National Institute of Mental Health

SURVEY OF FACILITIES AND PROGRAMS FOR MENTALLY DISORDERED OFFENDERS

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Public Health Service
Alcohol, Drug Abuse and Mental Health Administration

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Foreword

This report is a condensed and edited version of a longer report prepared by Westat, Inc. of Rockville, Maryland, under Contract No. 278–80–0012 (SM) to the then Center for Studies of Crime and Delinquency (now renamed the Antisocial and Violent Behavior Branch) of the National Institute of Mental Health. This report and a companion *Directory of Programs and Facilities for Mentally Disordered Offenders* are products of a nationwide survey of State and Federal facilities that housed and treated mentally disordered persons accused or convicted of crimes. This edited version of the longer report was prepared by Dr. Malcolm Gordon of the staff of the Antisocial and Violent Behavior Branch. This report and the *Directory* were originally prepared in 1983. Because of staffing shortages, the publication of the report and the *Directory* have been delayed. A summary of the findings contained in the survey report entitled *Survey of Facilities and Programs for Mentally Disordered Offenders: Advance Report* was prepared in March of 1984 and distributed to the institutions and administrators who responded to the survey. The *Directory* has been updated as of 1986 and recently published. The *Directory* and the *Advance Report* are available from the Antisocial and Violent Behavior Branch of the National Institute of Mental Health.

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Chapter 1

Background and Scope of the Study

This report and a companion volume, *Directory of Programs and Facilities for Mentally Disordered Offenders*, update and extend information published more than a decade ago that was based on two comprehensive surveys of facilities that house and treat mentally disordered offenders (Scheidemandel and Kanno 1969; Eckerman 1972). This monograph presents information about public facilities that house and treat mentally disordered offenders. Conceptually, as defined by Halleck (1987) and others, the term mentally disordered offenders refers to alleged and convicted offenders whose adjudication or confinement is handled differently from standard criminal justice processes owing to potential or evident mental disorder.

Several legal conditions or statuses subject alleged or convicted criminal offenders with mental disorders to specialized procedures and dispositions that eventually result for most in secure confinement and treatment. These can lead to involuntary confinement in prisons, mental hospitals, or program units within such facilities for treatment of mental disorders. For purposes of this study, therefore, "mentally disordered offenders" include the following:

- Defendants found not guilty by reason of insanity
- Defendants found incompetent to stand trial
- Persons adjudicated under special statutes, e.g., "sexual psychopaths" or "defective delinquents"
- Persons adjudicated guilty but mentally ill
- Convicted offenders who display symptoms of mental illness while serving a sentence, some of whom are transferred to a hospital for treatment of mental illness
- Juveniles who are convicted of or found involved in crimes and are committed for treatment of mental illness
- Defendants being evaluated for competency to stand trial
- Defendants being examined for criminal responsibility

This text reports on a study of the public facilities to which mentally disordered offenders are committed or transferred so that they may be securely confined while participating in programs designed primarily for treatment of their mental disorders. The study's focus is principally on the nature and characteristics of these facilities, their patient populations, staff, security conditions, treatment programs, and administrative or operational problems. It is not focused on the possible relationships between crime and mental illness, nor on the criminal justice or other legal processes per se that lead to confinement in such institutions. Although these latter topics are important and interesting, the present study restricts its focus by intent and design to the institutions and programs in which mentally disordered offenders are confined primarily for treatment.

Previous Studies

In 1969, under the auspices of the Joint Information Service of the American Psychiatric Association and the National Association for Mental Health, Scheidemandel and Kanno made the first effort to obtain a nationwide inventory of the facilities

available to meet the needs of this special group of persons, often dubbed "the mad and the bad." Based on the 1967 *Guide Issue* of the American Hospital Association, a list of facilities given statutory responsibility for such persons, and an identifying questionnaire sent to all State mental hospitals, they compiled a comprehensive list of such facilities. From this list, facilities either admitting fewer than 25 offenders or where offenders comprised less than 5 percent of total admissions during 1967 were eliminated, leaving 167 candidates for their survey. Of these, 14 reported that they no longer admitted mentally disordered offenders. Of the remaining 153 facilities, 131 responded, 98 in usable form, a response rate of 64 percent. Based on these responses, Scheidemandel and Kanno reported statistics on auspices, location, size, admissions policies, and level of security of facilities; the composition of admissions by sex, legal status, diagnosis, and crime type; number, composition, and training of staff; treatment programs; other activities; and cost. Where appropriate, the results of the present national survey are compared with the results of the Scheidemandel and Kanno survey.

At approximately the same time, another survey was independently conducted with support of the National Institute of Mental Health and published by Eckerman (1972). Using a set of directories, screening questionnaires, and inquiries of the relevant State agencies, Eckerman identified 262 candidates for the survey. After eliminating facilities that indicated they lacked a comprehensive, special program for mentally disordered offenders, 73 facilities remained, of which 68, or 93 percent, provided usable responses. Based on these responses, Eckerman published both a directory (National Institute of Mental Health 1972) and a monograph reporting the following information: educational background and time commitment of the program director: security features, activities for patients, and staffing patterns in the facilities; composition of persons admitted by sex and age; capacity, population size, referring institutions, diagnostic classification, and legal status composition; diagnostic and treatment procedures employed; discipline and education level of treatment staff; number of residents receiving various treatments; and suggested improvements in their programs. Where appropriate, Eckerman's results are compared with those of the present survey.

In 1978, an inventory of 48 facilities was compiled by Sheldon and Norman. Although they produced no statistical report, they reported on the following characteristics of each facility: capacity, average population, Joint Committee for the Accreditation of Hospitals (JCAH) accreditation status, primary modes of therapy, staff composition, security measures, room accommodations, and visitation procedures. During 1978 also, Steadman et al. (1982) surveyed a more comprehensive population of facilities—all facilities housing any mentally disordered offenders—in preparation for a study of transfer of such persons between correctional and mental health facilities.

Legal Developments

An update of the 1969 and 1972 surveys is of special interest at this time, in part because of widespread public concern in recent years with the mentally disordered offender. More important, however, the period since the earlier surveys has been one of intense judicial and legislative activity with respect to various classes of mentally disordered offenders.

Under a rubric frequently referred to as the patients' rights movement, a series of Federal court cases has established due process standards providing the right of the institutionalized mentally ill to treatment, limiting the period of confinement for persons found incompetent to stand trial who do not meet standards for civil commitment, establishing the right to refuse certain forms of treatment, setting forth conditions under which insanity acquittees must be released, and establishing the right of a mentally ill inmate to a hearing before transfer to a mental hospital.

More recently, perhaps reflecting a shift in concern from protection of the right of the institutionalized toward the protection of society, court decisions have attempted to limit both the right to treatment and the right to refuse treatment. Statutorily, States have been repealing and modifying laws that created classes such as mentally disordered sex offenders, defective delin-

quents, and psychopaths, thus eliminating special provisions for sentencing flexibility and treatment requirements that do not apply to convicted criminals. Most recently, many State legislatures have been considering and even enacting legislation providing for a verdict of guilty but mentally ill; at least two of the enacting States, Idaho and Montana, simultaneously abolished the insanity defense. With respect to juveniles, the philosophy of extending features of due process from adult courts to juvenile courts has made the issue of competency to stand trial and the insanity defense statutorily available to juveniles in several States. Simultaneously, a number of States have statutorily lowered the minimum age for waiver of juveniles to adult courts for more minor offenses. Together, these developments have raised the possibility of increasing numbers of youths being diverted as mentally disordered offenders by both adult and juvenile courts.

Specific Topics Covered in This Monograph

Statistics based on a new national survey can describe a part of the impact of these legal changes on facilities for mentally disordered offenders. But beyond collecting and tabulating information obtainable through a mail questionnaire, an important part of the present research was to follow up the national survey with detailed telephone interviews documenting more richly the nature of problems presented by these legal changes and concomitant societal, organizational, and fiscal pressures, as well as the nature of solutions adopted by 60 facilities. Finally, 11 facilities representing a diversity of legal and organizational situations and reporting specific attempts to deal with these situations were selected for case studies involving field interviews and observations at the facilities.

Chapter 2 describes the methodology of this research. Recent legal developments concerning the mentally disordered offender form the organizational basis for chapter 3. In addition to including an analysis of the pertinent statutes and case law, this chapter examines the existing literature on the impact of these laws and treatment advances on this special offender population. Because the laws discussed typically define the population that enters a facility, set standards and constraints governing treatment and security procedures, and determine conditions for release, this background is essential to an understanding of day-to-day facility operations.

Chapter 4 reports findings of the national mail survey. Chapter 5 discusses the results of the information obtained from site visits to 11 facilities. These facilities included a mix of auspices, legal statuses served, age range of residents, and localities. The facilities were chosen based on their responses to questions concerning their methods of dealing with certain complex problems or issues. Chapter 6 summarizes conclusions of this study and presents recommendations for further research, information collection, and dissemination.

Chapter 2

Study Methodology

The results reported throughout this monograph arise from work performed under a contract awarded in June 1980 by the National Institute of Mental Health (NIMH) through its Center for Studies of Crime and Delinquency.* Detailed in the request for contract proposals was the center's phased plan for a study of programs and facilities for mentally disordered offenders. The Westat design included the following elements:

- Identification of the population of facilities to be surveyed. This effort also produced the *Directory of Programs and Facilities for Mentally Disordered Offenders*, published under separate cover by NIMH.
- The national survey of facilities. This survey was designed to collect qualitative and quantitative information on facility characteristics including resident demographics and legal status, staffing patterns, security procedures, treatment programs, and legal/management issues.
- Analysis of extant statutory law. This was an indepth analysis of 50 State statutes defining legal status, commitment and prison-to-hospital transfer procedures, rights to receive and refuse treatment, procedures for treating mentally disordered juvenile offenders, and other matters.
- Indepth telephone followup with facility administrators on how legally mandated program changes affect the administration of the facilities.
- Two-day site visits conducted at programs that seemed, on the basis of the earlier stages, to have devised workable solutions to common problems.

Population Identification

Identification of the eligible population of facilities required, first, that the "mentally disordered offender" be defined operationally, and, second, that the entire universe of facilities housing such persons be limited to those likely to operate special programs for this group. A review of State statutes identified 10 categories of mentally disordered offenders, i.e., alleged and convicted offenders for whom questions arise as to their mental condition. These include the following:

- Defendants found not guilty by reason of insanity
- Defendants found incompetent to stand trial
- Persons adjudicated under special statutes, e.g., sexual psychopaths or defective delinquents, that concern the mentally aberrant nature of their criminality
- Persons adjudicated guilty but mentally ill
- Convicted offenders who display symptoms of mental illness while serving a sentence, some of whom are transferred to a security hospital for treatment of mental illness
- Juveniles who are convicted of or found involved in crimes and are committed for treatment of mental illness

*Now the Antisocial and Violent Behavior Branch of the Division of Biometry and Applied Sciences, NIMH.

- Defendants being evaluated for competency to stand trial
- Defendants being evaluated for criminal responsibility
- Defendants who are mentally retarded
- Defendants whose mental illness is attributed solely to substance abuse

For purposes of this study, the first eight categories were included as mentally disordered offenders. Programs solely for substance abusers and the mentally retarded were considered beyond the scope and intent of this study.

As indicated in chapter 1, the four previous surveys of facilities housing these categories used three different sets of inclusion criteria for facilities. Eckerman (1972) included 73 adult facilities of the following types: security hospitals having as a major function comprehensive treatment for one or more types of mentally disordered offenders, mental health units with a separate program performing the same function, and correctional facilities with a psychiatric unit providing comprehensive treatment for mentally ill prisoners. For all three types of facilities, "comprehensive" was defined to include (according to facility report) at least one modality in addition to psychotropic medication, under the direction of "appropriate and qualified mental health personnel." No facility size criteria were employed; however, included facilities were required to be dedicated solely to mentally disordered offenders.

Scheidemandel and Kanno (1969) surveyed 153 adult facilities in the following categories for which 1967 admissions of mentally disordered offenders exceeded either 25 in number or 5 percent of total admissions: public mental hospitals designated as primary institutions for mentally ill offenders; other hospitals reporting treatment of "a number of them regularly;" and State correctional institutions, Federal prison hospital departments, and other facilities treating them regularly. Later, Sheldon and Norman (1978), using the same criteria as Scheidemandel and Kanno, gathered information on 48 facilities.

Most recently, Steadman et al. (1982), attempting to identify all institutions specializing in the care and treatment of adjudicated mentally disordered offenders, located 256 facilities. Of these, 32 were considered "primary," in the sense used by Scheidemandel and Kanno, while 224 were classified as "secondary," i.e., facilities having specialized secure units but serving other types of individuals as well.

As stated by NIMH, the objective of the present study was to survey "all public facilities legally authorized to house mentally disordered adult and juvenile offenders for care and confinement." In addition to those facilities surveyed by Eckerman, this mandate was to include several types of institutions that were important components of the service delivery system by 1980. Examples include satellite centers performing evaluations, treatment, and prerelease preparation for specific catchment areas within such States as New York and Ohio; large mental hospitals operating forensic units but housing and treating some mentally disordered offenders within their general populations; and units in a number of States serving as the primary source of treatment for female mentally disordered offenders but also treating civilly committed persons.

To ensure that these facilities, as well as the more traditional types surveyed by Eckerman, were incorporated, a two-stage process was undertaken: enumeration of all facilities potentially serving a substantial number of mentally disordered offenders, then elimination of those for which this is not the primary population served.

During the period September–December 1980, potentially eligible facilities were identified in each State and the Federal system. Several approaches were used in doing this. First, contact was made with facilities listed in the previously discussed studies by Eckerman, Scheidemandel and Kanno, and Sheldon and Norman. In addition, State mental health directors, regional Alcohol, Drug Abuse, and Mental Health Administration (ADAMHA) directors, State planning agency directors, corrections commissioners, and heads of State juvenile justice agencies were written requesting lists of statewide facilities that provide long-term care to the categories of persons listed. Finally, lists developed by Steadman et al. (1982) for their study of corrections/mental health transfer and by Pappenfort

for his census of residential facilities for children and youth with special needs were used. After all lists were merged, and obvious duplicate listings eliminated, the candidate list contained 518 entries.

These 518 facilities were screened by telephone to verify that they were likely to fall into the desired universe and to eliminate undiscovered duplicate listings. Although most correctional and mental health facilities house one or more individuals in the categories of persons listed, maximum benefit was predicted from concentrating on programs serving enough of such persons to have developed special programs for them. The study was therefore limited to facilities meeting several criteria, as follow:

- The program is public.
- The facility/program provides housing and long-term treatment of the mentally disordered offender. Programs solely for evaluation of competency and/or criminal responsibility are not included.
- Either the facility has a special program for mentally disordered offenders such as a treatment unit, with capacity exceeding four, organized for this purpose, or the facility is the primary place in its geographic catchment area where mentally disordered offenders of one type or another are sent. This criterion was intended to exclude isolation units while including units that are necessarily small because they specialize in treatment of rare categories such as juvenile or female mentally disordered offenders.
- In the case of facilities that do not segregate mentally disordered offenders from other residents, at least 10 percent of the facility residents are mentally disordered offenders. This criterion was intended to exclude the many facilities that occasionally house a few mentally disordered offenders but are unlikely to provide special treatment, while including facilities with special programs for mentally disordered offenders that, due to overcrowding or the design of the treatment program, do not segregate them from other residents. While such facilities were excluded from the Eckerman survey, they comprise an important source of treatment for mentally disordered offenders in several States.

Telephone screening on these criteria eliminated 287 clearly duplicative or ineligible listings, leaving a set of 220 potentially eligible facilities, to which survey questionnaires were mailed in October 1981.

National Survey of Facilities

This section describes the steps—questionnaire construction, pretest administration, data collection, and file preparation—carried out in administration of the national survey. The section concludes with some comments regarding potential respondent errors that may effect the validity of the analysis presented in chapter 4.

Questionnaire Construction

The purpose of the questionnaire was to collect detailed information about the characteristics of each facility and its resident population, staffing levels, program characteristics, administrative activities, and legal/administrative issues of concern. The writing of the questionnaire began with an inventory of data items from the earlier surveys by Eckerman, Scheidemandel and Kanno, and Sheldon and Norman. As these studies did not include juvenile facilities, the *1975 Census of Public Juvenile Detention and Corrections Facilities* (Pappenfort and Young) was also consulted. To this initial inventory, questions were added concerning statutes and court decisions pertinent to the facilities, the desirability and availability of certain statistics, and detailed information on treatment services available. Incorporating all these items, the first draft of the questionnaire contained 13 sections. Three iterations of review and resulting revisions followed before the questionnaire was considered ready for pretest.

In drafting the questionnaire, both open-ended (free-response) and closed questions were employed. Open-ended questions have the advantages of permitting the respondent to define specifically what a complex con-

cept or relationship means to him or her, and to indicate the intensity of feeling concerning an issue—both free of presuggestion by the researcher. These advantages are especially important with respect to such areas of inquiry as the salience and specific nature of impact that a new statute or court decision may have on the operation of a facility. In mail surveys such as this one, however, open-ended questions place relatively heavy demands on respondents, in that such questions require a written response rather than a simple checkmark, number, or circled response code. These demands contribute to respondent error in ways discussed later in this section, and they also discourage responses altogether.

Therefore, in constructing the questionnaire, two principles were followed. First, the use of open-ended questions was limited to complex topics where their advantages were considered crucial. Second, open-ended questions were concentrated in the shorter of two questionnaire sections, to be completed by the facility's clinical director or other administrator familiar with therapeutic and administrative issues. The second section, which made heavier use of closed questions, addressed resident demographics and more easily measurable facility characteristics and procedures.

Pretest Administration

The two-section draft was pretested at five facilities. After each facility reported completing the survey using only the mailed questionnaires and instructions, project staff visited the facility and discussed the instruments with the administrators and staff who had completed them. This followup suggested the rewriting of several questions to improve clarity of the questionnaire and the resulting quality of the data. Following these visits, the questionnaire was finalized and submitted to the Federal Office of Management and Budget for approval.

Data Collection

In trying to achieve the highest response rate possible, letters endorsing the study were sought and received from the National Association of State Mental Health Program Directors, the American Association of Mental Health Professionals in Corrections, and the American Association of Correctional Psychologists. In addition, a letter urging participation was written by the chief of the Center for Studies of Crime and Delinquency, the sponsoring program unit within NIMH. These letters were mailed with the questionnaire, a glossary, an instruction letter, and a postpaid return envelope to 220 facilities in October 1981. In conversations with administrators, 11 additional facilities were determined to be within the scope of the study. Thus, 231 facilities were contacted in all.

Extensive telephone contacts extended the data collection period into March 1982. In part because of this intensive followup, however, the data collection effort netted the following results from the 231 mailed questionnaires:

- 55 ineligible facilities—eliminated by their responses to the first five questionnaire items, which tested the inclusion criteria discussed above
- 10 closed facilities or duplicate listings—either had closed during the period of the study or had duplicate names for the same program and received two instruments
- 38 refusals—some possibly representing ineligible respondents
- 128 completed responses, of which 127 provided usable information on matters beyond the eligibility criteria

Under the conservative assumption that ineligible, closed, and duplicate facilities occurred at the same rate among refusals as among respondents, these results imply a completion rate of 84 percent among eligible facilities.

Because the inclusion criteria for the present study were somewhat broader than those for the 1972 Eckerman study, and because 10 years had elapsed since the Eckerman study, it is not surprising that the new study netted a substantially larger universe of facilities than the 68 surveyed by Eckerman. At least 41 facilities were common to both surveys. Of the 60 addi-

tional facilities in the present survey, 17 were incorporated through expansion of the survey scope to include juvenile facilities. At least 7 of the additions offer comprehensive treatment to mentally disordered offenders but house only some of them in specially designated units. Other additions to the Eckerman population appear through new facilities (at least 8), additional special units of facilities surveyed by Eckerman (at least 5), and other causes such as status as the primary provider of treatment to mentally disordered offenders of some special diagnostic or geographic group.

