a discussion of supervisor-supervisee relationships and misconduct by clergy. These later chapters are the most valuable in providing clinical insights.

Part Two addresses conflicts about reporting offenses, including institutional responses and collateral damage to the families of perpetrators, victims, and the professional groups to which abusers belong. Here, as elsewhere, the central strength of Celenza's approach is her persistent (and very welcome) refusal to adopt a simplistic view of what is inescapably a complex subject, with multiple intersecting dynamics, as well as internal and external forces acting on the perpetrators and victims.

Part Three addresses what is arguably the essence of this book: the rehabilitation (when possible) of perpetrators. The author explores several topics, including therapy and monitoring or supervision of the transgressor (the latter with sample reports), prevention, reasonable therapeutic responsivity, countertransference factors, and the "Boundary Violations Vulnerability Index." The index is an assessment instrument (at present, not a validated questionnaire) designed by the author for practitioners to use to determine their own vulnerability.

This is a very valuable book for therapists of all disciplines, as well as forensic mental health professionals. Its greatest strength is the author's extremely refreshing and unusual openness to multiple viewpoints about the significance of the diverse attitudes and actions, motivations, dynamic forces, and proclivities of all players in the drama. Moreover, few works in this field pay as close attention to the psychology of perpetrators in the service of identifying the rehabilitatable ones and returning them to safe practice. This book is highly recommended.

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Disclosures of financial or other potential conflicts of interest: None.

Psychiatry in Prisons: A Comprehensive Handbook

By Simon Wilson and Ian Cumming. Philadelphia and London: Jessica Kingsley, 2010. 318 pp. $55.95 (paperback).

Handbook of Correctional Mental Health

Charles Scott (editor). Washington, DC: American Psychiatric Publishing, 2010. 626 pp. $82.00 (paperback).

Manual of Forms and Guidelines for Correctional Mental Health

Amanda Ruiz, Joel Dvoskin, Charles Scott, Jeffrey Metzner (editors). Washington, DC: American Psychiatric Publishing, 2010. 256 pp. $115.00.

Textbooks on correctional mental health were published on both sides of the Atlantic in 2010.

Psychiatry in Prisons: *A Comprehensive Handbook* is erudite, contentious, and thought-provoking. It contains a unique chapter on the languages of prisons. The authors assume a good deal of knowledge about the way U.K. prisons, in particular, run. For those who lack this knowledge, the *Handbook of Correctional Mental Health* will be a better place to start. It covers more than the title suggests, providing, among other things, authoritative treatments of the purposes of punishment and the alternatives to incarceration. *Psychiatry in Prisons* has two chapters on practice outside the U.K.; *Correctional Mental Health* has none that addresses the world outside the United States. This domestic focus is understandable: many of the important determinants of prison health care, including the availability of resources and skilled staff, differ from place to place. But I would have welcomed more discussion of the differences in national approach that these books describe.

In the past 40 years, forensic psychiatry in the United States has increased its involvement with prison mental health. Since 1969, all accredited forensic psychiatry training programs have provided their trainees with experience in treating people involved in the criminal justice system. In *Correctional Mental Health*, Kenneth Appelbaum points out also that many provide the experience through training programs that are based in correctional institutions.

Historical accounts of U.K. forensic psychiatry trace its involvement in correctional mental health to the birth of the subspecialty. Until the end of the 18th century, U.K. prisons were inhabited largely by people awaiting legally authorized beatings, capital punishment, or deportation, sometimes in combination. Long-term imprisonment became necessary only when forcible transport of prisoners to the American colonies ceased to be an option, and such sentences became commonplace only with the passing of the Penitentiary Act of 1779. Even then, temporary solutions, including Australia and the "hulks" on the Thames, were heavily utilized until the first state prison in England opened in Millbank, London, in 1821.

By this time, the special needs of the mentally ill in prisons had been recognized with the establishment of the Prison Medical Service in 1774, and the passing in the same year of the Health of Prisoners Act, requiring an experienced surgeon or apothecary in each local jail. Provision to admit offender patients to the new county asylums was made in 1808, and the Insane Prisoners Act of 1840 facilitated their transfer to the hospital (although Wilson and Cumming point out that this had also occurred earlier, by other mechanisms).