File Preparation

Following receipt of the instruments, senior project staff scanned them for completeness, reasonableness, and consistency. Because this review raised questions with respect to each completed response, each of the 128 facilities was called at least once with questions on the data supplied.

For each open-ended question, a preliminary coding scheme was developed based on the responses from the first 30 facilities. Following instrument coding, the coded data were checked for accuracy. Wherever a questionable response occurred, the questionnaire was examined and, if necessary, the facility was called for clarification and/or the data were modified.

Care was taken to construct a clear and complete questionnaire, to maximize the response rate subject to time and resource constraints, and to avoid errors during file creation. The reader should be aware, however, of sources of potential error that suggest caution in evaluating the survey findings presented in chapter 4.

First, because not all mailed questionnaires were completed and returned, the possibility of nonresponse bias exists. That is, responding facilities may differ systematically from nonrespondents in ways that affect the statistics presented in chapter 4. While the precise nature of such biases is unknown it can be conjectured that nonrespondents may have considered themselves ineligible at higher rates than respondents, and that facilities failing to participate in the research may be less likely to have ongoing research programs of their own, have smaller administrative staff, or be in the process of litigation or major administrative restructuring.

A second source of potential bias lies in item nonresponse—the failure of a respondent to answer a specific question. Item nonresponse affects open-ended and closed questions somewhat differently. When a respondent fails to answer a closed question, usually either he or she can be excluded from the relevant analysis or the answer can be treated as not ascertained. Item nonresponse rates on the closed questions fortunately were generally less than 2 percent and rarely exceeded 6 percent. Item nonresponse therefore does not appear to be a significant source of bias. The number of respondents is reported for all results in chapter 4 for the reader's information, however.

Item nonresponse presents a different problem with respect to open-ended questions. A nonanswer to an open-ended question (e.g., What changes, if any, has the decision in *Jackson* v. *Indiana* caused in your State?) may represent either item nonresponse (due to respondent fatigue, for example) or an absence of the effect being surveyed. For this reason, in chapter 4, analyses of all open-ended responses are presented in terms of percentage of respondents citing an effect. Telephone followup, site visits, and other conversations with facility administrators, however, suggest that due to respondent fatigue, these analyses may seriously underestimate the true incidence of effects. Such potential underestimates are noted in text.

A third source of potential bias lies in the answers of respondents themselves. Due to respondent burden, in situations where a closed question (e.g., "Are there...issues...of concern to you...?") permits a respondent to skip a more burdensome open-ended question (e.g., "Please describe the issue."), a negative bias can be expected in answers to the closed question. Such biases are discussed in chapter 4 where they are thought to have affected an analysis.

Bias may also arise from misunderstanding of questions, a desire "to make the program look good," and related circumstances. Such biases may take such forms as overstatement of the variety of treatment modalities available or percentage of respondents receiving a given form of treatment. The extent of such biases cannot be

directly ascertained without validation. Validation of all responses on all questionnaires was beyond the scope and resources of this project. Where responses appeared questionable or inconsistent within a questionnaire, however, the facility was called to verify the information provided. Moreover, where analysis of the data revealed patterns that appeared implausible in light of informed opinion, other research, or statutory conditions, reservations are expressed in accompanying text.

Legal and Library Research

The purpose of the legal and library research was to identify the nature and scope of the major judicial decisions that had affected or were expected to affect the programs, activities, and conditions at facilities for both adult and juvenile mentally disordered offenders.

The research consisted of an analysis of case law relevant to the placement, confinement, and treatment of mentally disordered offenders.

The library research was conducted between January and March 1981 by four graduate students from area universities. This research was to determine through published sources the impact that changes and interpretations in the law were having on facilities. Administrative and treatment impacts of these laws were examined primarily along the following dimensions: prediction of "dangerousness," right to less restrictive placement, rights to receive and refuse treatment, treatment to competency, prison to mental hospital transfer, special issues in treating mentally disordered juvenile offenders, and early impact of statutes providing the verdict of guilty but mentally ill.

Followup Interviews

The followup consisted of indepth telephone interviews with 60 administrators of responding facilities. The purposes of this stage of the study were to amplify and interpret answers in the national survey, to assess the impact of site-specific and other legal changes, and to identify programs as case study candidates. The survey questionnaire responses, as well as information from a brief review of recent major State and district court cases, were used to formulate the interview protocol. The interviews lasted about 1 hour and were conducted by social workers hired for the site visits.

Many of the topics of the interviews varied by State and facility. The topics of core questions, which were asked of each respondent, however, included: whether residents were handled differently (in terms of placement, release, right to receive and refuse treatment) based on legal status (i.e., found incompetent to stand trial, not guilty by reason of insanity, and penal transfers); how issues of confidentiality affect the program; burden of proof used for transfer; and the standard(s) used for informed consent to treatment.

These data were not separately tabulated. The information gathered during this stage, however, was useful in interpreting the national survey data analyzed in chapter 4.

Site Visits

The overall study was designed so that analysis of problematic issues could be conducted following the synthesis of the legal issues, the analysis of the survey data, and the indepth telephone probes. Accomplishing this objective required (1) the identification of issues upon which to focus concerted attention and (2) the selection of facilities at which program analysis of conditions and activities related to those issues could be conducted through indepth interviews and observation. The issues that emerged as important for focused attention were litigation and legislative activity; major changes in administrative structure within both the facility and the State, statewide budget cutbacks, fluctuations in population size, prerelease programs, and the followup of releasees.

Based on information concerning these issues and the programmatic and administrative responses to them, 11 programs were selected for site visits. The visits occurred between July and September 1982.

During the 2 days at each site, facility personnel participated in structured interviews of approximately 1 hour in duration. Efforts were made to interview at least one

staff member in each of the following personnel categories: clinical director, psychologist, social worker, nurse, ward aide, security staff member, chief of security, patient's rights advocate, and superintendent. In this way, each site visit obtained as many different impressions of the facility as time and resources allowed.

The interview protocols covered a variety of issues, including the following: historical context of program and motivation for inception; admissions process and sources of referral; staffing issues such as orientation, training, job satisfaction, and turnover; programming and treatment composition; release decision and decisionmakers; community concerns; knowledge of legal issues and constraints; and program cost and budget issues.

Each site visit was conducted by a two-person team consisting of a senior project team member supported by a consultant. The consultants were hired especially for this task and were master's level social workers with previous research experience on mentally disordered offenders.

Prior to the site visits, the consultants were given a 2-day orientation to the project. In addition, each did a comprehensive study of written material previously received from the facilities, the issues receiving special attention at the respective facilities, and the applicable State statutes.

The site visits provided a method to collect information not obtainable through either a mail questionnaire or a telephone interview. It allowed the capture of multiple impressions about the facility. Although the site visits were not evaluative of the program, analysis of issues that affect facilities daily was enhanced by interviews with staff at all levels of responsibility for day-to-day patient care. Information obtained from the site visits clarified previous understanding of organizational problems, such as the competition for resources and the tensions between competing objectives. Following each site visit, a case study report was prepared. Chapter 5 presents an issue-oriented synthesis of case study findings.

Summary of Methodology

The research was designed in multiple methods and stages so that a comprehensive picture of facilities and programs providing care and treatment to adult and juvenile mentally disordered offenders could be achieved. This picture included the constraints placed on the administrators and staff by the legal, technical, and political communities of which they are a part. The work was accomplished by using four methods of data collection—a national mail survey; indepth telephone interviews; library research including legal statutes, case law, and previous research; and onsite field observation and data collection. The legal and library research identified the basic and broad issues to be explored, while each consecutive phase of the data collection allowed concentrated focus upon and in-depth analysis of different subset of issues.

Chapter 3

Recent Legal Developments

The past 25 years have witnessed an avalanche of statutory revisions and court cases in the area of overlap between mental health and corrections. Prior to this period, the courts maintained what has been called a hands-off policy toward mental patients and prisoners. This policy was occasionally rationalized by the principle that constitutional rights essential to protect those subject to the State's police power were unnecessary when the State's purpose was a "benign" one such as treatment of mental illness.

Beginning in the 1960s, the courts began to recognize the problems of the institutionalized—both prisoners and mental patients. Through judicial decisions and new statutes, various due process rights were granted them. Although interest still exists in preserving such individual rights as the right to treatment, the thrust of more recent litigation and legislation has been toward balancing these rights against the resource constraints of institutions and the security of society. The growing number of States debating and passing laws making available the verdict of guilty but mentally ill and sometimes concomitantly eliminating the insanity defense attest to this new harsher posture toward the group who may be mentally ill as well as guilty of a criminal offense.

Concurrent with the evident changes in emphasis and direction of that balancing has been a tightening of civil commitment criteria—"the 'broad' paternalistic bases for commitment have been rapidly replaced with bases grounded in the 'police power' concept of dangerousness" (Wexler 1983, p. 2). As Halleck (1987) has noted, commitment criteria for mentally disordered offenders are less stringent than for other mentally ill persons. The release criteria for those both "mad" and "bad" are more stringent, however. In addition, decisions such as *Vitek* v. *Jones* may indirectly cause some prisoners to lose some of their rights. As Halleck notes, *Vitek* not only provides due process procedures for transfer from correctional to mental health authority but also changes the transferred inmate's status from prisoner to patient. Therefore, "one of the potential disadvantages for offenders who are transferred from a correctional to a hospital setting is that they may be subjected to treatments they could refuse as prisoners."

The continuing legal interest in the mentally disordered offender; the changes in emphasis on due process, patients' rights, and public protection; and the increased interaction between the mental health and legal systems have been continually affecting the facilities studied in many ways. Changes with respect to the processes for determining whether offenders are mentally disordered, the institutions in which they can be kept, the procedures for prison-to-hospital transfer, the treatment that *must* be given, the treatment that *can* be given, and the duration of the commitment all have had impacts on the day-to-day operation and administration of these facilities. Therefore, to understand or correctly interpret similarities and differences in these facilities today, compared with earlier studies or across States, requires at the very least some appreciation of the statutory and case law conditions and changes in those relevant areas of law.

Hence, as a basis for understanding and analyzing the structures that govern these facilities, analysis of State statutes was conducted during 1981 for all States in the following areas: competency to stand trial, insanity acquittees, the concept of dangerousness, the legally sane but mentally ill offender, prison-to-hospital transfer, right to receive treatment, right to refuse treatment, sexual psychopaths, and mentally dis-

ordered minors. The 1981 status of each of these legal areas is described in the following sections, together with a discussion of representative social science literature on these topics. The discussion of impact of these laws on the facilities is amplified by the results of the national mail survey reported in chapter 4 and onsite observations reported in chapter 5.

Competency

The collective belief in this country that it is unfair to try someone in absentia is the basis for the common law rule that a defendant cannot be convicted of a criminal offense unless he can participate in his defense in a meaningful way. In 1960, in its finding in *Dusky* v. *United States*, the U.S. Supreme Court stated the test to be used in determining competency to stand trial is as follows:

> [t]he test must be whether he has sufficient present ability to consult with his lawyers with a reasonable degree of rational understanding, and whether he has a rational as well as a factual understanding of the proceedings against him.

At the time of *Dusky*, a defendant found to be incompetent to stand trial usually was committed to a mental hospital until he became competent. Criminal proceedings could then be resumed.

Although the purpose of having a procedure to determine whether a person was capable of being tried was to protect incompetent defendants, in practice the process sometimes punished them instead. Some defendants never became competent and were incarcerated for life in a secure facility, even though they might not have been guilty of any crime. Others, although guilty, were incarcerated in mental health facilities for a longer period of time than if they had been convicted and sentenced for their crime. Still others, who were returned for trial and convicted, were subjected to two periods of deprivation of liberty, one in the hospital and one in the prison. As stated by Alan Stone in his 1975 monograph, *Mental Health and Law: A System in Transition*:

> Inconsistency and confusion aside, the real tragedy of the incompetency process is that it has, in many places, lost its distinct purpose of protecting defendants and has become merely another element in the array of techniques used by the state to effect the same result: involuntary confinement of worrisome individuals in grossly substandard facilities. (p. 205)

Legal Background on Competency

When the U.S. Supreme Court decided the case of *Jackson* v. *Indiana* in 1972, it placed some limits on the length of time States could hospitalize incompetent defendants solely on the basis of their inability to stand trial. Jackson, a deaf, mute retardate, had been committed as incompetent to stand trial in 1968 after being charged with two thefts amounting to $9. Jackson argued that commitment under these circumstances was virtually a "life sentence" without his ever having been convicted of a crime, and that the commitment deprived him of his rights to due process and equal protection under the 14th Amendment. The court agreed, holding that:

> a person . . . who is committed solely on account of his incapacity to proceed to trial cannot be held more than the reasonable period of time necessary to determine whether there is a substantial probability he will attain that capacity in the foreseeable future.

Otherwise, under *Jackson*, the State must release the defendant or start civil commitment proceedings. Moreover, even when the defendant is making progress toward competency, the Court said commitment would be allowed only when progress toward that goal is demonstrated.

The Court also noted that other courts and commentators had suggested that some defenses could be raised and resolved without the defendant's participation. Specifically, it pointed out that the Court's previous decisions did not preclude State courts from establishing procedures by which an incompetent defendant's innocence could be established.

Although 10 years had elapsed since

Jackson, its impact on both the length of detention and the legal status of incompetent defendants was still unclear at the time these data were analyzed. A review of incompetency statutes in 1979 found that 24 States and the District of Columbia still allowed incompetent defendants to be held indefinitely, thus presumably violating *Jackson*. Our own review of State laws in 1981 found a smaller but still substantial number of States, 17, ignoring the Supreme Court's decision.

Ten States and the District of Columbia use the "reasonable period of time" test established in *Jackson*. Neither the Supreme Court nor these States specifically define the term, however. The length of time incompetent defendants can be held before a State must release them or initiate civil commitment proceedings is therefore unknown. The remaining 23 States have established statutory limits for detention of incompetents ranging from 3 months to 10 years. Whether these variations are due to differing definitions of "reasonable" or to the belief that *Jackson* does not apply to offenders charged with violent offenses is unknown.

Overall, the length of hospitalization for persons found incompetent to stand trial should have decreased for two reasons. First, the Court's requirement in *Jackson* that commitment can be justified only if progress is being made toward competency virtually requires some treatment (or training in the case of retardates). Presumably, the treatment and/or training programs such as those observed during the present study and discussed in chapter 5 are successful in restoring some proportion of the incompetents to competency. Second, in at least a dozen States, the period of commitment is statutorily less than 2 years. Because both of these conditions place limits on the confinement of incompetent defendants, where none previously existed, the length of confinement should presumably have decreased.

It must be remembered, however, that it is not clear whether *Jackson* holds for persons charged with "violent" offenses or those considered to be "dangerous" because of their mental condition. To take this issue to its extreme, if actually all incompetents were dangerous, *Jackson's* effect on their length of detention would be limited to those restored to competency because of the treatment or training that it seems to require. Of course, it is doubtful that the proportion of dangerous defendants is so high. Moreover, most States that have revised their incompetency laws since *Jackson* have not divided them into dangerous and nondangerous groups. On the other hand, States have tightened civil commitment standards and may have forced some mentally ill people who commit minor offenses into the criminal system. Thus, they may add to the number of incompetent offenders.

Besides possible effects on the number and length of stay of the incompetent population, *Jackson* could have had an effect on the number, background, and activities of the facilities personnel. One reason would be that an active treatment program would require more mental health professionals. In addition, similar persons would be required to evaluate the incompetents for reports now required by many States on the progress patients are making toward competency.

Jackson may also have had a considerable impact on civil mental health facilities. If incompetent defendants are not restored to competency within a reasonable time, they must be released or civil commitment proceedings instituted. The impact on the civil facilities will vary, depending on what percentage of the incompetents meet civil commitment standards. Also, the requirement in at least 10 States that civilly committed incompetents cannot be released without judicial approval may interfere with treatment goals and lengthen the hospitalization period.

Regardless of the current effect of implementation of *Jackson* on the facilities treating people who are incompetent to stand trial, future challenges are likely to lead to decisions having additional impact. These include the following:

- Actions requesting implementation of *Jackson* where the State has not done so
- Actions challenging implementation as not conforming with *Jackson*
- Actions challenging the applicability or nonapplicability of *Jackson* to violent offenses and dangerous offenders
- Actions challenging the requirement, in at least 10 States, that judicial ap-

proval be obtained before civilly committed incompetents can be released.

Extant Literature

Much of the concern expressed in the literature in this area has to do with recent reluctance to civilly commit nondangerous persons and accompanying statutory revisions, noted earlier, mandating dangerousness as a requirement for civil commitment, even of "nonrestorable" incompetents and persons found not guilty by reason of insanity. One consequence of this situation, according to a study by Dickey (1980), has been a significant increase in the number of nondangerous accused offenders raising the competency issue. Examining the situation in Wisconsin, Dickey's study of the effects of the State's Mental Health Act reveals that, since passage of the act in 1975, the number of requests for competency examinations for criminal defendants "substantially" increased. A very high percentage (42 percent) of persons committed as incompetent to stand trial were charged with misdemeanors (many charges being disorderly conduct). Another significant finding was that, once committed, most such persons had their criminal charges dropped, regardless of their progress toward competence.

Dickey concludes that an unexpected result of Wisconsin's reform through the 1975 Mental Health Act was the roundabout route to the mental hospital for persons who were troublesome but not dangerous to the community. Thus, the courts and hospitals have been seeing an increasing number of inappropriately referred offenders, for whom little in the way of treatment is available or needed.

In 1980, Pendleton reported on an innovative California program that seeks to respond to the requirements of *Jackson* and other case law developments. In an attempt to plan rationally a treatment regimen designed to restore offenders to competency, staff at the Atascadero State Hospital utilize a multidisciplinary instrument to assess the various areas of competency deemed important in the legal-psychological context. Called the Competency to Stand Trial Assessment Instrument, it evaluates competency in 13 areas and is implemented by a multidisciplinary team of attorneys, psychiatrists, and psychologists. The instrument was developed at the Laboratory of Community Psychiatry, Harvard Medical School (McGarry 1972).

This instrument determines the specific deficits to be addressed by the hospital in each case. Treatment includes psychotropic drugs, individual and group psychotherapy, and occupational therapy. During the period of treatment, offenders participate in videotaped mock trials and are examined and reexamined for competency. Successfully passing such examinations may result in return to court for trial.

Among the reported results of the Atascadero program were the following:

- Only 10 percent of the referrals were unable to attain competency within the statutory time limit (36 months, or the maximum sentence for the charge[s], whichever is less).
- Of those referred back to court as competent, 97.5 percent "successfully complete(d) the trial process."
- The average length of stay to those treated to competency and returned to court was 104 days.

While widespread concern has been expressed regarding determinations of incompetency and commitments of those found to be incompetent to stand trial, some observers prefer to focus on the acceptance of the principle that more incompetent defendants could be tried without recourse to temporary commitments and accompanying competency restoration efforts. For example, Ringer and McCormack (1977) suggest that incompetents should be tried more often than is now the case. The State ought to be required

> . . . to tender all needed assistance (to the accused): the assignment of counsel, time, and treatment to recover as much of his wits as he can . . .

Ringer and McCormack would assign considerable resources to the incompetent accused during the trial in order to finalize the court process.

In a similar vein, Burt and Morris (1972) have argued that the continuance process could be used to secure a "reasonable" (e.g.,

6-month) period in which to attempt to restore competence. Following that period, they argue that most unrestored incompetents could be tried under certain safeguards, such as extended discovery, special instructions to the jury to make no inferences from the defendant's affect or failure to testify, and provisions to expedite retrial if new evidence is discovered. Such a procedure would, they attest, achieve a measure of the fairness intended through application of the commitment process to incompetents without eliminating the finding of fact provided through trial. It is reasonable to expect that adoption of this approach would encourage mental health facilities to place additional emphasis on programs, such as Atascadero's, designed to restore competency. In addition, this procedure would likely increase the burden on correctional facilities to provide long-term treatment to mentally ill offenders tried and convicted under the extraordinary protections.