Broadmoor, the first high-security hospital serving England and Wales, opened in 1863, although, in a move that seems to have anticipated the present ambivalence of mental health services toward mentally disordered offenders, it was closed to insane convicts for some years because they were seen as too troublesome. The Prison Medical Service and the high-security hospitals both have claims to be the birthplace of forensic psychiatry in the United Kingdom.[1] Either way, concern over the mental health of prisoners seems to have been central to the inception of the subspecialty. Given the history they describe, there is an irony to Wilson and Cumming's reflection that prison psychiatry is now effectively a subspecialty of its own.

Prison is a hard place in which to be mentally ill. *Correctional Mental Health* points to people with schizophrenia and mental retardation, in particular, as being vulnerable to abuse and neglect because they fail to understand prison culture and prison rules. Services can focus either on treating their patients in prison or on transferring them out. *Correctional Mental Health* concentrates on the second of these. One assumes this emphasis reflects the experience of the chapters' authors and current practice. I would have welcomed discussion of why the United States differs in this regard from other countries. Some obvious explanations, including a lack of cooperation between state-based departments of correction and mental health and the absence of the necessary statutory provision, seem to beg the question.

Psychiatry in Prisons describes the Foucaultian justification for concentrating instead on providing treatment in prison. Society's wish to exclude and reform "the other" leads to the exclusion of all forms of deviance. By this analysis, any attempt to "screen out" the mentally ill is bound to fail. As both books suggest, there are more prosaic explanations also for the high prevalence of mental disorder in custodial settings, some of which lend themselves more easily to remedy. Prisons select from the general population some people whose

crimes are directly or indirectly a consequence of their psychiatric diagnosis. Other people become symptomatic only when in prison environments, or their symptoms are worse there.

For these reasons, Wilson and Cumming argue, however energetically assessments are implemented and transfers to hospital effected, prisons will continue to require substantial psychiatric input. The scale of the challenge also makes screening out mentally disordered people a questionable notion, even when there are beds for them to go to. A prison with a population of 1,000 sees several times that number pass through its gates in a year, and an inmate's contact with services can be brief and unpredictable.

Both books describe the high-risk nature of prison populations. Seventy percent of U.K. prisoners have a substance abuse problem on being taken into custody, and only 20 percent of these will have received any treatment before they get there. Only 20 percent of the prisoners have writing skills higher than those of an 11-year-old. The prison suicide rate is five times higher among males, 18 times higher among young males, than that of the general population. Follow-through is crucial but difficult. Despite resettlement efforts, many released prisoners face the settlement difficulties of homelessness, unemployment, and poverty. Only 50 percent of released prisoners have a general practitioner.

The scale of the United States makes the equivalent numbers there even more striking. Something over 2 million people are presently incarcerated. The prevalence rates for psychotic disorders reported here are surprisingly inconsistent, varying between 1.5 and 11.5 percent. Even if the true rate is at the lower end of the range of estimates, however, there are tens of thousands of people with psychotic symptoms who are incarcerated in the U.S.

Despite the obvious advantages of knowing where one's patients are, prison is a difficult place for the clinician to deliver care. Knowing where one's patient is does not necessarily mean one can get to see him. *Psychiatry in Prisons* points out that the prison health care center, the nearest thing to a prison inpatient unit in the U.K., often contains people with physical illnesses in addition to those with psychological conditions. Their focus is often on containing risk, rather than improving health, and the units may not be staffed for 24 hours. Limits on resources distort clinical decision-making. Wilson and Cummings point out that treating mentally ill prisoners can deny them admission to the hospital; as their symptoms remit, they are removed from the waiting list.

Many of the difficulties overlap unhelpfully: pre-sentence prisoners, with their higher rates of psychosis, are turned over more rapidly than those who have been sentenced. Delay in transferring people to U.K. hospitals was once blamed on the limited number of beds in secure psychiatric facilities. *Psychiatry in Prisons* points out that it may have more complicated, and less tractable, causes. Despite a recent substantial increase in secure hospital places, 42 percent of prisoners being transferred to hospitals in England wait more than three months to get there.