In another statement addressing this issue, Gobert (1973), after a critique of *Jackson*, proposes a different solution, aimed primarily at those individuals who seem likely to be permanently incompetent—such as those who are severely mentally retarded. He would have them tried at a "provisional trial," which would determine if the individual committed the acts attributed to him. Due to his incompetency, however, he would not have a defense if tried in a criminal court. The individual would then be institutionalized for a period not to exceed the length of sentence if found guilty in a criminal court. Should an individual regain competency, he would then stand trial and the time spent in an institution would be subtracted from the sentence. Should a "provisional" not guilty verdict be reached, the accused would be in a position to benefit more fully from a treatment program.

Insanity Acquittees and the Issue of Dangerousness

As can be seen in the statutes governing both commitment and release of individuals found not guilty by reason of insanity, the concept of dangerousness is raised in 23 States. For some, the concept is pertinent to commitment criteria, for others to release criteria, for still others to both. Dangerousness is also a criterion in the release of other mentally disordered offenders such as sexual psychopaths and defective delinquents.

For almost a century, many psychiatrists and attorneys argued that *M'Naghten* and "irresistible impulse," the existing tests for determining criminal responsibility, were unsatisfactory. Under *M'Naghten*, the accused would be acquitted if his "disease of the mind" at the time of the act rendered him ignorant of the "nature and quality of the act or of the fact that he was doing wrong." These advocates contended that severely mentally disordered defendants were being found guilty because they did not meet these tests, and therefore urged the courts and legislators to adopt a rule more accurately reflecting the relationship between mental abnormality and crime. In the 1950s, their efforts began to achieve some successes. First, in 1954, the U.S. Court of Appeals adopted a new test in the *Durham* case. A few years later, the American Law Institute's Model Penal Code proposed a new rule ("the ALI test"), which the vast majority of the States and all but one of the Federal appellate courts adopted during the next two decades. The ALI test provides that a person is not responsible for criminal conduct if, at the time of such conduct, as a result of mental disease or defect, the defendant lacked substantial capacity to appreciate the criminality of his conduct or to conform his conduct to the requirements of the law.

Although the reformers achieved their goal of a new insanity defense, it is not clear that as a result more defendants were found not guilty by reason of insanity. It is frequently claimed that the defense is rarely used and is even more rarely successful (Slovenko 1977). Yet, few published data are available about either the extent that the plea is raised or the extent to which such pleas are successful (Steadman 1980a). Nevertheless, perhaps because the issue of insanity tends to be raised in highly publicized cases involving spectacular crimes, the public believes that the number of acquittals is high. Substantial public concern therefore exists about whether the laws governing dispositions, restrictions, and release of insanity acquittees properly safeguard the community. Balancing this

concern about the danger to the community against the widespread doubt among mental health professionals about the opportunity for effective treatment in overly restrictive settings has led to great diversity in State laws governing insanity acquittees.

In 1983, the American Bar Association recommended a new test for insanity that eliminates the voluntary prong of the American Law Institute test ("or to conform his conduct to the requirements of the law"). It will be several years before the effect, if any, of this recommendation on the courts and legislatures can be determined. Although the change, if adopted, might reduce the number of insanity acquittees, it is too early to tell if this will happen.

Statutes Governing the Insanity Defense

Understandably, the public does not want an insanity acquittee to be released immediately, or after a short period of treatment, and then commit new offenses. Many States try to minimize this possibility by subjecting insanity acquittees to more lenient commitment and more restrictive release laws than those applicable to mentally ill people who have not committed criminal acts (persons civilly committed).

More than half the States require or allow automatic indeterminant commitment of all or certain categories of insanity acquittees. The majority of the other States require a hearing on the acquittee's current need for hospitalization but use different criteria for criminal commitment or a less stringent burden of proof than they require for civil commitment. Only a few State laws reflect the belief that special commitment procedures are not required for insanity acquittees; consequently, acquittees in those States are handled under the civil commitment law.

The constitutionality of different commitment procedures for insanity acquittees and other mentally ill persons has been challenged on both due process and equal protection grounds. Most courts, however, especially in recent years, have held that the acquittees' commission of a criminal act justifies different treatment of the two groups.

Although again data are lacking, it is unlikely that many insanity acquittees are immediately released in States in which the question of their need for hospitalization is determined under regular civil commitment laws. If, in fact, insanity acquittees are usually hospitalized, it is doubtful that protection of the community requires the use of mandatory or special criminal commitment procedures.

The more difficult problem is whether the public is protected by laws that apply the same leave and release procedures for insanity acquittees and other civilly committed persons. The latter group, as part of their treatment and rehabilitation, frequently are allowed, in fact encouraged, to leave the hospital grounds for educational programs, employment, and home visits. The dilemma is that if insanity acquittees are denied these privileges, efforts to rehabilitate them may suffer, while if they are treated as civil patients, the community might be endangered.

A similar problem is present when the appropriate procedures for conditional or total release are considered. A civil patient is frequently released by the hospital not necessarily because he or she has recovered but also because, in a professional's judgment, the patient received the maximum benefit from hospitalization. Again, a danger to the community may exist if insanity acquittees are released under the same circumstances. For this reason, many States require special procedures and/or requirements for the release of insanity acquittees. Thirty States allow release only after a judicial hearing. However, 17 require a hearing whenever the application for release is contested.

The criterion for release frequently is either that the defendant is no longer mentally ill or, if mentally ill, is no longer dangerous. The latter would appear to be a reasonable standard if danger could be appropriately defined and predicted with reasonable accuracy. A number of States, however, appear to require a finding that the defendant is neither dangerous nor mentally ill. To make this finding, the judge and the mental health experts must predict criminality unrelated to mental illness, which is an even more difficult task, clinically and statistically. It would also be an inappropriate legal criterion, because it is not applied to the release of prisoners whose sanity was never questioned.

Regardless of whether the standard for release is "no longer mentally ill" or "no longer dangerously mentally ill," a serious problem arises from the fact that some people are "synthetically sane," meaning that their symptoms are controlled by medication. The release of civilly committed persons under such circumstances is not widely regarded as a problem, since they can easily be rehospitalized. A reasonable concern, however, is that release of insanity acquittees under such circumstances might result in additional criminal offenses. Again, the problem exists of lack of data on the number of ex-patients who stop taking medication and the consequences of such action. Concern about this phenomenon, however, and the lack of adequate followup to maintain medication was repeatedly expressed by facility staff interviewed in the course of the present research. The legal solution might be to require "real" as opposed to "synthetic" sanity as a release standard in cases where the acquittee has inflicted or attempted to inflict serious bodily injury, or to have a stringent conditional release system as the American Bar Association's proposed mental health standards recommend.

One other release problem that occurs when State laws distinguish between those civilly committed and those found not guilty by reason of insanity is whether a maximum length of confinement should be established. In recent years, State laws governing release of those civilly committed increasingly protect the patients' right to liberty. The indeterminant commitments of the past have been replaced by such requirements as periodic review of benefit from treatment, new hearings after a specified time period on the need for present hospitalization, and the commission of a recent act that demonstrates dangerousness.

When insanity acquittees are hospitalized under ordinary civil commitment laws, these protections also apply to them. Some legislatures have feared, however, that if insanity acquittees are hospitalized under criminal commitment laws, lifetime incarceration might result because of strict release criteria. Consequently, at least eight States have adopted laws that allow hospitalization on an acquittee for no longer a period than the hypothetical sentence the acquittee would have received if convicted of the crime. These laws do not necessarily mean that the acquittee will be released at that time, because general civil commitment would be available if the acquittee remains mentally ill. These provisions seem to adopt the reasoning of the Supreme Court in the *Baxstrom* v. *Herold* case. In that case, the Court held that persons who had been transferred to mental hospitals must be released or civilly committed when the sentence is completed.

Although maximum hospitalization statutes were advocated as a means of protecting insanity acquittees from lifelong incarceration, they could be used in a punitive manner. It is possible for hospital personnel or courts to use such laws to hold acquittees until the end of the hypothetical sentence.

Legally, persons found permanently incompetent to stand trial and insanity acquittees differ from persons convicted for a criminal offense in that they have not been adjudged blameworthy. Yet they also are thought to be different from the civilly committed mentally ill in that they either have or are alleged to have committed a crime, while it is assumed in most States that the civilly committed have not. The criminal justice system has been struggling with how to avoid punishing insanity acquittees, while at the same time protecting the community from their potential commission of future crimes.

Neither treating all acquittees identically to those civilly committed, nor justifying different substantive criteria and procedural rules for them on the grounds that they have been charged with and frequently have actually committed a criminal act, seems completely appropriate. A better solution might be to treat equally dangerous persons in the same way, regardless of whether they entered a hospital with or without a criminal charge. It is important to recognize that some civilly committed patients have committed criminal acts. In fact, with the tightening of civil commitment laws, some believe that more people are literally forced to enter mental hospitals via the criminal route.

Next, attention should be paid to the fact that the principal fear concerning the insanity acquittee is that he or she will commit further acts dangerous to life or limb. Not all acquittees have allegedly committed such an act, however. Instead, they may

have committed a nondangerous crime, while the nonprosecuted civil patients may have brutally attacked a neighbor or a friend. Therefore, courts and legislatures may turn to policies and procedures that treat all violent mentally ill persons by one set of procedures and all nonviolent by another—a civil commitment system that some might consider more rational and fair.

Extant Literature

The concept of dangerousness is raised in a variety of legal contexts—commitment and release of those found not guilty by reason of insanity or incompetent to stand trial, defective delinquents, and sexual psychopaths (Shah 1978). Agreement is widespread, however, that dangerousness is extremely difficult to determine. As noted by Shah, dangerousness is a legal term, although the determination is usually made by mental health professionals. Steadman (1978) has stated that "psychiatrists are poor predictors" of dangerousness. Predictions of behaviors with low base rates often result in excessive overprediction—the false-positive issue.

In a general statement on this subject, Brooks (1978) cautioned that, while involuntary commitments of mentally ill prisoners and persons found not guilty by reason of insanity or incompetent to stand trial have increasingly been restricted to mentally disordered offenders who are clearly dangerous, too many persons are being classified as "dangerous to self or others" to justify complacency. The culprit is, according to Brooks, excessive discretion exercised by the major actors in the judicial and mental health fields. In his opinion, this discretion needs to be curbed by the application of objective standards (not specified) that could lead to more accurate determination of dangerousness.

Fagin (1976) attempted to analyze some of the reasons why dangerousness is so often reported as being wildly overpredicted. He argues that among the possible explanations are the following:

- Violence base expectancy rates are extremely low, a condition that limits the predictive accuracy of standard statistical techniques.
- Clinical v. statistical methodologies for predicting dangerousness are often in conflict.
- "Corrective feedback" to sharpen predictive techniques is sorely lacking.

Fagin made an important point that must be borne in mind when the matter of predicting dangerousness is being considered. In his words, "[b]ecause violent or dangerous behavior tends to be a relatively rare event, the base rate will be low, and hence our predictive task will be more difficult."

In this same vein, Steadman (1980b) points out that much of the prediction of dangerousness among mental health and criminal justice populations results in overpredictions of from 8 to 10:1, partly because of the quite low violence base expectancy rate for these as well as the general population. Based on a review of clinical prediction studies, Steadman concludes that predicting no one will be dangerous is more accurate than attempting to predict who will. As he finally stated, "False-positive rates are high, greatly exceeding any accepted criminal law evidentiary standards."

A recent work by John Monahan (1981) examines the multitude of problems associated with clinical predictions of violent behavior—a term he argues is preferable to dangerous. After analyzing the work to date in violence prediction, Monahan concludes that, while such prediction is difficult, "there may be circumstances in which prediction is both empirically possible and ethically appropriate." He then indicates ways in which this predictive process can be improved. He offers a set of 14 questions for the clinician to use in predicting violent behavior and feels that these will be a "reasonable guide to prediction."

Chapters 4 and 5 point out a number of operational problems posed for institutions by the discrepancy between the actual state-of-the-art dangerousness prediction as reported in the literature and the state of the art presumed by the law.

The Guilty but Mentally Ill Verdict

The first law providing the verdict of guilty but mentally ill was adopted in 1975

by the State of Michigan. At the time of this writing, seven other States had enacted legislation providing this verdict: Alaska, 1982; Delaware, 1982; Georgia, 1982; Indiana, 1978; Illinois, 1981; Kentucky, 1982; and New Mexico, 1982. Several other States were actively considering such laws.

These laws are more controversial, however, than this list of States adopting such laws suggests. For example, both the National Commission on the Insanity Defense and the American Bar Association oppose such laws.

These laws can be divided into two groups:

1. Verdicts of guilty but mentally ill with a requirement for psychiatric evaluation and a requirement or option of hospital treatment

2. Verdicts of guilty with mandatory placement (through sentence or civil commitment) in mental hospitals prior to imprisonment

The guilty but mentally ill verdict is triggered by a plea of guilty but mentally ill or by raising the insanity defense. In most States with such laws, the verdict is reached when the jury finds that the defendant is guilty and mentally ill but was not insane at the time of the offense. The defendant is convicted as if the verdict were guilty.

Although guilty but mentally ill laws can be used to provide treatment for mentally ill offenders, this may not be their principal purpose. Instead, many believe that their aim is to reduce the number of insanity acquittees and thereby reduce public concern that "insane" offenders, released after a short period of hospitalization, will commit new offenses. The laws have been operating too short a time to determine if they have achieved this purpose. The other effects of their existence are difficult to predict and were not measured in this survey. For example:

- Will more or fewer mentally ill offenders be hospitalized in States with guilty but mentally ill statutes?

- Will offenders be placed in facilities operated by departments of corrections instead of departments of mental health? Will the quality of care change?

- Will hospitalized offenders remain institutionalized for a longer or shorter period than if they had been found not guilty by reason of insanity?

As of 1983, only two States with guilty but mentally ill statutes, Delaware and Kentucky, required that treatment be provided, and only Delaware requires that the guilty but mentally ill offender be hospitalized. At this time, there is no reason to anticipate that guilty but mentally ill laws will add to the number of people treated or the quality of treatment.

Since John Hinckley was acquitted of his attempt on President Ronald Reagan's life on grounds of insanity, additional States have adopted guilty but mentally ill laws, and others are considering narrowing or eliminating their insanity test of making the defendant bear the burden of proof on the insanity issue. The net effect of these changes is likely to be to put more mentally ill people in prison.

Related Laws

Ten other States have special laws that provide mental health treatment for convicted offenders. They more closely resemble transfer statutes than guilty but mentally ill laws in that neither an insanity defense nor a guilty plea is necessary to initiate them. These laws can be divided into two subgroups, existing in five States each. In subgroup one, the offender is first sentenced and then placed in a mental hospital until the sentence expires or until the offender has recovered sufficiently that transfer to another facility is appropriate. Consequently, they are virtually identical in effect to transfer laws. In subgroup two, however, the offenders evidently are not sentenced after conviction but are simply civilly committed.

Almost all of these laws have been enacted within the past decade. These new approaches all speak of providing treatment for the mentally ill offender. The principal emphasis of the first subgroup, however, seems to be on preventing verdicts of not guilty by reason of insanity, while the intent of the other laws seems to be on providing mental health treatment to those convicted of crimes. Under these laws, the criteria for placement in a mental hospital vary, as do

the kind of institution in which offenders should be placed and the period of confinement.

Previous Research on Facility Impact

As the time lag between legislation, implementation, and analysis of effects is lengthy, only Michigan's guilty but mentally ill law is old enough for its impact to have been examined by researchers. In a review of Michigan's guilty but mentally ill statute, Amarilio (1979) began by placing the legislative history of the act in the context of a State Supreme Court decision, *People* v. *McQuillan*, ordering release of certain mental hospital patients not meeting civil commitment criteria. Two of these releasees subsequently committed violent crimes. In response to public pressure to provide more secure custody of defendants pleading insanity, a 1974 statute provided a fourth alternative verdict. Thus, guilty but mentally ill was added to the three possibilities available prior to the new statute: guilty, not guilty, not guilty by reason of insanity.

By virtue of this statute, persons found guilty but mentally ill are sentenced to terms of confinement with treatment to be provided (if needed according to psychiatric evaluation) by either the mental health or the corrections system. Among the problems for such persons pointed out by Amarilio are the lack of due process safeguards regarding transfer from prisons to mental hospitals, and the possible deficiency of suitable programs for these offenders within the mental health system.

Although no systematic, comprehensive impact evaluation of Michigan's experience with guilty but mentally ill laws has been carried out, several effects have been noted by researchers and other observers. First, although Criss and Racine (1980) could not obtain time-series data on the frequency with which the insanity defense is raised, they note approximately 40 insanity acquittals per year in Michigan courts between 1967 and 1973, with a slight increase to nearly 45 per year between 1975 and 1979. This would suggest that availability of guilty but mentally ill had no dramatic impact on successful use of the insanity defense; however, they note 78 insanity acquittals for 1974, the year before *McQuillan*, raising the question whether introduction of guilty but mentally ill averted a more dramatic increase in successful use of the insanity defense. Criss and Racine also note a steady and substantial increase since 1975 in the percentage of insanity acquittees diagnosed as suffering from readily treatable mental illnesses rather than personality disorders, and a 4-month drop since 1975 in the average period of hospitalization of insanity acquittees. They suggest that these results reflect appropriate use of the insanity defense and "effective pretrial mental health treatment, which results in the remission of the symptomatology that provided the basis for acquittal."

In remarks to the 1982 Annual Conference of the National Association of State Mental Health Forensic Directors, William Meyer, director of Michigan's Center for Forensic Psychiatry, attributed the recent more appropriate use of the not guilty by reason of insanity verdict in part to a provision of Public Act 180 that defendants pleading insanity be examined by center staff psychiatrists in addition to defense psychiatrists, rather than to the guilty but mentally ill provision of the act. He estimated that three-fourths of all guilty but mentally ill offenders are not mentally ill according to psychiatric diagnosis, but are instead primarily sex offenders who have pled guilty but mentally ill in exchange for shorter periods of confinement, as well as other persons attempting to manipulate the system.

J.M. Grostic (1978), in an analysis of the constitutionality of Michigan's guilty but mentally ill verdict, expresses grave reservations about the "reform" the new verdict provides accused persons. He states that the

> . . . consequences to the defendant may be identical whether he is convicted under one verdict or another. At most the GBMI verdict may help ensure that convicted defendants who need treatment for mental illness will receive it. (p. 190)

Of greater concern to Grostic is his belief that the new verdict may "effectively deprive some legally insane defendants of an insanity defense."

Prison–to–Hospital Transfer Statutes

Laws governing hospitalization and release of mentally ill persons differ, depending on whether the allegedly ill person is in the community or is a prisoner in a correctional facility. During the past 20 years, State civil commitment statutes have been changed to make it easier for the mentally ill in the community who want inpatient treatment to apply for hospitalization and more difficult to commit them when they object to hospitalization. The criterion justifying commitment frequently has been narrowed to "dangerousness to self or others as evidenced by a recent overt act." In addition, procedural safeguards such as the following have been added. In most jurisdictions, before being hospitalized, a person is entitled to a judicial hearing of which he has notice, the right to court-appointed counsel, the right to call witnesses on his behalf, and the right to cross-examine the State's witnesses. Although by no means entitling persons being civilly committed to all the rights afforded persons accused of committing a crime, hospitalization laws have moved in this direction.

The U.S. Supreme Court has also added some protections. In *O'Connor* v. *Donaldson*, the Court held that nondangerous mentally ill people cannot be confined without treatment if they are capable of surviving in the community. In *Addington* v. *Texas*, the Court said that the State must prove need for hospitalization by "clear and convincing" evidence. Similarly, the adoption of statutory provisions for periodic review of the civil patient's mental condition, limits on the length of detention without a new hearing, and other procedural protections have increased the likelihood that patients who no longer need hospital care will be released.

In contrast, at least until quite recently, mentally ill prisoners had none of these rights. Voluntary applications by prisoners were virtually unknown. Instead, the initial hospitalization decision was made by corrections personnel. If the hospital agreed to receive the prisoner, he or she was transferred without a hearing. Return of the prisoner to the correctional facility was also an administrative decision, usually made by the staff of the hospital. No consultation or notification of the prisoner was required.

In fact, until 1966 when the U.S. Supreme Court decided *Baxstrom* v. *Herold*, mentally ill prisoners could be kept in a hospital for the criminally insane even after their sentence expired (either without any commitment hearing or by one that had broader commitment criteria or few of the procedural protections afforded civil patients). The Court ended these practices by its holding in *Baxstrom*. Since that decision, prisoners transferred to a mental hospital must be released at the end of their sentences or have their need for hospitalization determined in a civil commitment hearing, using the same procedures and criteria applied to other allegedly mentally ill persons.

Little attention was paid to the transfer procedure itself, however, until the Court decided in 1980 in *Vitek* that the Nebraska transfer statute was unconstitutional. The statute was typical of those in other States. It allowed transfer to a mental hospital when a physician or psychologist found that the prisoner was mentally ill or retarded and could not be given proper treatment within the correctional facility. The Court decided that due process required the following procedural safeguards before a prisoner could be transferred to a mental health facility:

- Written notice of the proposed transfer
- A hearing
- The right to be heard in person and to present documentary evidence
- Disclosure to the prisoner of the evidence being relied on
- An opportunity to present witnesses, confront and cross-examine State witnesses, except upon finding, not arbitrarily made, of good cause for not allowing these rights
- An independent decisionmaker (who may be from the prison or hospital administration)
- A written statement by the factfinder of the evidence relied on and the reasons for transfer
- Access to State-furnished qualified and

independent assistance if the prisoner cannot furnish his own

- Notice of the foregoing rights

These procedures do not give prisoners and nonprisoners the same rights in regard to hospitalization. *Vitek* does not deal with the criteria for hospitalization, merely the process. For example, a prisoner might be transferred because he is thought by the factfinder to need care, while a nonprisoner could not be involuntarily hospitalized unless he was dangerous to himself or others as evidenced by a recent overt act. *Vitek* does not require a judicial hearing, counsel, or establishment of mental illness by clear and convincing evidence.

Some States, however, have gone considerably beyond *Vitek* in reforming their transfer laws, some now prohibiting transfer unless civil commitment criteria and procedures are followed. More than 20 States have enacted laws mandating civil commitment standards and procedures. The American Bar Association's proposed standards also take this position.

Many States, based on an examination of their statutes, have not complied with *Vitek*. This is not surprising, since the statutes were surveyed only a year after the decision. It is possible that more States have in fact implemented the law by administrative regulations of which we are unaware, or are simply following it without amending the statute or transfer regulations. An additional number of States may not be following the decision because they do not believe it applies to them. Does *Vitek* apply in States where one mental hospital to which a prisoner may be transferred is a facility under the jurisdiction of the department of corrections rather than the department of mental health? Probably whether the facility is under the jurisdiction of one department or the other makes no legal difference, but it is possible that some State authorities may have erroneously concluded that, because *Vitek* involved an interdepartmental transfer, the decision affects only transfers of this type.

The next question is whether *Vitek* applies to a mental health facility located within the correctional institution, e.g., a separate unit or wing. Again, the State might question whether the decision is applicable, although the reasoning of the opinion indicates that, if the transfer is not an emergency and is for a period longer than 10 days, *Vitek* should apply. The Court was concerned about stigma and mandatory treatment, which remain issues even if the treatment occurs in a separate unit of the facility.

Previous Research on Facility Impact

An analysis of the literature on the transfer of persons between corrections and mental health systems provides a clear picture of the problems associated with the "mad and bad" person in both the prison and mental health systems. No one in either system really wants the acting-out disturbed offender. Various legal developments have tightened the criteria used to transfer persons from prison to a mental health facility. These criteria generally require a finding that the prisoner be dangerous to self or others. Unfortunately, prison confinement may severely damage the mentally disordered who are not yet overtly dangerous. When a prisoner is found to be mentally disordered but not transferrable, his or her treatment is usually limited to drug therapy. In a critique, Speiglman (1977) concluded the following concerning the psychiatric staff of a unit for "psychotic" prisoners:

> Beyond meeting with other staff members, the two major responsibilities are writing prescriptions for psychoactive drugs after interviewing prisoners, and writing reports for . . . prisoners' files and to the parole board. (p. 28)

Speiglman also found that both staff shortages and full staffing result in pervasive drug use. The so-called voluntary acceptance of drugs by prisoners was belied by threats to transfer resistant offenders to highly restrictive confinement.

In a survey of three State prison systems, Kaufman (1980) found a number of conditions that made prison psychiatry ineffective and often inappropriate. Among these were overcrowding, absence of ancillary programs (e.g., recreation and vocational training), and widespread use of solitary confinement of disturbed prisoners. Kaufman stressed the negative effects of the

latter, claiming that sensory deprivation consequent to periods of solitary confinement may induce electroencephalogram (EEG) changes lasting for many weeks following release from the confinement.

Another deficiency noted by Kaufman is the overprescription of drugs by personnel "with little knowledge of drug effects." His survey conclusion constitutes a plea to transfer disturbed prisoners in the following statement:

> . . . serious consideration should be given to transferring the responsibility for the care of mentally disturbed inmates from the penal system to specialized psychiatric hospitals outside the cor- rectional system. (p. 570)

In the same journal as Kaufman's article, Seymour Halleck (1980) editorialized that "(Kaufman's) observations suggest that psychiatric care of prisoners is getting worse rather than better" (p. 603).

In a study of the effects of Pennsylvania's 1976 Mental Health Procedures Act, Bonovitz and Guy (1979) concluded that a substantial number of nondangerous persons ". . . are being 'protected' from involuntary commitment in a prison." This was an unforeseen consequence of the 1976 Act's provision of "stringent criteria" for involuntary mental hospital commitment, requiring that a person so committed must present a ". . . clear and present danger of harm to himself or others."

After a followup study, Bonovitz and Guy found that the prison system was subjected to a sharp rise in the number of requests for psychiatric consultations. Many of the allegedly disordered inmates had committed less serious crimes than other inmates and had relatively short arrest records. Being "nondangerous," they were difficult to transfer to more appropriate facilities for treatment.

Recently, New York (Couglin and Webb 1982) has had pilot projects operating at two prisons, which are designed to treat a group of inmates with chronic mental disabilities who are not receiving adequate care because of existing gaps in the mental health service delivery system. Collectively referred to as the Intermediate Care Program, these projects attempt to reintegrate offenders into the general prison population through delivery of a multidisciplinary group of services. One of the anticipated advantages of this approach is prompt intervention with disturbed inmates, made possible in part because it will not require time-consuming (and often unsuccessful) procedures to transfer inmates to mental health facilities.

Among the treatment modes often associated with imprisoned mentally disordered offenders is behavior modification. It is often criticized as being sometimes cruel and unusual punishment, a violation of right to treatment, and a technique providing psychiatrists unwarranted control over the lives of inmate/patients. Responding to the last of these concerns, Halleck (1980) states that the application of behavior modification has been limited through legal action, so it is quite difficult to make the case that it gives psychiatry too much control over offenders. He said that:

> Litigation that limits the use of aversive therapy, and even the use of token economies or generalized reinforcers, has already curbed the power of psychiatrists altering human behavior. . . . (p. 30)

A final note is in order regarding the mentally disordered offender in the prison setting. The rapid and widespread shift from indeterminate to determinate sentencing has been hailed by many as long overdue reform required because of our lack of adequate treatment measures. This lack, it is said, makes it impossible to set sentences in such a way as to allow flexible termination of confinement based on effectiveness of treatment. Commenting on this, T.L. Clanon (1979) argued that the California determinate sentence statute, as an example, does not provide either fairness to the offender or protection to the public. In a vigorous criticism of the advocates of determinate sentencing, Clanon stated:

> Recognition of the limits of the rehabilitative model and discretion in sentencing can readily be perverted into denial of the responsibility to use the tools we do have in appropriate cases. . . . The result, if this tendency continues, will be a loss of public protection which is unnecessary and which

will gain no one more individual liberty. It is quite conceivable that irresponsibility will increasingly masquerade as concern for individual freedom. (p. 188)

Legal Rights to Receive and Refuse Treatment

In the 1961 pathfinding report of the American Bar Foundation, *The Mentally Disabled and the Law* (Lindman and McIntyre 1961), analysis of State statutes did not identify any provisions regarding the right of mentally disordered offenders to treatment while committed. Nor was there any discussion of such a right being developed under case law or seriously considered by the legal or mental health profession. The right to refuse treatment area, however, included presentation of a number of issues. A brief overview of these discussions will serve as a backdrop for developments that have been building in the 25 years since the publication of the bar foundation report.

Throughout *The Mentally Disabled and the Law*, references were made to the *Draft Act Governing Hospitalization of the Mentally Ill* (National Institute of Mental Health 1952). This 1952 document was meant to serve as a guide to the State legislatures and others working toward revisions in their commitment statutes. Of importance with regard to a right to refuse treatment is the section of the draft act dealing with consent to treatment. The act calls for involuntary commitment when a person has been found to be unable to make "responsible" decision about his or her voluntary hospitalization and treatment. The draft act does not offer criteria for judging when and how a decision is responsible, but it is worth noting that over a quarter of a century later, Tepper and Kaslow (1979) propose a theory and practical applications of "informed decisionmaking" as related to patient participation in treatment decisions. Their work is reviewed in a subsequent section.

The bar foundation report did review case and statutory law in the matter of patient consent to various treatments, including electroconvulsive therapy and psychosurgery. Its findings provided a rather clear picture of the then-current state of professional (medical and legal) thinking. The prevailing idea was that consent, while to be sought, need not be required if professional judgment concluded such treatment to be necessary. For example, the report concluded with regard to electroconvulsive therapy that "there are no statutes or cases dealing with consent. . . ." Further, the report cited an earlier Pennsylvania Department of Justice advisory opinion, which had said that hospital superintendents may "for the patients' best welfare, without first obtaining written permission," administer electroshock and "such other treatments indicated as necessary and proper." The only restriction placed on the superintendents was their "sound discretion." Perhaps because of this opinion's reflection of the state of the art, the report reached a conclusion recommending the creation of "independent" review agencies that would protect patients to whom hospital staff seek to administer major treatments, especially psychosurgery. As indicated in subsequent sections, this approach is still being advocated today, but more as a means of protection against subsequent litigation than as a means of protecting patients.

In the discussion that follows on rights to receive treatment and to refuse treatment, references to statutes and analyses of relevant statutory provisions are based on this project's legal research as described in chapter 2.

Right to Receive Treatment

At the time of this writing, 29 states and the District of Columbia do not have statutory provisions giving mentally disordered offenders the right to receive treatment. Only 12 States explicitly afford a statutory right to treatment to all mentally disordered offenders; 2 States afford the right only to not guilty by reason of insanity; 6 States provide right to treatment only to incompetence to stand trial. The right may be presumed for at least certain subgroups in at least 22 other States, however. First, for 16 States, the right to treatment for all or some mentally disordered offenders is presumed from civil statutes providing the right to all those committed to the department of mental health. Because in those States, mentally disordered offenders (those persons found not guilty by reason of insanity or incompetence) are committed to departments of mental health, it is probable

that the right is extended to them. Second, in 2 additional States (Oregon and Maryland), the right is presumed on the basis that the statutes require that the appropriate authorities prepare individual treatment plans. Third, institutions in 4 of the 30 jurisdictions having no statutory right to treatment provision are under court orders to provide the right (District of Columbia, Nevada, New Jersey, Texas).

As indicated by Bazelon (1969) and Brooks (1980) the mentally disordered offender has no federally protected right to treatment. No clear statement in this area has yet been issued by the U.S. Supreme Court. As they suggest, however, there may well be an "evolving legal doctrine" in this area based on a number of developments in case law in various parts of the country. For the District of Columbia, cases during the past two decades (*Rouse* v. *Cameron*, *Dixon* v. *Weinburger*) suggest that involuntarily committed offenders have a statutorily based right to treatment and a right to treatment in the "least restrictive environment." On appeal, these cases were decided on grounds other than the constitutionality of a right to treatment.

A 1972 Supreme Court case, *O'Conner* v. *Donaldson*, is often cited as providing a right to treatment for a committed patient. Tepper and Kaslow (1979) point out that the finding in this case, that of a civilly committed patient, far from laying down a right to treatment, requires only that such a person be discharged if he or she does not receive treatment and is not dangerous to self and others.

Two Alabama cases, *Pugh* v. *Locke* and *James* v. *Wallace*, decided in 1976 ordered major reforms in the State correctional system, including a number designed to provide adequate treatment for mentally ill and retarded inmates. These cases, following on the 1973 *Wyatt* v. *Stickney* case, which set standards for that State's mental hospitals, found that mentally disordered inmates were entitled to certain "minimum constitutional standards of confinement". Among these were: transfer of those identified as disturbed or retarded to "facilities designed for such persons," provision of appropriate care for inmates identified as requiring mental health services in prison, and recruitment and employment of mental health professionals and support personnel.

Finally, reference should be made to a significant New Jersey juvenile court case, *In Interest of R.G.W.*, decided in 1976. This case involved a juvenile charged with murder who was first found incompetent to stand trial, then, 2 years later, was acquitted by reason of insanity with his hospitalization continued. During a period of 2½ months, he did not receive the treatment the court specified based on testimony of two psychiatrists (defense and prosecution). The court ordered a different institutional placement and went so far as to state that the offender had a right to a specific treatment mode: one-to-one therapy.

While the survey results reported in chapter 4 indicate that hospital and prison administrators do not perceive day-to-day impacts associated with implementation of court rulings affirming right to treatment, some observers have reported administrative impacts of affirming rights in this area. Judge Bazelon (1969), after advancing a quid pro quo argument in favor of the right to treatment (i.e., that treatment is owed in return for involuntary confinement), reviewed the difficulties in securing this right at the hospital level. He cited the continued slow progress at St. Elizabeths Hospital in the District of Columbia in implementing the *Rouse* v. *Cameron* ruling. He further claimed that legislatures have been quite reluctant to enter this arena, thus leaving reform almost exclusively to the courts.

Wexler (1976) looked at a number of treatment issues facing this society as a result of both resolved and unresolved legal questions. He put forward a conceptual framework that proposes to assist decisionmakers who have to come to grips with aspects of the right-to-treatment issue that have not been settled in law. This framework would classify the committed mentally disordered into two classes: parens patriae patients (i.e., those for whom the State assumes the protective responsibilities of "parent") and police power patients (i.e., those held for the protection of society).

According to Wexler, the right to treatment seems clearly to apply to the parens patriae patient. Two bases are offered for this conclusion. First is the quid pro quo argument raised by Bazelon earlier that, in return for involuntary confinement, one is owed treatment. Second, it may be assumed

that these patients are legally incompetent and should receive treatment to restore them to competence. With regard to persons committed pursuant to the police power, however, Wexler felt grounds were insufficiently established to call convincingly for a right to treatment.

Brooks (1978) has reviewed recent developments in mental health law and found that legal "doctrine" has been evolving along a certain evolutionary line, albeit "begrudgingly." This line of development consists of various case rulings that order humane conditions, individualized treatment programs, adequate treatment personnel, and right to the least restrictive alternative. These "rights," often subsumed under a quid pro quo rationale, seemed to suggest to Brooks the eventual development of a general right to treatment.

A most recent Supreme Court case, *Youngblood* v. *Romeo*, touched on the right-to-treatment issue with regard to an involuntarily committed mentally retarded patient in Pennsylvania. While the case was sent back to the lower court with no opinion vis-a-vis a federally protected right to treatment, the views of two sets of justices in concurring opinions suggest active controversy over whether the Court ought to consider such an issue in the future. Chief Justice Warren Burger wrote in a concurring opinion that raising the question of a right to "reasonable" treatment as stated in the Pennsylvania statute was "frivolous," and that a Supreme Court opinion interpreting the statutory language would result in blurring Federal-State differences to the point of being meaningless.

Justice Harry Blackmun (writing for himself and two other Justices) argued that the right-to-treatment issue was a serious one, which, if brought to the Court in an appropriate context, might well be considered.

Right to Refuse Treatment

Very closely related to the right to receive treatment is the right to refuse it. A part of this closeness has to do with two other rights: to treatment in the least restrictive environment and to a treatment modality that is the least intrusive treatment alternative. With respect to the latter, certainly, if one has a right to the least intrusive form of treatment, then does not one also have the right to refuse any other form?

Unlike the si' 'on with regard to right to treatment, it is not possible simply to add up the number of States with statutory provisions giving offenders the right to refuse treatment. If this were done, it would reveal that 7 States either require that consent be obtained or grant the right to refuse treatment in the case of all mentally disordered offenders. Further, 7 other States have similar provisions affecting those found incompetent to stand trial, while 2 States have these provisions for those acquitted by reason of insanity. Thus, it would appear superficially that in only 16 States can offenders refuse treatment or withhold consent to it. However, when one adds States having statutes by which mentally disordered offenders are civilly committed, another 18 States can be added to the list, for a total of 34. This addition needs to be done, as these latter States place restrictions on administering treatment to *all* civilly committed patients.

Of 34 States either giving a right to refuse treatment or restricting its administration, 8 statutorily limit this restriction to selected treatment modalities. Thus, 3 States restrict treatment by psychosurgery, 3 by aversive therapies, and 2 by electroconvulsive therapy.

It should also be noted that seven States allow competent patients to refuse all treatment, if such refusal is based on religious grounds or if the patient intends to rely on prayer for improvement. On the other hand, seven States statutorily allow overriding a patient's refusal if failure to treat would be life threatening. Based on discussion with facility administrators, it appears that such an override is fairly commonly provided through administrative regulations.

A review of case law developments suggests a clear, if contentious, evolution of the status of right to refuse treatment. As put by Brooks (1980) in his review of mental health law, society gradually began to realize during the late 1960s that

> . . . Certainly highly intrusive experimental, irreversible, and risky treatments were being administered to mental patients with a minimum of protection. (p. 345)

Brooks also pointed out that this realization started with increased public awareness of psychosurgical procedures and electroconvulsive therapy. Subsequently, aversive strategies and psychotropic drugs entered the picture and also gave rise to concern. Much of the case law action during the late 1960s and early 1970s centered around the issue of consent. Such questions as "Should consent be obtained prior to treatment?," "Who should consent?," and "What is informed consent?" have been addressed in various cases. In addition, case law has developed around the qualifying variable, type of treatment, and related questions, such as "How intrusive?," "How significant are the side effects?," and "How much risk is posed by the treatment?"

In the 1972 Alabama case *Wyatt* v. *Stickney*, involuntarily committed patients were found to have a right to treatment *and* a right to refuse certain "intrusive" and "risky" treatments such as electroconvulsive therapy, aversive therapies, and psychosurgery. In addition, the court ruled that patients for whom such treatments are believed necessary must give expressed and informed consent after consultation with an attorney or interested party.

Shortly after the *Wyatt* decision, the Michigan case *Kaimowitz* v. *Department of Mental Health* questioned the ability of any patient to give informed consent following long periods of institutional commitment. Institutionalization, the Michigan court found, may significantly diminish a patient's capacity to consent, especially when such "experimental" and "intrusive" measures as psychosurgery are involved.

A 1973 Iowa case, *Knecht* v. *Gillman*, upheld a criminally insane patient's right to refuse certain "aversive behavioral conditioning techniques . . . that induced vomiting." The court's ruling was based on the grounds that such treatment was unconstitutionally cruel and unusual. The court further found that this type of treatment could be administered only if the patient "knowingly and intelligently . . . consented to it".

More recently, support for the right to refuse treatment has been forthcoming under a right to privacy doctrine—a right that encompasses the right to bodily integrity, personal security, and the protection of one's mental processes. In *Rogers* v. *Okin*, "Boston State Hospital Case," patients sought to prohibit the hospital from using certain psychotropic drugs without their consent. As reported by Lasagna (1982), Massachusetts requires informed consent prior to employing psychosurgery and electroshock therapy but does not in the case of the questioned medication.