Both books are strong in describing how good care can be provided. *Correctional Mental Health*'s coverage of malingering seemed particularly sensible, to me. A well-written section on suicide prevention is skeptical about the role of screening, a view seemingly at odds with those expressed in other chapters. I would have liked to see the differences explored in more detail. Screening has the potential to save money, yet the advantages of focusing resources have to be weighed against the consequences of reducing the services received by those who are "screened out." The key to good care probably lies not only in knowing best practice but also in ensuring that that practice is supported in an often unsympathetic environment. A particular strength of *Psychiatry in Prisons* is that the content of its chapters seems consistently to be informed by the experience of the authors in managing psychiatric services in custodial settings.

More broadly, one of the themes of *Psychiatry in Prisons* is that imprisonment should be seen as an opportunity to get treatment to a hard to reach population. The editors have some suggestions. Case identification could focus on areas where mental ill health is particularly prevalent, such as disciplinary infractions. Instead of the present, "emergency-only" rule, compulsory treatment could be made possible in prison using the broader criteria of the U.K.'s Mental Health Acts. Conclusions such as these raise an obvious question. By what standard should prison mental health services be judged?

The concept of equivalence between prison mental health services and mental health services elsewhere appeared in the World Health Organization's Health in Prisons Project,[2] has been advocated by the Council of Europe since the 1990s,[3] and was accepted as a guiding principle by the U.K. Prison Service in 1999.[4] In 2000, it was endorsed by the American Psychiatric Association.[5] As an aspiration it seems beyond reproach. Yet Wilson and Cummings make a good case that such a policy tends to obscure, rather than clarify, two ideas at the core of recent attempts to provide better services to prisoners.

The first of these is a value judgment, that prisoners have the same right to health care as other people. Given the limited progress on both sides of the Atlantic that these books describe, there must be some doubt about how widely this judgment is shared. It probably doesn't matter, however; whatever the desired end-point, the need for improvement seems clear. The second idea is that services to prisoners should be structured in the same way as services to the general population. This notion has fostered the handing over of commissioning of mental health services for prisoners in the United Kingdom to the National Health Service and the development of "Prison In-Reach Teams." This model sees the prison health care center as a short-term inpatient unit, with longer term provision available through transfer to ordinary hospital wards, medium-security psychiatric units or high-security hospitals.

Kenneth Appelbaum's lucid description in *Correctional Mental Health* of the impact of the prison environment on the clinical practice of mental health professionals and on those professionals themselves made me doubt whether assertions that prison mental health services should be "held to a community standard," a claim that appears later in the same volume, can ever be meaningful. The circumstances in prison are so different, the problems of prisoners so heterogeneous, and the challenges to clinicians and administrators at times so extreme that they seem to demand analyses in their own terms. From the perspective of providing good care, prison can seem another country. To pretend otherwise risks prescribing inappropriate solutions.

How might things improve? *Correctional Mental Health* places its faith in the motivational power of litigation, particularly class action litigation, and the consequent court orders, consent decrees, and other legal paraphernalia. A whole chapter is devoted to the topic, and it is the best review I have read. *The Manual of Forms and Guidelines for Correctional Mental Health* is best seen as a companion volume in this respect, providing the documentation that allows court orders to be enforced. It does not contain copyrighted material and thus excludes many of the better recognized and widely used scales.

It seems unarguable that judicial fiat and transparent documentation can have a role in preventing some of the worst care. I am less persuaded that they can promote excellence. Many aspects of good practice, such as contacting informants, obtaining past records, and properly planning discharges seem to depend, in addition to resources, on good training, good management, and a good relationship between prison clinicians and the rest of the mental health community, both academic and clinical. The best practices I see in prison are not the result of someone's filling out a form; but perhaps someone was able to do what he did only because the paperwork reassured him that the ship was not sinking. Making things better is complicated, and each of these texts makes a substantial contribution.

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Disclosures of financial or other potential conflicts of interest: None.