The State hospital did use admission packets to inform patients of "their opportunity to choose from alternative therapies, to be informed of the risks and possible side effects of treatment, and to refuse treatment at any point." In practice, however, patients were medicated forcibly, the hospital claiming that they were incompetent to make treatment decisions as outlined in the admission packets, and that the only forced medication was during psychiatric emergencies. The trial court found that patients must be permitted to refuse psychotropic drugs unless adjudged incompetent, in which case consent must be obtained from a guardian. The first circuit court of appeals found that, generally, a committed person has a right to "privacy, bodily integrity, or personal security." The case was remanded to the trial court to work out procedures for determining competency in "situations where any delay could result in significant deterioration" of the patient's mental health, after other "reasonable" and "less restrictive" treatments have been ruled out.

This case eventually went to the U.S. Supreme Court under the name of *Mills* v. *Rogers*. The Court did not rule on the treatment issue, sending it back to the lower court in 1982 for reconsideration in light of a related case decision.

In 1978, an involuntarily committed patient in New Jersey asked the Federal district court to issue an injunction to prevent the hospital from medicating him against his wishes (*Rennie* v. *Klein*). Over several years, he had been receiving various psychotropic drugs. In his petition, he asked the court to find that, absent an emergency, he had the right to refuse treatment and cited his fear and actual experience of a number of side effects. In the court's ruling, a significant statement was made regarding the applicability of the right of privacy to this plaintiff (and, one may assume, those similarly situated):

> . . . an involuntarily committed mental

patient has a constitutional right of refusal based on a new and evolving constitutional doctrine, the right of privacy. The court characterizes this as "broad enough to include the right to protect one's mental processes from governmental interference" and applicable to "establish an individual's autonomy over his own body."

This Federal district court qualified this right of privacy only when a patient is dangerous to self or others, and when a finding of incompetency is made. Also, the court stated that a patient should be able to choose the "least intrusive or risky" drug.

Finally, and perhaps most important, the court stated that a patient who refuses treatment has a right to procedural due process before his refusal can be overruled. This would include "a hearing before a disinterested fact finder and the right to a free lawyer and to a free, independent psychiatrist".

Potential Impact on Facilities

It would seem that, with regard to the emerging rights to receive treatment and to refuse it, the latter has the most potential for affecting the mental health/corrections systems, a conclusion consistent with survey results reported in chapter 4. S.H. Nelson (1981) pulls together some of these impacts and introduces a number of suggested "solutions" required by legal developments.

Nelson states that there ought not to be a right to refuse treatment for any patient involuntarily committed "with a diagnosed and treatable mental disorder . . ." Nelson claims that case law in cases such as *Rogers* and *Rennie* ignores the matter of patient competence to make or participate in treatment decisions and suggests that most courts, scholars, and others ignore a patient's "right to the pursuit of happiness" when they support a right to refuse treatment.

According to Nelson, abuses of involuntary commitments have been reduced significantly with the development of patient bills of rights, due process safeguards, and increasing acceptance of the least restrictive alternative doctrine. Insistence on the right to refuse medication would produce a number of unfortunate consequences for patient and institution. These include the following:

- Clinically, patients would begin treatment later in their commitments than would be best for them.
- Since "results of research . . . indicate that medication is the single most effective treatment for psychotic disorders," the right to refuse it would lead to "chronic psychoses in many patients. . . ."
- Hospitals would find untreated patients difficult to care for, and the level of serious violent behavior would rise, requiring staffing shifts in the direction of patient control.
- Average length of commitments would increase.
- Hospitals might encounter a "triple bind": (a) involuntary patients would not be treated without consent, (b) courts might prevent them from keeping untreated patients, and (c) hospitals might be liable if untreated released patients are still dangerous. (p. 384–385)

Finally, Nelson proposed a number of solutions to these problems. He would require that involuntary commitments always include competency determinations, and that they also contain a statement of the diagnosed mental disorder together with a finding that a "reasonable" probability of successful treatment exists. Administratively, hospitals can provide "active" peer review of treatment decisions, regular monitoring of drug side effects, medical audits of prescribing practices, and opportunities for patients to get second opinions on preferred treatments.

Tepper and Kaslow (1979) argue that "informed" decisionmaking capacity is the key to coping with the evolving doctrine of right to refuse treatment. They believe that a "standard" has been evolving that a person "deemed competent to consent to a course of treatment also has the right to reject certain treatment procedures." What is not happening, they say, is the development of definitions of competency with which to

implement appropriately the right to consent to or refuse treatment. Tepper and Kaslow contend that the specific competence required in this area is the ability to make an "informed decision." This consists of (a) the ability to understand the nature of the treatment, (b) the probable consequences of having vs. not having the treatment, and (c) the cognitive ability to make an informed decision. After reviewing the competency screening test developed at Harvard Medical School to screen for competency to stand trial, they suggest that a cognitive ability screening instrument could be designed to measure a person's ability to make informed decisions regarding treatment.

Louis Lasagna (1982), agreeing with Tepper and Kaslow in this regard, counsels that commitment determinations and competency findings be made conjointly and that involuntary commitments be ordered only for those who are not competent to make or participate in treatment decisions.

Brooks (1980), after reviewing the case law, found that both the right to treatment and the right to refuse it may pose serious problems for patient and hospital. He seemed to believe strongly that the most obvious solution to these problems is through negotiations and compromises that are likely to benefit a resisting patient without disruption of effective treatment programs.

As a final note, one should examine the amicus brief filed in the *Rogers* v. *Okin* case on behalf of the American Psychiatric Association and the Massachusetts Psychiatric Society on December 22, 1982, in the Massachusetts Supreme Judicial Court (Klein 1982). In arguing that involuntarily committed patients did not have a right to refuse antipsychotic medication, the brief made several important points that need to be reviewed as indicating current professional and legal thinking.

First, it was argued that a number of significant State interests are involved in drug refusals. Among these are institutional order and safety, which may well be endangered by patient refusals to be medicated. In addition, the State's parens patriae interest is a vital one, including two major components:

- First, the State, having denied the individual his liberty through commitment, has a clear interest in seeing that liberty is restored.
- Second, the State also has an interest in ensuring effective treatment so as to decrease the likelihood that, once released, patients will again become dangerous to themselves or others and/or need rehospitalization.

The brief presents a review of research literature, arguing that use of antipsychotic medication can result in significantly shorter hospital commitments and a lower rate of rehospitalization, putting the right to refuse treatment at clear odds with these components of the parens patriae interest.

The amicus brief also responded to the argument that antipsychotic drugs are unsafe and ineffective by stating that

> . . . a careful analysis of the scientific literature convincingly demonstrates that antipsychotics are safe and effective, and, therefore, that there is no basis for carving out a special judicial rule when dealing with this form of treatment. (p. 22)

In response to the argument that the right to refuse treatment rests on the presumed (unless specifically determined otherwise) competence of the committed patient, the brief made the point that the presumption of competence is based on a "misunderstanding" of the historical trend resulting in statutory acceptance of this presumption. Specifically, the brief argues that presumed competence was never intended to cover treatment refusal, since "appropriate treatment remains at the heart of the State's endeavor."

Finally, this amicus brief is in essential agreement with the thrust of the Nelson article discussed earlier: that, should the court require a finding of incompetence before denying a patient's wish to refuse treatment, that determination ought to be made at the time of commitment.

Sexual Psychopath and Defective Delinquent Laws

Enactment of sexual psychopath laws began in the 1930s, usually in response to a

highly publicized sex offense resulting in the death of the victim. (Sutherland 1950, Group for Advancement of Psychiatry, 1977) These laws, which typically provided sentences of "one day to life," were designed to fulfill two purposes. First, they were to provide the public with increased protection from sex offenders by allowing incarceration for a longer period of time than a sentence for the underlying criminal offense. The second purpose of the psychopath statutes was to provide the sex offender with treatment for his condition and the possibility of release once treatment had succeeded. Presumably, the laws would benefit both the public and the offender. The offender would receive help and be released when cured, which might be a shorter period than his sentence, while the public would be protected from the premature release of a dangerous offender. The alleged psychopaths did not qualify for the insanity defense, and, at least in many States, the laws were not meant to apply to offenders who could be transferred to mental hospitals.

Originally, these laws were designated sex psycopath statutes and were aimed solely at sex offenders. Later laws broadened their scope and name to psychopath or defective delinquency laws. Some States, while keeping the designation of sex psychopath laws, included within them offenders who had committed nonsexual offenses.

The laws were based on the following assumptions:

- There is a specific mental disability called sexual psychopathy, psychopathy, or defective delinquency.
- Persons suffering from such a disability are more likely to commit serious crimes, especially dangerous sex offenses, than normal criminals.
- Such persons are easily identified by mental health professionals.
- Treatment is available for the condition.
- Large numbers of persons afflicted with the designated disabilities can be cured.

Little or no hard data supported these assumptions at the time these laws were enacted. During the past decade, considerable literature has appeared to dispute the assumptions and assert that the laws have not and cannot fulfill their stated purposes.

For example, the Group for the Advancement of Psychiatry (GAP) report, *Psychiatry and Sex Psychopath Legislation: The 30's to the 80's* (1977), indicates that these laws lack clinical validity and that sexual psychopathy is not a psychiatric diagnosis. The report found that "sexual psychopathy is a questionable category from a legal standpoint and a meaningless grouping from a diagnostic and treatment standpoint." Treatment provided under sexual psychopath programs has been inadequate and ineffective. No reliable data exist to demonstrate the effectiveness of treatment provided by these programs. It concluded that sexual psychopath laws should be repealed. Other authors support the GAP report's conclusions. The Task Panel on Legal and Ethical Issues of the President's Commission on Mental Health also called for repeal of sexual psychopath statutes (Monahan 1981).

In addition, the commentary to the American Bar Association Criminal Justice Standard 18.2–5 (1980) severely criticized psychopathic offender statutes. The commentary discussion concludes by stating that "a strong case can be made for their total elimination." The jurisdiction of the standards committee, however, was limited to sentencing procedures, and thus a recommendation for repeal was believed to be beyond the committee's jurisdiction. This committee now has such jurisdiction, and its proposed standards recommend the repeal of sexual psychopath laws.

In recent years, State legislatures have been responding to these criticisms. At least 13 States have repealed their psychopath statutes, and 12 other States have modified their laws. For example, the Maryland statute has been modified so that the offender must volunteer or consent to remain in the program. Most of the statutory modifications have reduced the maximum length of commitment to the length of the criminal sentence. Only 5 States currently have a provision allowing for indefinite commitment of sexual psychopaths. These offenders are usually kept separate from other mentally disordered offenders, by placing them either in separate facilities or in special programs.

Depending on a variety of factors, recent and anticipated legislative changes may have a variety of impacts on offenders and on the program themselves.

- It is possible that both the type of offender served and the nature of the treatment may change in States that enact laws limiting sex psychopath programs to offenders who apply for them. The volunteers could be more amenable to treatment and might benefit from different treatment procedures than those utilized for involuntary patients.

- Laws limiting the period of commitment of sexual psychopaths to the length of the criminal sentence may reduce the number of offenders who receive treatment in special facilities and programs for this group.

- Mental health professionals will spend more time on treatment and less time testifying in court if sexual psychopath laws are voluntary or the commitment period is no longer than the sentence.

- The time spent in court and trial preparation by diagnostic and treatment staff will be eliminated or substantially decreased if the program is either voluntary or limited to the length of the sentence.

- The impact on other facilities for mentally disordered offenders when offender programs are eliminated or modified will depend on State laws governing hospitalization of offenders. If most of the offenders are not civilly committable and State laws use that criterion for transfer, mental health facilities for mentally disordered offenders will not be affected by the repeal of sexual psychopath laws. If the State uses different criteria for transfer, it is possible that many of these offenders will be placed in mental hospitals with other mentally disordered offenders.

It is likely that most States will repeal their involuntary sex offender and defective delinquency laws in the next few years, and that most offenders who would have been classified in these groups will be placed in prison. No data suggest that these offenders meet the civil commitment standards being increasingly used as criteria for involuntary placement of prisoners in a mental health facility. In short, enhanced protection of the public from repeated dangerous offenders will probably be accomplished by increased use of recidivist laws, rather than resort to the mental health system.

Mentally Disordered Minors

Changes in State laws governing minors who commit criminal offenses have created new assessment and treatment problems for both mental health and correctional personnel. Until the late 1960s, the prevailing view was that almost all youngsters accused of crime should be adjudicated in the juvenile justice system, where little attention was paid to the issues of competency to stand trial and insanity. Neither the concept of guilty nor the procedures governing its determination were considered important before the U.S. Supreme Court's decisions in *Kent* v. *United States* and *In re Gault*. The dispositional stage, not the factfinding stage, was the focal point of juvenile delinquency proceedings. Consequently, it was usually at disposition that the issue of the youngster's mental disability was first considered. Judges in many States had the authority to place the youngsters in mental health facilities directly, while in other States they could hold civil commitment proceedings or order that such proceedings be instituted.

Sometimes a youngster's need for mental health treatment was not apparent until he or she was already in a correctional facility. If correction officials thought transfer to a mental health facility was necessary, formal transfer procedures, like transfer of adults before the *Vitek* decision, were literally nonexistent. Transfer depended almost entirely on the willingness of the mental hospital or mental retardation facility to accept the child.

Changes in both the statutes governing juvenile court procedures and those defining conditions for waiver of minors to adult court are likely to raise the issue of mental health status for youthful offenders earlier in the adjudication process than before, and

perhaps to confront facilities for mentally disordered offenders with large influxes of such persons. These changes are examined in the following section.

Changes in Juvenile Court Procedures

The increasing criminalization of juvenile court procedure has caused approximately 10 States to specify by statute, court rule, or judicial decision that the issues of incompetency to stand trial and the defense of insanity are available in the juvenile court. Moreover, it is likely that their availability in juvenile court is constitutionally required under the reasoning of the *Gault* case.

Consequently, examinations for these purposes have become increasingly common. For this reason, both legal and mental health professionals probably will be forced to decide whether tests used to determine competency and insanity for adults are appropriate for children and young adolescents, or, alternatively, what new tests are required.

The insanity test issue will be an especially important question in the next few years, because many States are in the process of narrowing or eliminating the insanity defense for adult offenders. There would not seem to be a constitutional problem if a State chose to use a broader insanity definition for children, at least when the defense is raised by the child. The Supreme Court's decisions thus far have said that youngsters should not be deprived of the constitutional rights of adults. It has no way suggested that it would be unconstitutional to grant them additional protection.

Changes in Waiver Criteria

Minors are tried as adults when juvenile court jurisdiction is limited to youngsters of particular ages or to those charged only with specified offenses. In some jurisdictions, for example, the juvenile court does not have jurisdiction over a child charged with murder, regardless of his or her age. In others, like the District of Columbia, all 16-year-olds charged with felonies are supposed to be handled as adult offenders.

In approximately two-thirds of the States, the juvenile court has original jurisdiction over all youngsters charged with crime, but, in most of these jurisdictions, some youngsters can be transferred or waived to the criminal court. Before the 1970s, the legislative trend was to prohibit the waiver of any youngster under the age of 16. A large number of States revised their waiver statutes during the past decade, however, and the vast majority of these States lowered the waiver age. Currently, fewer than one-fourth of the States require that a minor be 16 in order to be subjected to transferral to criminal court. More than one-fourth of the States allow waiver at any age, at least for serious offenses. Age 14 is becoming the most common waiver age for those States specifying a minimum.

In approximately half the States, courts are supposed to consider mental illness as a factor in the waiver decision. The statutes usually do not define mental illness for waiver purposes, however, nor do they necessarily specify how a finding of mental illness is supposed to affect the waiver decision.

Some states make it clear that by mental illness they mean incompetency and prohibit waiver if the youngster is not competent to stand trial. In others, mental illness has the same meaning as it does under the civil commitment code. States using this definition could commit a child instead of waiving him or her to adult court.

The net effect of changing the age and offense jurisdiction of the juvenile court in recent years has been to increase the number of minors tried as adults. These minors, of course, can be found incompetent to stand trial or not guilty by reason of insanity. As with youngsters tried in juvenile court, the same issues exist as to whether different tests of competency and insanity should be used for minors and adults.

In addition, a convicted youthful offender may be mentally ill though neither incompetent nor insane. Judges increasingly will have to decide whether and to what extent the mental illness should mitigate the severity of the sentence. Appropriate placement of these youngsters must also be decided. Should they be sent to prison unless they meet the adult civil commitment standard, usually of dangerousness to self or others? Or should "need for treatment," the standard frequently used for committing children who are not offenders, apply?

Treatment and Placement of Mentally Ill Minor Offenders

Appropriate placement of mentally disordered youthful offenders is a difficult issue, regardless of whether adjudication occurs in a juvenile or adult court, and regardless of whether the mental illness is noticed before trial, at the time of the verdict or sentence, or after incarceration.

Some States treat mentally ill offenders in special facilities. It is questionable whether such facilities are suitable for minors. The Joint Commission on Mental Health of Children said that neither children nor adolescents should be placed on wards with adults. Unless the number of mentally ill minors is very large, creation of special units or institutions for them cannot be justified in terms of their numbers. Consequently, States are going to face the alternative of inappropriate care, or adopt the alternative of placing them under the control of departments of mental health or youth services rather than corrections.

Another issue is whether procedural protections available to adult offenders under *Vitek* or under State law are applicable to minors tried as adults and to those tried in juvenile court. Under proposed ABA standards, transfer of an adult offender who wishes mental health treatment does not have to meet civil commitment standards if the prisoner, the correctional institution, and the mental health facility all agree that hospitalization is appropriate. Clearly, the same criteria should apply to the transfer of minors, whether they are considered adult offenders or delinquents.

The more difficult question is whether a need-for-treatment standard should govern transfer to a hospital when any of the parties, the correctional facility, the hospital, or the youngster object to the transfer. It has been argued that the best policy would be to use the same criteria for hospitalization of minors, whether or not they are offenders, on the grounds that the State has a special interest in providing appropriate mental health care for minors.

Previous Research on Facility Impact

When one looks at the impact of existing laws regarding juveniles, certain generalizations become evident. Being "mad, bad, and young" usually means that no agency wants to be responsible for one's care and treatment.

The last national survey of juvenile justice systems revealed that at least 50 percent of all juveniles referred to courts "receive no specific services at all" (Sarri and Hasenfeld 1976). Several years earlier, Ferster and Courtless (1972), after an analysis of dispositions in an affluent suburban county, concluded the court there rarely offered meaningful treatment services. "Chances not services" seemed to be that county's response to juvenile delinquency, they found. After studying samples of adolescent murderers and mental hospital patients, Sadoff (1978) concluded that quite often juvenile offenders ". . . are not eligible for an adult prison or for a State hospital. . . . [They] require maximum security, but also rehabilitation, education, and pyschotherapy" (p. 132).

Conrad's (1977) review of the juvenile justice and mental health systems' performance vis-a-vis violent juveniles points out another generalization that can be made:

> . . . That law is . . . particularly solicitous of the accused juvenile, partly because of the diminished responsibility of any juvenile before the juvenile court, and partly because of . . . society's unwillingness to propel a child into the rigors of the criminal justice system. . . . (p. 14)

Conrad also speaks to the problem of system failure to provide sufficient resources to provide meaningful diagnostic and treatment services. In his words,

> . . . Courts in large cities are too overwhelmed . . . to deal properly with their caseloads or to assess specific cases in light of full information. [Correctional systems] have neither the expertise nor the program models for effectively controlling, let alone rehabilitating, [these offenders]. (p. 14)

Partly because of the deficiencies noted by Conrad and the problem noted earlier of the "mad and bad" juvenile, McKenzie and Roos (1979) concluded from a survey in California that the most disordered and

violent offenders are sent to prison-like facilities. "Dangerous children" are not welcome at the scarce residential psychiatric facilities. Following their five-county survey, McKenzie and Roos found that:

> No therapy-oriented facility is likely to accept hardcore violent and disturbed juveniles, and should one slip through, he probably will be ejected at the first violent outburst. (p. 53)

The treatment-oriented youth institutions manage to accept the most treatable juveniles, leaving the others to correctional facilities.

If some movement is occurring in the development of programs for juvenile offenders, one would assign it to the general area of peer group treatment. For example, Martin (1980) reports on "social skills development training" used with adolescent female patients. James and James (1980) suggest that a coed residential milieu can provide the most effective setting for peer group therapy.

While Warren and others have done some work designed to test the effectiveness of various treatment strategies with different kinds of juvenile offenders, little followup research is discernible after a review of the literature. One study found that youngsters charged with the same crime differ significantly in character structure, attributes for therapeutic involvement, and recidivism rates.

Chapter 4

Statistical Description of Facilities and Programs

This chapter reports statistical findings of the national mail survey of facilities for mentally disordered offenders. As explained in chapter 2, these findings are based on 127 usable responses collected between November 1981 and April 1982. Following a brief description of the range of organizational structures and capacities of the responding facilities, the remaining subsections report findings in the following areas:

- Facility population characteristics
- Treatment approaches employed
- Staffing levels and other staff characteristics
- Security features and procedures
- Management issues
- Legal issues
- Research and statistical activities

For most of the tables in this section, the facility is the unit of analysis, and results are presented as unweighted percentages of all responding facilities. Because respondents occasionally skipped some questionnaire items, the bases for the percentages vary somewhat across tables. The number of respondents is reported for each table. A few tables describe demographic or other characteristics of the population of responding facilities. This population includes only mentally disordered offenders housed in f lities for long-term treatment, plus other persons housed in those facilities, such as persons undergoing evaluation for competency or criminal responsibility and civilly committed mental patients. As with statistics based on facility counts, item nonresponse causes population counts to vary slightly across tables; these are reported for each table.

It may be helpful to point out special meanings of a few terms used heavily throughout this chapter. "Responding facilities," the organizations that completed questionnaires, are subdivided into both "institutions"—geographically distinct entities under the direct authority of administrative agencies—and "units"—components of institutions. Also, throughout most of the chapter, the terms "adult" and "juvenile" refer to the age jurisdiction of the referring court, i.e., statutory rather than chronological categories. Thus, some "adults" are "minors" (i.e., persons under 18 years old) who have been waived to adult court. Where needed for clarity, "chronological adults" is used to denote persons 18 and older.

As shown in table 4–1, all 127 facilities with usable responses operate under State auspices, with the exceptions of five Federal facilities (three governed by the U.S. Bureau of Prisons and two by the Department of Health and Human Services) and a unit of a municipal health department. Nearly two-thirds of the respondents are governed by mental health authorities, and nearly one-fourth by corrections authorities. Most of the remainder, classified as "social services/other," are operated by departments with responsibility for youth, community rehabilitation, social services, or institutions; a few operate under cooperative agreements between corrections and mental health authorities. Overall, 77 of the 127 respondents are units of larger facilities, rather than separate institutions. This predominance of units over institutions exists among corrections, mental health, and social services/other authorities.

Table 4–2, like many of the tables in this chapter, classifies the responding facilities in terms of organizational auspices (corrections, mental health, social services/

Table 4–1. Organizational auspices of responding facilities by auspices

Level of Government	Number of facilities by auspices								
	Corrections		Mental Health		Social Services/ Other		All Auspices		
	Institution	Unit	Institution	Unit	Institution	Unit	Institution	Unit	All
Federal*	0	2	0	2	0	1	0	5	5
State	12	16	32	45	6	10	50	71	121
Local	0	0	0	0	0	1	0	1	1
All	12	18	32	47	6	12	50	77	127

*In its survey response, one U.S. Bureau of Prisons unit classified its auspices as other than correctional. As with all other facilities, this facility's self–classification of auspices is used throughout this chapter.

Table 4–2. Eligible sex and age jurisdiction of responding facilities, by auspices

Eligible sex categories	Number of facilities															
	Corrections				Mental health				Social services/Other				All auspices			
	Adults and juveniles	Juveniles only	Adults only	All	Adults and juveniles	Juveniles only	Adults only	All	Adults and juveniles	Juveniles only	Adults only	All	Adults and juveniles	Juveniles only	Adults only	All
Males only	2	2	22	26	2	3	34	39	0	4	7	11	4	9	63	76
Females only	0	0	4	4	0	0	0	0	0	0	0	0	0	0	4	4
Both sexes	0	0	1	1	5	6	28	39	2	2	2	6	7	8	31	46
Not ascertained	0	0	0	0	1	0	0	1	0	0	0	0	1	0	0	1
Total	2	2	27	31	8	9	62	79	2	6	9	17	12	17	98	127

other) and the age jurisdiction of courts from which residents are received (adult, juvenile, or both). This table displays, by those characteristics, the number of facilities housing males only, females only, and both sexes. Half the facilities admit only male "adults," in the sense that residents are committed or sentenced by courts wth jurisdiction over adults rather than juveniles. Most of the remainder admit both males and females, with only 4 facilities admitting women exclusively. All 4 are under correctional auspices, and none admit juveniles. There are 29 facilities admitting juveniles, of which 12 also admit adults. None of these 29 are reserved for females, and only 15—all under mental health or social services/other auspices—admit them at all. Overall, the male–female restrictions of facilities responding to the present survey are similar to those reported a decade ago by Eckerman (1972): 60 percent male-only in the present survey, and 68 percent in 1972; 3 percent female-only in 1981, compared with 1 percent in 1972; and 36 percent admitting both sexes in 1981, compared with 31 percent in 1972.

As shown in table 4–3, reported design capacities vary widely across responding facilities. Three units with capacities of 10 or fewer fell into the eligible universe because of the primary nature of their responsibility for certain categories of mentally disordered offenders in their geographic catchment areas. While units with capacities between 11 and 50 exist under all three auspices, such small units are relatively more common under social services/other than either corrections or mental health authorities. Capacities between 51 and 250 are common for both institutions and units under all auspices.

For units, capacities exceeding 250 are rare under all auspices. Among institutions, however, such large capacities were reported by nearly 60 percent of correctional respondents and one-third of mental health respondents, but by no social services/other respondents.

It is of interest that the mean capacities reported both overall and for mental health facilities—institutions and units combined —are slightly smaller than the mean of 169 reported by Eckerman for 23 mental health facilities. However, Eckerman reports a mean capacity of 560 for 19 "security hospitals," the remainder of his respondents. The latter figure is substantially larger than that for any subgroup among respondents to the present survey. The decrease in size may reflect statewide decentralization of programs for mentally disordered offenders, which has occurred in several States, sometimes in response to court orders.

In interpreting table 4–3, it is important to recognize that some facilities integrate mentally disordered offenders with other persons. Figures in the table represent total capacity, not capacity for mentally disordered offenders. The latter is typically not static for integrated facilities but varies according to flows of offenders, persons being evaluated for competency/insanity, and civilly committed persons. Facilities exclusively for mentally disordered offenders, however, were found with capacities ranging as high as 1,254. The legal status composition, as well as other characteristics of facility population, are examined in the following section.

Facility Population Characteristics

Facilities were asked to provide statistics on various characteristics of their populations, including composition by legal status, demographic variables, psychiatric diagnosis, and offense types. In general, these data were reported by 126 respondents as of their respective dates of questionnaire completion, which ranged between early November 1981 and mid–April 1982. Because of certain definitional issues and because not all respondents were able to provide all requested statistics, the size of the population covered differs across tables.

While the population statistics reported in this section should not be treated as precise counts, they do provide the most comprehensive picture available as of 1981 of the populations housed in the facilities with primary responsibility for housing and treatment of the mentally disordered offender.

Overall, responding facilities reported a total population of 19,543, of which 88.3 percent were males and 11.7 percent were females. Within mental health facilities, females were slightly more prevalent, comprising 13.8 percent of the population.

Table 4–3. Capacity of responding facilities, by auspices

Capacity	Percent of facilities								
	Corrections		Mental Health		Social Services/ Other		All		
	Institution (N=12)	Unit (N=18)	Institution (N=31)	Unit (N=47)	Institution (N=6)	Unit (N=12)	Institution (N=49)	Unit (N=77)	All (N=126)
10 or less	0.0%	5.6%	0.0%	2.1%	0.0%	8.3%	0.0%	3.9%	2.4%
11 - 25	0.0	11.1	0.0	19.1	0.0	33.3	0.0	19.5	11.9
26 - 50	0.0	33.3	16.1	25.5	16.7	8.3	12.2	24.7	19.8
51 - 100	8.3	33.3	19.4	21.3	33.3	33.3	18.4	26.0	23.0
101 - 250	33.3	11.1	32.3	25.5	50.0	16.7	34.7	20.8	26.2
251 - 500	25.0	5.6	19.4	6.4	0.0	0.0	18.4	10.3	10.3
501 or more	33.3	0.0	12.9	0.0	0.0	0.0	16.3	0.0	6.3
All	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Mean Capacity (Number of Residents)	475	72	244	86	108	54	284	78	158

Legal Status of Facility Populations

Responding facilities were asked to provide legal-status distributions of their resident populations as of the date of questionnaire completion. The aggregate results are reported in table 4-4, by auspices and age jurisdiction of the court ordering incarceration, hospitalization, or examination. Of the population of 16,289 categorized by the 127 facilities, approximately 70 percent were hospitalized in mental health facilities, with 23 percent in correctional facilities and 7 percent in social services/other facilities. Within each of these subgroups of facilities, legal-status composition of the resident population differred substantially, in part because of statutory restrictions. While all residents of responding correctional facilities were mentally disordered offenders, facilities in other categories also housed some persons admitted under civil commitment proceedings.

Among mental health facilities exclusively for adults, the largest single group was persons found not guilty by reason of insanity, comprising 21.5 percent of the population. The fraction reportedly found incompetent to stand trial was only slightly smaller (17.4 percent). Some responding facilities reported that some of their civilly committed patients (comprising 14 percent of the total) are former incompetents, committed following a determination that they were unlikely to regain competency—the procedure mandated by the Supreme Court in *Jackson* v. *Indiana*. Without detailed records analysis, facilities were unable to separate these "unrestorable incompetents" from other civilly committed persons.

Penal transfers (convicted inmates transferred from the general prison population to special units or mental hospitals for treatment of mental illness) make up 10.5 percent of the population, and persons sentenced as sex offenders constitute another 12.2 percent. Although facilities performing solely evaluation for competency or criminal responsibility were excluded from the survey, many of the included facilities perform such evaluations in addition to long-term treatment. Persons being evaluated for competency make up 9 percent of the population of adult mental health facilities, persons being evaluated for criminal responsibility another 8.8 percent, and those being evaluated for both simultaneously make up a fraction of the 5.6 percent "other" patients.

Among correctional facilities, more than half of the residents are penal transfers. Sex offenders constitute another 13.7 percent of the population in these facilities, while "others"—primarily prisoners being segregated for short terms due to episodes of "acting out"—represent another 21.7 percent. Readers familiar with State laws in this area may be surprised to see even a small number of incompetents and insanity acquittees, as well as persons being evaluated, housed in correctional facilities; these persons are all Federal prisoners residing in special Bureau of Prison facilities set aside for such individuals.

Social services/other facilities house and treat primarily sex offenders (in some facilities exclusively), civilly admitted residents, and juveniles sentenced to treatment. Nearly all other legal categories are represented to a lesser extent within this class of agencies, however.

As one familiar with the juvenile justice system would expect, the overwhelming majority (nearly 90 percent) of all juveniles housed in responding facilities have been either sentenced to treatment or civilly committed. The adult legal categories include substantial numbers of minors waived to adult court, however.

Because statutes providing the guilty but mentally ill verdict are quite new in all but three States, persons institutionalized under that provision comprise less than 1 percent of the total population. The variation in sentencing, evaluation, and treatment procedures prescribed under different statutes providing the verdict, however, make it not surprising that such persons are found in facilities under all auspices.

Steadman et al. (1982) report statistics on adjudicated adult mentally disordered offenders in 356 facilities, presumably every facility in which they are housed. Many respondents to the Steadman survey were evaluation centers, temporary holding facilities, or facilities not primarily organized for long-term treatment of mentally disordered offenders and were therefore not included in the present survey. Nevertheless, it is of interest to compare legal-status distributions between the two studies. Considering only the adjudicated adult cat-

Table 4–4. Legal–status composition of adult and juvenile resident populaton, by auspices and age jurisdiction

Legal status	Corrections				Mental health				Social services/Other				All			
	Adults and juveniles (N=77)	Juveniles only (N=154)	Adults only (N=3449)	All (N=3680)	Adults and juveniles (N=1664)	Juveniles only (N=251)	Adults only (N=9509)	All (N=11424)	Adults and juveniles (N=242)	Juveniles only (N=265)	Adults only (N=678)	All (N=1185)	Adults and juveniles (N=1983)	Juveniles only (N=670)	Adults only (N=13636)	All (N=16289)***
Adults																
Being evaluated for competency	0.0%	0.0%	0.8%	0.7%	4.2%	0.0%	9.0%	8.1%	0.4%	0.0%	7.8%	4.5%	3.6%	0.0%	6.9%	6.2%
Being evaluated for responsibility	0.0	0.0	0.6	0.6	1.0	0.0	8.8	7.5	0.8	0.0	3.7	2.3	0.9	0.0	6.5	5.6
Guilty but mentally ill	0.0	0.0	1.4	1.3	0.6	0.0	0.6	0.6	0.0	0.0	0.6	0.3	0.5	0.0	0.8	0.7
Incompetent to stand trial	0.0	0.0	0.5	0.5	2.8	0.0	17.4	14.9	4.1	0.0	8.6	5.8	2.8	0.0	12.7	11.0
Not guilty by reason of insanity	0.0	0.0	0.0	0.0	3.8	0.0	21.5	18.4	17.8	0.0	7.5	7.9	5.4	0.0	15.4	13.6
Penal transfers	28.6	0.0	60.7	57.5	19.1	0.0	10.9	11.9	0.0	0.0	16.8	9.6	17.1	0.0	23.8	22.1
Sex offenders	13.0	0.0	14.3	13.7	2.6	0.0	12.2	10.5	0.8	0.0	40.4	23.3	2.8	0.0	14.1	12.1
Civilly admitted*	0.0	0.0	0.0	0.0	57.9	0.0	14.0	20.1	74.4	0.0	11.6	21.8	57.7	0.0	10.3	15.7
Other	0.0	0.0	21.7	20.3	4.6	0.0	5.6	5.3	0.0	0.0	3.0	1.7	3.9	0.0	9.5	8.4
Juveniles																
Being evaluated for competency	0.0	0.0	0.0	0.0	0.4	12.8	0.0	0.3	0.0	0.0	0.0	0.0	0.3	4.8	0.0	0.2
Incompetent to stand trial	0.0	0.0	0.0	0.0	0.2	0.8	0.0	0.0**	0.0	0.4	0.0	0.1	0.2	0.5	0.0	0.0**
Not guilty by reason of insanity	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Sentence to treatment	58.4	100.0	0.0	5.4	1.1	18.7	0.0	0.5	0.0	92.1	0.0	20.6	3.2	66.4	0.0	3.1
Civilly admitted*	0.0	0.0	0.0	0.0	1.4	61.4	0.0	1.8	1.2	0.4	0.0	0.3	1.3	23.2	0.0	1.1
Other	0.0	0.0	0.0	0.0	0.2	6.4	0.0	0.2	0.4	7.2	0.0	1.7	0.2	5.2	0.0	0.2
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0

* In some states, includes persons who are involuntarily civilly committed after a finding that they are unlikely to regain competence to stand trial.

** Indicates non-zero population less than 0.05% of total population.

***Total differs from overall total of 19,543 due to item nonresponse.

Table 4–5. Legal–status distributions, 1978 and 1981

Legal status	Percent of population in status 1978* n=14,140	1981** n=9,681
Incompetent to stand trial	24.0%	18.5%
Not guilty by reason of insanity	22.2	22.9
Sex offenders	17.3	20.4
Penal transfers to:		
Special units in corrections	19.0	21.9
Mental health/ other	17.5	15.2
Guilty but mentally ill	0.0	1.2
Total	100.0	100.0

* Source: Steadman et al. 1982.

**Includes only facilities designed primarily for treatment of mentally disordered offenders.

egories, Steadman and associates report 14,140 individuals for 1978, compared with 9,681 in the present survey.

Table 4–5 summarizes the legal–status distributions emerging from the two surveys. The two distributions convey a similar impression, specifically, that the adjudicated adult share of the mentally disordered offender population is distributed more or less evenly across the five major categories. Some of the differences are no doubt due to the use of different facility selection criteria in the two surveys; in addition, some discrepancy is introduced by nonresponse in the present survey and the heavy reliance on "best estimates" for facilities in most States in the survey by Steadman et al.

Nevertheless, the reported differences are interesting to consider in light of the changing legal environment. For example, the relative decrease between 1978 and 1981 in the number of adjudicated incompetents from 24.0 percent to 18.5 percent could perhaps reflect shorter stays associated with increasing success of programs for restoration to competency.

Crime Types of Facility Residents

Responding facilities were also asked to provide statistics on the crime types of which their populations had been accused or convicted, counting only the most serious charge. Because many responding mental health facilities contain civilly committed persons as well as mentally disordered offenders, the population covered by the crime–type distribution (13,651) is somewhat smaller than that covered by the legal–status distribution. The results are presented in table 4–6.

As indicated there, the majority of mentally disordered offenders, 68.7 percent, have been charged with crimes against persons. Among these crimes, the single most common category is homicide, with which 17.8 percent have been charged. Considering all facilities admitting adults only, the proportion charged with homicide varies substantially by auspices—21.5 percent within correctional facilities, 17.6 percent within mental health systems, and less than 12.9 percent in social services/other facilities. Among facilities admitting juveniles only, the fractions charged with homicide are substantially less: 3.9 percent in corrections, 6 percent in mental health, and 10.3 percent in social services/other. Overall, the proportion of residents charged with rape is 11.2 percent, with little difference across facilities admitting adults and juveniles.

Because crime classification and reporting practices differ across States and across surveys, it is impossible to make precise comparisons between the offense distributions for mentally disordered offenders and the general prison population. Nevertheless, it is clear that, based on charge, residents of facilities for mentally disordered offenders have more frequently been charged with crimes against persons than have residents of correctional facilities as a whole. According to the Bureau of Justice Statistics (1981), 57.5 percent of inmates of States correctional facilities in 1979 had been convicted of "violent" offenses, a classification roughly equivalent to this study's "crimes against persons" group, which accounted for 68.7 percent of charges within responding facilities. Among facilities for mentally disordered offenders, the reported prevalence of homicide charges

Table 4–6. Offense distribution for population of facilities, by facility auspices and age jurisdiction*

Offense	Proportion of population charged with offense												
	Corrections			Mental health			Social services/Other			All			
	Adults and juveniles (N=77)	Juveniles only (N=154)	Adults only (N=3268)	Adults and juveniles (N=780)	Juveniles only (N=134)	Adults only (N=7955)	Adults and juveniles (N=58)	Juveniles only (N=195)	Adults only (N=1030)	Adults and juveniles (N=915)	Juveniles only N=483)	Adults only (N=12253)	All (N=13651)**
Crimes against persons													
Homicide	13.0%	3.9%	21.5%	18.5%	6.0%	17.6%	12.1%	10.3%	12.9%	17.6%	7.1%	18.2%	17.8%
Rape	7.8	10.4	10.4	9.1	8.2	10.5	19.0	12.8	20.0	9.6	10.8	11.3	11.2
Other sex offenses	5.2	13.6	6.5	7.4	2.2	13.8	5.2	6.7	14.3	7.1	7.7	11.9	11.4
Other crimes against persons	45.4	23.4	30.6	36.4	53.7	27.3	20.7	38.5	17.7	36.2	37.9	27.4	28.3
Property crimes													
Arson	2.6	9.1	2.5	2.8	6.0	4.9	10.3	4.1	2.5	3.3	6.2	4.1	4.1
Other crimes against property	26.0	36.4	17.8	20.6	21.6	16.3	24.1	24.6	26.0	21.3	27.5	17.5	18.1
Other	0.0	3.2	10.7	5.1	2.2	9.6	8.6	3.1	6.6	4.9	2.9	9.6	9.1

* "Age jurisdiction" refers to the jurisdiction--adult or juvenile--of the court(s) sentencing or committing persons housed in the facility.

**Total differs from overall total of 19,543 due to item nonresponse and presence in some facilities of civilly committed persons having no criminal charges.

was 17.8 percent, compared with a combined 13.6 percent rate in State correctional facilities for murder and attempted murder.

For sex offenses, the Bureau of Justice Statistics uses only one classification, sexual assault, which accounted for 6.2 percent of all charges among the general prison population in 1981. This rate was just over half the frequency of rape charges reported by facilities for mentally disordered offenders, and just over one-fourth the combined rate for rape and other sex offenses reported by the latter group. Thus, even without exact comparability between crime classifications, the high prevalence of crimes against persons, particularly sex offenses, among mentally disordered offenders is apparent.

Psychiatric Diagnoses of Facility Populations

Responding facilities were asked to report statistical breakdowns of the primary psychiatric diagnoses of their mentally disordered offender populations, using *Diagnostic and Statistical Manual* (DSM-III) (American Psychiatric Association 1980) categories if possible. Among respondents, 78 facilities provided breakdowns using DSM-III categories, and 18 facilities provided DSM-II (American Psychiatric Association 1968) breakdowns. For many facilities, the number of diagnoses reported far exceeded the number of residents, indicating that respondents had reported at least primary and secondary diagnoses. Aggregate statistics based on the unweighted mean percentage of *diagnoses* in each category, rather than the percentage of *persons* with diagnoses in each category are reported.

A question of interest to researchers in the field is whether certain diagnoses are associated with the commission of crimes against persons. Adopting the Bureau of Justice Statistics classification of homicide, rape, and other crimes against persons as "personal" crimes, facilities are classified by whether more or less than half of their residents had been charged with personal crimes. Separate diagnostic distribution for the two sets of facilities are reported in the Appendix for facilities using DSM-III (table A-1) and those using DSM-II categories (table A-2).

The three most common DSM-III diagnostic categories are schizophrenic disorders, substance abuse disorders, and conduct disorders that appear prior to adolescence. Together, these three categories account for more than half of all diagnoses. Of the three, the first two occur somewhat less frequently in high violent crime incidence facilities than in low violent crime incidence facilities, while early-observed conduct disorders are more common in the first type of facility. While diagnoses of mental retardation, paranoid disorder, psychosexual disorder, and adjustment disorder are all relatively infrequent overall, they do occur at somewhat higher rates in the first type of facility.

DSM-II diagnoses of schizophrenia and personality disorders are by far the most common, accounting jointly for more than 70 percent of all diagnoses. Schizophrenia occurs slightly more frequently in the high violent crime incidence facilities, a result at odds with DSM-III respondents. Personality disorders are somewhat more common in low-incident facilities. Less common diagnoses associated with high-incidence facilities include mental retardation, affective psychoses, and childhood/adolescent behavior disorders.

Comparisons with previous studies suggest certain trends in recent years. Eckerman (1972) reports a diagnostic distribution of the populations of 88 facilities responding to his survey. Because Eckerman's categories are evidently aggregated from DSM-II categories, his published data are reproduced in the rightmost column of table A-2. Relative to the present study, Eckerman reports substantially greater concentrations of personality disorder and mental retardation diagnoses but fewer psychoses.

Scheidemandel and Kanno (1969) report a diagnostic distribution of admissions to 77 facilities during 1967. Their most common category, schizophrenic reaction, is still the most prevalent category reported by respondents to this survey. However, the concentration varies from 25 percent of admissions in the earlier study to 50.6 percent among DSM-II respondent populations and 36.5 percent among DSM-III respondent populations in the current study. Scheidemandel and Kanno's second most numerous category, sociopathic personality disturbance, accounting for 20 percent of 1967 admissions, is not a category in DSM-II or

Table 4–7. Age distribution of residents, by auspices and age jurisdiction of referring court

Age category	Percent of residents by age jurisdiction and auspices																
	Corrections				Mental health				Social services/Other				All				
	Adults and juveniles (N=77)	Juveniles only (N=148)	Adults only (N=5659)	All (N=5884)	Adults and juveniles (N=1643)	Juveniles only (N=319)	Adults only (N=8757)	All (N=10719)	Adults and juveniles (N=238)	Juveniles only (N=194)	Adults only (N=702)	All (N=1134)	Adults and juveniles (N=1958)	Juveniles only (N=661)	Adults only (N=15118)	All (N=17737)	General prison population** (N=245981)
14 & younger	1.3%	8.1%	0.0%	0.2%	0.6%	39.5%	0.0%*	1.3%	0.0%	5.7%	0.0%	1.0%	0.5%	22.5%	0.0%*	0.9%	2.6%
15 - 17	31.2	81.1	3.1	5.4	2.9	57.7	0.7	2.8	21.0	91.8	0.1	20.2	6.2	72.9	1.6	4.8	
18 - 34	67.5	10.8	62.5	61.3	33.8	2.8	63.0	56.7	38.2	2.6	65.7	49.1	35.7	4.5	62.9	57.7	75.3
35 - 64	0.0	0.0	33.1	31.8	37.7	0.0	32.6	32.4	23.1	0.0	33.8	25.7	34.4	0.0	32.8	31.8	22.1
65 & over	0.0	0.0	1.3	1.3	25.0	0.0	3.7	6.8	17.6	0.0	0.4	4.0	23.1	0.0	2.7	4.8	
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.00

* Percentage less than 0.05.

**Source: Sourcebook of Criminal Justice Statistics 1981 (U.S. Department of Justice, Bureau of Justice Statistics), Table 6.30, p.482.

DSM–III. Their third most numerous category—no mental illness—was reported to be 12 percent of 1967 admissions. The comparable DSM–II category—no psychiatric disorder, however, represented only 2.0 percent of respondent populations and the DSM–III category of factitious disorders was only 0.8 percent. For other major categories, substantial consistency is seen between 1967 admissions and 1981 populations: alcohol and drug addiction, from 7 percent among 1967 admissions to 9.3 percent within the 1981 population; sexual deviation, from 5 percent to 6.8 percent; and mental retardation, from 5 percent to 4.2 percent (DSM–II) and 4.3 percent (DSM–III).

In addition to the statistical breakdowns by primary diagnosis, each facility was asked to state the number of mentally disordered offenders in its program with a secondary diagnosis of mental retardation. To estimate the proportion of mentally disordered offenders who are mentally retarded, the counts of primary and secondary diagnoses of mental retardation were added together, and the sum was divided by the reported number of mentally disorderd offenders. Table A–3, in the appendix, reports medians and unweighted means of these estimated proportions, by facility auspices and age jurisdictions of referring courts.

Based on this procedure, an estimated 19 percent of all mentally disordered offenders in responding facilities have diagnoses of mental retardation. Among facilities admitting adults, the estimated proportion lies within the range of 10 to 18 percent, regardless of auspices. Among facilities admitting juveniles only, the estimates are substantially higher, ranging from 19.7 percent in mental health facilities to 58.8 percent in social services/other facilities, with an overall mean of 35.7 percent.

Some respondents are thought to have included secondary diagnoses in their reported accounts of primary diagnoses. If such respondents also reported the count of secondary diagnoses of mental retardation separately, the estimation procedure described here would double–count them, leading to an overestimate of the proportion diagnosed as mentally retarded. It is likely that this overestimate is on the order of only 1 to 2 percent. The distribution of mentally retarded offenders by facilities suggests a strongly skewed distribution, in which a few facilities house mentally retarded offenders in proportions far greater than the reported means would suggest, while the proportion in most facilities is less than the reported mean.

Demographic Characteristics of Facility Populations

Facilities were asked to provide statistical breakdowns of their populations by several demographic descriptors, including age and ethnicity. Results based on these breakdowns are discussed in this section.

Table 4–7 summarizes the age distribution of the population housed in the 125 facilities for mentally disordered offenders (MDO facilities) that reported age statistics. For comparison, the table also reproduces statistics published by the Bureau of Justice Statistics (Flanagan et al. 1982) on the age distribution of the general population of adult prisons. If one excludes juvenile–only facilities from the comparison, the under–18 fractions become about equal for the two populations (3.1 percent for MDO, 2.6 percent for the general prison population), while the over–35 fraction increases to 38 percent for the MDO facility population, compared to 22.1 percent for the general prison population.

Among subgroups of MDO facilities, the population of mental health facilities contains a slightly larger 35–and–over fraction than do the populations of facilities under other auspices, whether one examines all facilities or just the adult–only facilities. Within the adult–only facilities, however, the fraction under 17 is 3.1 percent in corrections, which is larger than the corresponding fractions in adult–only facilities in the other systems.

A related question is examined in the appendix, table A–4, which summarizes the facility reports of the ages of their youngest residents. Four of nine juvenile mental health facilities reported that their youngest residents were younger than 10 years old, and one 4–year–old resident was observed during a site visit. The table indicates that all mentally disordered offenders in the 10–or–younger group resided in juvenile–only facilities at the time of the survey. One adult–only mental health facility reported a resident between the ages of 11 and 14, and 21 adult–only facilities housed

Table 4–8. Ethnic distribution of population, by region and auspices of facility

Ethnic category	Percent of population in category, by region and auspices															
	Northeast			Central			South			West			All			
	Corrections	Other	All	Corrections	Other	All	Corrections	Other	All	Corrections	Other	All	Corrections	Other	All	General prison population*
Caucasian																
Number	570	1434	2004	465	1628	2093	820	1273	2093	764	2232	2996	2619	6567	9186	121295
Percent of facility population	64.3	59.9	61.1	39.8	59.2	53.4	44.4	40.2	41.7	37.4	62.8	53.5	44.0	55.3	51.6	44.4
Black																
Number	271	742	1013	534	963	1497	1002	1763	2765	983	768	1751	2790	4236	7026	128554
Percent of facility population	30.6	31.0	30.9	45.7	35.0	38.2	54.2	55.6	55.1	48.1	21.6	31.3	46.9	35.7	39.4	47.1
Hispanic																
Number	42	173	215	48	133	181	3	106	109	219	409	628	312	821	1133	19522
Percent of facility population	4.7	7.2	6.6	4.1	4.8	4.6	0.2	3.3	2.2	10.7	11.5	11.2	5.2	6.9	6.4	7.2
Other																
Number	3	44	47	122	27	149	24	29	53	76	146	222	225	246	471	3607
Percent of facility population	0.3	1.8	1.4	10.4	1.0	3.8	1.3	0.9	1.1	3.7	4.1	4.0	3.8	2.1	2.6	1.3
Total																
Number	886	2393	3279	1169	2751	3920	1849	3171	5020	2042	3555	5597	5946	11870	17,816**	272978
Percent of facility population	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0

* Source: Sourcebook of Criminal Justice Statistics 1981 (U.S. Department of Justice, Bureau of Justice Statistics), Table 6.30, p.482.

**Total differs from overall total of 19,543 due to item nonresponse.

youth between 15 and 17. As expected, the vast majority of adult-only facilities, 93.8 percent, reported the ages of their youngest residents between 15 and 21.

Responding facilities were asked to provide statistical breakdowns of their populations by ethnic category, and 126 were able to do so. In table 4–8, results are summarized by region and auspices and compared with Bureau of Justice Statistics ethnic breakdowns for the general population of adult correctional facilities. Considering all auspices, Caucasians constitute a 51.6-percent majority of the population in facilities for mentally disordered offenders for the country as a whole, as well as in all regions except the South. This relationship contrasts with the ethnic distribution in the general prison population, where blacks outnumber Caucasians, 47.1 percent to 44.4 percent, and 8.5 percent of residents are members of other ethnic groups. Considering only correctional facilities, however, the ethnic distributions for mentally disordered offenders and the general population resemble each other very closely.

Regional ethnic distributions within facilities for mentally disordered offenders are clearly related to regional distributions in the general population. Caucasians are most heavily represented in Northeastern facilities, blacks in Southern facilities, and Hispanics and others (primarily Asians and American Indians) in the West.

In summarizing demographic characteristics of the population of facilities for mentally disordered offenders, one can say that, in absolute terms, the population is predominantly younger than 35 and Caucasian by a small majority. Compared with the general population of adult prisons, however, this special population is older and composed of fewer members of minority ethnic categories.

Population Flows

Facilities were asked to supply data on population flows — admissions, releases, deaths, and escapes/elopements — during their most recent annual reporting periods, generally either calendar or fiscal year 1981. Means were computed for each flow by facility population category, and the results are reported in table 4–9, together with mean population. Of the 127 respondents, only 111 were able to supply data on all four types of flows; moreover, tabulation of even these responses suggests the presence of reporting errors. Nevertheless, table 4–9 is suggestive of certain patterns.

First, the high mean admissions rates relative to facility populations suggest that, except for the largest facilities, the average length of stay is shorter than 1 year. Taking the ratio of mean population to the mean of admissions and releases as an estimate of average length of stay, the estimate is 0.6 years overall, ranging from 0.2 years in the smallest categories of facilities, increasing gradually with population, and reaching 1.34 years in the largest population category. Because of probable reporting errors, and an element of approximation in the estimation method, these estimates should be considered quite tentative. By comparison, Steadman et al. (1982), using the same procedure, estimates average length of stay as 1.08 years. Their higher estimate is to be expected, since their population excludes juveniles and persons being evaluated for competency and/or responsibility.

Second, the data on rates of death and escapes/elopements suggest that the incidence of these events is strongly and positively related to facility size. The mean annual count of deaths (including suicide, homicide, and natural causes) ranges between 0 and 2 across facilities with populations of fewer than 500, but jumps to 18 for facilities with populations exceeding 500.

Facilities were asked to supply escape/elopement data separately, according to whether or not the missing resident was returned. Because many respondents were unable to do so, however, both categories are included in the escape/elopement data in table 4–9. Again, annual rates are low in the smaller facilities, ranging between 1 and 9 per year in facilities with populations of 250 or fewer. However, the rate jumps to 31 in facilities with populations between 251 and 500, and 38 in the largest facility category.

Treatment of Mentally Disordered Offenders

A major purpose of this survey was to ascertain the status of treatment in facilities for mentally disordered offenders. Fa-

Table 4-9. Mean population flows, by population category

Type of Population Flow	Mean annual rate by population category							
	10 or less (N=4)	11-25 (N=11)	26-50 (N=21)	51-100 (N=22)	101-250 (N=30)	251-500 (N=10)	501 or more (N=8)	All (N=106)
Admissions	45	130	113	276	278	595	796	290
Releases	38	117	106	236	267	537	668	260
Deaths	0	0	1	0	1	2	18	2
Escapes/Elopements*	1	5	9	4	4	31	38	10
Net population change*** (minimum/maximum)	+6/+7	+8/+13	-3/+6	+36/+40	+6/+10	+31/+62	+72/+110	+18/+28
Mean population	6.5	16.3	37.6	71.7	158.7	326.5	981.6	174.1
Estimated mean length of stay**	0.16	0.13	0.32	0.28	0.58	0.58	1.34	0.63

* Includes escapes/elopements with and without return.

** Ratio of mean population to mean of admissions and releases.

***Minimum computed assuming no return of persons escaping or eloping. Maximum computed assuming 100% return of persons escaping or eloping.

cilities were queried concerning their use of individualized treatment planning and case conferences, various treatment modalities, diagnostic assessments, and ancillary services. Respondents were also asked to describe their use of community resources, the availabilty of prerelease services, transitional release programs, and postrelease followup. Survey results on these topics are summarized on the following pages.

Treatment Planning and Case Conferences

As shown in table 4–10, more than 90 percent of all respondents reported that individual treatment plans are prepared for residents and reviewed at regular intervals by a social worker, psychologist, psychiatrist, or team of professionals. Moreover, the treatment planning process appears to be part of standard procedure regardless of auspices. It is significant that the treatment planning process appears to be motivated by a treatment orientation rather than by legal requirements, since fewer than half of all facilities reported a legal requirement for individual treatment planning. It may be significant that site visits found oral rather than written treatment plans to be the standard in some facilities. Moreover, it is not clear that review of treatment plans normally includes objective measurement of progress toward long-term goals. Nonetheless, respondents reported that some form of treatment planning has been institutionalized in virtually all facilities in the respondent universe.

As an adjunct to treatment planning, facilities were asked to report on the frequency and purposes of case conferences. Conferences were reportedly held at least weekly in 93.5 percent of all responding correctional facilities, 91.1 percent of all mental health facilities, and all social services/other facilities. The most frequently cited purposes of the case conferences were individual case review (by 92.1 percent of all respondents), significant case management decisions (91.3 percent), and examination of special problems (85.0 percent). More than half (53.5 percent) of all facilities (and, rather surprisingly, 30 percent of correctional facilities) reported holding case conferences for forensic evaluation. Unfortunately, the data do not permit us to tell how frequently an average resident's case is reviewed. Moreover, no qualitative assessment of the case conference process was attempted.

Treatment Modalities and Services

Table 4–11 reports statistics on the availability of various forms of treatment and the median level of participation in each form among facilities where it is available. Psychotropic medication, as expected, is the most universal form of treatment, with 97.6 percent of all responding facilities reporting it to be available. The data suggest some use of discretion in its administration, however, as the median percentage of residents receiving medication was reported to be only 61 percent. Widespread availability of psychotropic medication is not a new phenomenon; Scheidemandel and Kanno (1969) report its use for "some, most, or all patients" by 96 percent of their responding facilities. Eckerman (1972) reports medication was provided by 83 percent of facilities for which available types of treatment were ascertained.

The other most commonly available treatment modalities are weekly individual and group therapy, with nearly 90 percent of all respondents reporting such therapy to be available. Participation rates are substantial, with a median of 60 percent of residents participating in group therapy and 34 percent in individual therapy, where those treatments are available. These results suggest moderate increases in the availability of verbal therapies, since Scheidemandel and Kanno report "regularly scheduled group psychotherapy" in only 82 percent of their responding facilities and individual therapy in only 74 percent. In contrast, Eckerman, rather surprisingly, reports use of individual psychotherapy by 97 percent and group psychotherapy by 91 percent of facilities for which treatment modes were ascertained. Staffing data and observation during site visits suggest that, most commonly, social workers and psychologists supervise ward aides or psychiatric technicians in therapeutic work. In addition, weekly ward meetings are considered group psychotherapy in some facilities.

Table 4–10. Status of individual treatment planning, by auspices and organizational level

Status of Individual Treatment Planning	Percent reporting status by auspices and organizational level								
	Corrections		Mental Health		Social Services/ Other		All		
	Institution (N=12)	Unit (N=18)	Institution (N=32)	Unit (N=47)	Institution (N=6)	Unit (N=12)	Institution (N=50)	Unit (N=77)	All (N=127)
ITP's Not Prepared	0.0%	11.1%	0.0%	0.0%	16.7%	0.0%	2.0%	2.6%	2.4%
ITP's Prepared But Not Reviewed	8.3	0.0	0.0	2.1	0.0	0.0	2.0	1.3	1.6
ITP's Prepared and Reviewed	91.7	88.9	96.9	95.7	83.3	91.7	94.0	93.5	93.7
Not Ascertained	0.0	0.0	3.1	2.1	0.0	8.3	2.0	2.6	2.4
Total	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
ITP's Required By Law	33.3%	5.6%	65.6%	57.4%	33.3%	50.0%	54.0%	44.1%	48.0%

Table 4–11. Availability of therapies and participation, by auspices

Mode of Treatment	Percent reporting availability, and participation rate*							
	Corrections (N=30)		Mental Health (N=77)		Social Services/Other (N=18)		All (N=125)	
	Availability	Median Participation Rate	Availability	Median Participation Rate	Availability	Median Participation Rate	Availability	Median Participation Rate
Psychoanalysis	10.0%	67%	13.0%	10%	5.6%	--%	11.2%	11%
Weekly Individual Therapy	93.3	33	87.0	34	83.3	50	88.0	34
Less Frequent Individual Therapy	73.3	20	63.6	16	50.0	17	64.0	17
Weekly Group Therapy	86.7	35	92.2	60	83.3	75	89.6	60
Less Frequent Group Therapy	33.3	18	40.3	13	22.2	10	36.0	15
Other Psychotherapy	10.0	4	22.4	8	22.2	42	19.4	8
Psychotropic Medication	96.7	59	98.7	68	94.4	47	97.6	61
Electroconvulsive Therapy	13.3	2	24.7	0	5.6	--	19.2	0
Other Somatic Therapy	6.7	--	2.6	--	0.0	--	3.2	89
Behavior Modification	53.3	19	64.9	29	72.2	67	63.2	27
Occupational Therapy	50.0	25	81.8	41	50.0	52	69.6	41
Art Therapy	56.7	25	63.6	14	66.7	41	62.4	20
Psychodrama	20.0	33	26.0	6	11.1	--	22.4	8
Movement/Dance Therapy	10.0	--	37.7	14	16.7	22	28.0	23
Other Ancillary Therapy	26.7	5	27.6	9	38.9	23	29.0	10

*Median participation rates based on only facilities where treatment is available.

-- Indicates insufficient number of facilities for meaningful computation of median.

The availability of occupational therapy has declined from the 80 percent of facilities reported by Scheidemandel and Kanno to the 69.6 percent reported by respondents to the present survey. This is not surprising in view of security constraints on available tools and equipment and the fact that release to the community is a rare event, even though most facilities do so occasionally. Such programs are available in a greater proportion of mental health facilities than others. Generally, implementation of a substantial occupational therapy program has been preceded by discussions between treatment and security staff to set mutually acceptable ground rules concerning tool use in the therapeutic area and storage of crafts in living areas.

Psychoanalysis was reported to be available by 11.2 percent of all facilities, and substantial participation (a median of 11 percent of residents) was reported. However, the low reported availability of psychiatrists (discussed in the next section) suggests that the term "psychoanalysis" was being used by respondents in a nonconventional sense, due to either lack of understanding or an attempt to inflate the data.

Comparison of table 4–11 with results of Scheidemandel and Kanno suggests a substantial decrease in the prevalence of somatic therapies between 1967 and 1981. Electroconvulsive therapy reportedly was used for "some, most, or all patients" by 34 percent of the 1967 respondents, and other somatic therapies (e.g., Indoklon and insulin shock) by 6 percent, compared with 19.2 percent and 3.2 percent of facilities, respectively, among 1981 respondents.

Table A–5, in the appendix, reports the availability of a number of diagnostic tests in institutions, by auspices. While each of the tests commonly applicable to both males and females was reportedly available (on site or off premises) in more than 80 percent of all facilities, wide variations in the incidence of routine use were reported. The vast majority of facilities routinely give physical (96.9 percent) and psychiatric (88.2 percent) examinations, although psychological tests are given routinely by only 69.3 percent. Eckerman asked his respondents whether they employed these same tests, without specifying whether such use was routine or occasional. He reports that 91 percent reported giving a physical examination upon admission, 97 percent a psychiatric examination, and 84 percent psychological/IQ tests.

More than 80 percent of facilities routinely administer some blood chemistry tests. Only 29.1 percent of respondents reported routine screening for substance abuse, however. As one might expect, while more expensive tests such as computerized axial tomography (CAT) scans, electroencephalograms (EEGs), electrocardiograms (EKGs), and neurobehavioral tests are generally available, they are routinely used by only about one–fourth of all facilities. On average, a smaller proportion of correctional facilities than others report routine use of these tests.

Facilities were asked to indicate the availability or nonavailability of a number of ancillary services. Based on their responses, table A–6, in the appendix, reports, by auspices and age jurisdiction of referring court, the percentage of facilities reporting availability of various academic, recreational, vocational, and other services facilities. Among academic programs, general equivalency diploma (GED) preparation (available in 83.5 percent of respondent facilities), tutoring (73.2 percent), and other elementary or secondary education (68.5 percent) were the most widely available programs. As one might expect, these programs were most frequently reported available in facilities serving juveniles only. It is somewhat surprising, however, that they are less widely available in facilities admitting both juveniles and adults than in adult–only facilities. They were also less often reported available by mental health facilities than by facilities under other auspices. Nonetheless, such programs have become far more widely available since 1967, when Scheidemandel and Kanno reported availability of academic education in only 42 percent of their responding facilities.

Among recreational programs and facilities, movies (available in 91.3 percent of all facilities), outdoor sports (90.5 percent), and gymnasium (74.8 percent) are the most widely available. As with the most prevalent academic programs, all three are most common among juvenile–only facilities but are more common in adult–only facilities than in facilities serving both populations.

Except for vocational aptitude testing (available in 61.4 percent) and inpatient job

programs (62.2 percent), all vocational services are far less widely available than academic and recreational programs. This is perhaps to be expected, since 9 percent of the responding facilities never release residents to the community, and others do so only rarely. Correctional facilities are more likely than others to provide job training (50.0 percent in corrections versus 38.6 percent overall) and vocational aptitude evaluation (70.0 percent versus 61.4 percent), presumably in the expectation of eventual parole. However, only 10 percent of correctional facilities perform outside job placement, a function more frequently carried out by parole authorities. Outside job placement is available in 55.6 percent of responding social services/other facilities. The availability of inpatient job programs has increased to 62.2 percent in 1981 from 33 percent of facilities in 1967, as reported by Scheidemandel and Kanno. The availability of job training has decreased from 49 percent to 38.6 percent during the same period.

Life skills training is available in more than half of all facilities (55.9 percent), approximately the same proportion reported by Scheidemandel and Kanno. Legal services were reported by approximately two-thirds of all respondents. Interestingly, legal services are less widely available in juvenile-only facilities (52.9 percent) than in facilities that serve adults (69.1 percent).

In addition to services provided by institutional staff, more than 95 percent of all respondents have arranged for provision of services by one or more community organizations. As shown in appendix table A-7, 19.5 percent of all respondents reported working relationships with just one community organization. Most commonly, the single organization is a postsecondary educational institution (college, university, medical school, or nursing school); however, vocational rehabilitation agencies, alcohol abuse programs, and other agencies were also cited. Among respondents, 75.8 percent reported ties to multiple agencies. Looked at another way, 65.4 percent of all respondents reported relationships with vocational rehabilitation agencies, 76.3 percent with postsecondary educational institutions, 55.9 percent with alcohol abuse programs, and 37 percent with another type of agency. The others named included community mental health centers, various volunteer groups, parole authorities, and child/youth services agencies.

Prerelease and Release Services

Respondents were asked to describe the nature of their prerelease services, distinguishing between release to other institutions and release to the community. The results are reported in tables 4-12 and 4-13. Even if "not ascertained" responses in table 4-12 (i.e., blank or unintelligible) are combined with "no services" responses, about 90 percent of all facilities that release residents to other institutions (i.e., 83.5 percent of all facilities) provide some form of prerelease services. Most commonly, these services are administrative arrangements (reported by 56.7 percent of respondents) and treatment planning (37.8 percent).

Among facilities releasing to the community, table 4-13 shows that nearly 60 percent of all respondents reported prerelease counseling and testing. Moreover, 33.9 percent reported, in their own answers to open-ended questions, "negotiating terms of treatment with community agencies." Respondents' choice of this terminology presumably reflects a more aggressive stance than that taken by another 21.3 percent of facilities, which report "referral to community agencies." Besides the court, the most commonly named specific community agency was a community mental health center. Use of the term "negotiation" possibly reflects the perception, frequently relayed to us informally by facility staff and administrators, that community mental health centers are reluctant to accept responsibility for released mentally disordered offenders, and that rather aggressive negotiation is required to obtain suitable supervision and treatment plan followup for releasees by community mental health centers.

The 116 facilities that release residents to the community were asked to describe the nature of any transitional release programs they provide; of these, 99 provided usable responses. Table A-8 in the appendix reports that, of the 99, only 15.2 percent reported offering no transitional release programs, while 6.1 percent reported only work/education release, 2 percent reported only partial release, 23.2 percent reported

Table 4–12. Prevalence of prerelease services (release to other institutions), by auspices

Prerelease services (release to institutions)	Percent providing services			
	Corrections (n=30)	Mental health (n=79)	Social services/ other (n=18)	All (n=127)
No services	6.7%	7.6%	5.6%	7.1%
Administrative arrangements	50.0	55.7	72.2	56.7
Orientation	20.0	8.9	16.7	12.6
Treatment planning	50.0	32.9	38.9	37.8
Psychosocial examination	3.3	3.8	5.6	3.9
Counseling	3.3	1.3	0.0	1.6
Other	13.3	5.1	0.0	6.3
No release to other institutions	6.7	6.3	11.1	7.1
Not ascertained	10.0	11.4	0.0	9.4

only conditional release (i.e., a form of release in which the releasee can be returned to the facility under certain conditions), and 6.1 percent reported only some other special release program. Another 47.4 percent reported some combination of the above, usually including conditional release. Summarized another way, 40.5 percent reported using work/education release, 31.4 percent reported partial release, and 26.3 percent reported some other special release program.

As shown in tables 4–14 and 4–15, 52.8 percent of the responding facilities reported making at least occasional unconditional releases to the community. Nearly a quarter (24.4 percent) of all facilities, almost half of those making such releases, reported additional followup with the person released. Such followup was usually reported to be for providing support and information about

Table 4–13. Prevalence of prerelease services (release to community), by auspices

Prerelease services (release to community)	Percent providing services			
	Corrections (n=30)	Mental health (n=79)	Social services/ other (n=18)	All (n=127)
No services	10.0%	2.5%	0.0%	8.7%
Court/board hearing	0.0	5.1	11.1	4.7
Administrative notification	16.7	15.2	11.1	15.0
Medical/dental/medication	3.3	2.5	0.0	2.4
Negotiate terms of treatment with community agencies	23.3	40.5	22.2	33.9
Refer to community agencies	23.3	21.5	16.7	21.3
Provide information to other agencies	10.0	8.9	5.6	8.7
Furloughs/trial releases	3.3	5.1	11.1	5.5
Counseling/testing	66.7	50.6	83.3	59.1
Other	3.3	11.4	11.1	9.4
No release to community	6.7	7.6	16.7	8.7
Not ascertained	10.0	8.9	5.6	8.7

Table 4–14. Prevalence and objectives of followup with unconditional releasees, by auspices

Status of followup contact with unconditional releases	Percent providing services			
	Corrections (n=30)	Mental health (n=79)	Social services/ other (n=18)	All (n=127)
Unconditional releases occur	33.3%	59.5%	55.6%	52.8%
Unconditional releases and followup occur	10.0	26.6	38.9	24.4
Followup to provide support	3.3	16.5	33.3	15.7
Followup to inform of community resources	6.7	15.2	27.8	15.0
Followup to evaluate adjustment	3.3	20.3	22.2	16.5
Followup for other purposes	6.7	10.1	16.7	10.2

community resources and for evaluation of the releasee's adjustment. A slightly higher proportion of facilities, 30.7 percent, reported followup with community agencies concerning persons released unconditionally to the community. Such followup was used most commonly to monitor a referral or to evaluate the releasee's adjustment. Although the respondents' written comments concerning purposes of followup were not typically very specific, facility staff and administrators frequently emphasized the need to monitor maintenance of medication by releasees both to the community and to other institutions, and to other units within an institution. Failure to maintain medication is apparently seen by many staff members as a frequent cause of "failure" of a releasee in his or her new environment.

Facility Staffing

This section reports survey results on facility staffing levels, trends in the education levels of senior staff, staff training, and other issues.

Table 4–15. Prevalence and objectives of agency contact concerning unconditional releasees, by auspices

Status of followup contact with community agencies	Percent of facilities in status			
	Corrections (n=30)	Mental health (n=79)	Social services/ other (n=18)	All (n=127)
Unconditional releases occur	33.3%	59.5%	55.6%	52.8%
Unconditional releases and agency contact occur	10.0	35.4	44.4	30.7
Agency contact to evaluate adjustment	3.3	25.3	27.8	20.5
Agency contact to follow up referral	10.0	25.3	44.4	24.4
Agency contact for other purposes	3.3	5.1	16.7	6.3
Purpose of agency contact not ascertained	0.0	2.5	5.6	2.4

Staffing Levels

Facilities were asked to provide data on the number of full-time equivalent staff, both authorized and currently in place, broken down into a number of categories. These data were combined with resident population data to calculate staff-to-resident ratios by category for each facility. Based on usable responses from 112 facilities, aggregate results on staffing ratios are presented by auspices and type of population served in table A-9, and by facility population category in table A-10. (Both tables appear in the appendix.)

Ratios based on current staff levels at the time of the survey, and population as of the date of questionnaire completion were calculated. These figures include not only permanent staff but also consultants and contractors. For most categories of staff, a few "outlier" facilities exhibited very high staff-resident ratios, compared with other facilities. While the outliers varied from one staff category to another, they skewed the distributions rather dramatically. Therefore, median rather than mean ratios are reported, since they are considered more representative of conditions in typical facilities.

The median number of staff per 100 residents is 136.5, over all facilities. The figure varies substantially by population served, however, from 121.5 in facilities serving adults and juveniles, to 133 in adult-only facilities, and 219 in juvenile-only facilities. When treatment staff only are considered, the medians are 81.5 overall, 76.5 in adult-only facilities, 83.5 in facilities serving adults and juveniles, and 129 in facilities serving only juveniles.

Within correctional facilities, the median number of staff per 100 residents is only 65.5—less than half the overall median. Substantial variation exists within corrections, however, by population served: 63.5 in adult-only facilities, 88.5 in facilities serving both populations, and 98 in juvenile-only facilities. Mental health facilities show the highest staffing levels of any system—a median 175.5 per 100 residents overall, 161 in adult-only facilities, 216 in facilities serving a mixed population, and 262 in juvenile-only facilities.

The composition of staff differs by auspices in ways that are consistent with frequently expressed orientations of the various categories of facilities. Summing over staff categories, responding correctional facilities report medians of 18.6 treatment staff and 10.6 security staff per 100 residents, a treatment/security staff ratio of about 1.75 to 1. Among mental health and social services/other facilities, the respective treatment/security staff ratios are approximately 11 to 1 and 13 to 1. These differences are consistent with an emphasis on security considerations in correctional facilities, and a treatment emphasis in facilities under other auspices. The interpretation should be treated cautiously, however, since technicians filling a dual treatment/security role in many mental health facilities comprise nearly 70 percent of all treatment staff.

Corresponding patterns are observed in the median number of psychiatrists per 100 residents: 1.1 within corrections and nearly 3 in other categories. Similarly, other graduate-level therapists, primarily social workers and psychologists, are found at rates of about 5 per 100 residents within corrections and 8 per 100 residents within other systems.

Correctional facilities report smaller numbers of staff performing functions other than treatment, security, and education. Combining senior administrators, other administrators and clerical workers, and maintenance staff, correctional facilities report a median of 7.3 per 100 residents, with 21.8 in mental health, and 22.0 in social services/other facilities.

The effects of facility size on staffing patterns are displayed in appendix table A-10, where median numbers of staff per 100 residents are reported by facility population category. Statistics on senior administrators reflect economies of scale; the number of senior administrators (i.e., superintendent, administrator, and clinical director) is fixed, regardless of facility population. Similarly, the number of treatment staff per 100 residents declines as facility population increases, both overall and for the individual categories of treatment personnel. Educators (i.e., teachers and librarians) are rarely reported at all in facilities with populations of 25 or fewer; however, above that level, the number per 100 residents declines as population increases. A different pattern appears with

Table 4–16. Use of outside resources, by auspices

Type of outside resources	Percent of facilities reporting use of resource			
	Corrections (n=30)	Mental health (n=78)	Social services/ other (n=18)	All (n=126)
Volunteers	40.0%	43.6%	16.7%	38.9%
Medical interns and residents	3.3	28.2	16.7	20.6
Field placement/ graduate students	46.7	51.3	16.7	45.2

respect to security staff: except for the largest and smallest facility categories, the number of security staff increases as facility population increases. This may result from the security orientation of correctional facilities, which tend to have larger populations than others; it may also reflect a presumption that security issues require more staff attention in larger facilities than in smaller.

Tables A–11 and A–12 in the appendix explore the relationship between staffing levels and availability of treatment. Facilities were classified by auspices in table A–11; then facilities within each classification were grouped by quartiles with respect to staff–to–resident ratio. For each quartile, table A–11 reports the percentage of facilities reporting availability of treatment modalities.

Data reported in the two tables show only weak relationships between staffing levels and availability of treatment modalities. As one might expect, psychoanalysis, behavior modification, and psychodrama are reportedly more frequently available in quartile 3 and 4 facilities—those with the highest staff–to–resident ratios. The differences are slight with respect to these approaches, however, and no patterns are discernible with respect to other modalities. As shown in table A–12, these patterns become slightly more distinct when the comparison is limited to treatment personnel only. Even with this restriction, however, one could not conclude that a strong relationship exists between staff–to–patient ratios and treatment availability.

To present a complete picture of human resources in facilities for mentally disordered offenders, it is important to consider the extent to which staff and consultants are augmented by outside resources. Therefore, facilities were asked to report whether they make use of volunteers, medical interns and residents, and field placement/ graduate students; the results are reported in table 4–16. Students, the most commonly used outside resources, were reportedly used by 45.2 percent of responding facilities. Next most frequently used are volunteers, by 38.9 percent of all respondents. Only 20.6 percent of facilities reported use of medical interns and residents. The table indicates that social services/other facilities use outside resources less frequently than facilities under other auspices. Mental health and correctional facilities make use of volunteers and students in about equal numbers. Mental health facilities, however, use interns and residents (presumably in psychiatry) far more frequently than other facilities.

Trends in Education of Senior Staff

Facilities were asked to report the academic degree level and discipline of three senior administrators: the facility superintendent, the administrative director, and the program director. The distribution of degree levels is reported by auspices in table A–13, and the distribution of academic field or discipline is reported in table A–14 (both tables in the appendix). For comparison, corresponding data reported by Eckerman in 1972 for the program director are also shown. Nonresponse to this item in the present survey ran quite high; therefore,

Table 4–17. Reported training frequency, by auspices and source of training

Frequency of training	Percent of facilities											
	Corrections (N=30)			Mental health (N=79)			Social services/other (N=18)			All (N=127)		
	In-house training	Consultant training	Outside training	In-house training	Consultant training	Outside training	In-house training	Consultant training	Outside training	In-house training	Consultant training	Outside training
Never	3.3%	26.7%	10.0%	1.3%	25.3%	13.9%	0.0%	22.2%	11.1%	1.6%	25.2%	12.6%
Only when hired	10.0	6.7	6.7	11.4	0.0	1.3	5.6	11.1	5.6	10.2	3.2	3.2
Irregular intervals	6.7	30.0	40.0	29.1	31.6	60.8	11.1	33.3	44.4	21.3	31.5	53.6
At least yearly, but not monthly	3.3	3.3	13.3	1.3	3.8	1.3	5.6	5.6	0.0	2.4	3.9	4.0
At least monthly, but not weekly	30.0	16.7	6.7	30.4	19.0	10.1	44.4	11.1	5.6	32.3	17.3	8.7
At least weekly	46.7	6.7	0.0	25.3	13.9	0.0	27.8	5.6	0.0	30.7	11.0	0.0
Unspecified	0.0	10.0	23.3	1.3	6.3	12.7	5.6	11.1	33.3	1.6	7.9	18.1
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0

both 1972 and current percentages are "normalized" to percentages of respondents.

In general, the program director position described in the 1972 survey resembles most closely the clinical director position in the current survey. Comparing the level of highest degree for this position, table A–13 indicates a clear, if gradual, trend toward increasing educational levels between 1972 and 1981. During that period, the proportion of program/clinical directors with M.D. degrees increased from 70 percent to 76.3 percent, overall. As one would expect, the predominance of M.D. clinical directors is greatest in mental health facilities, with 86.2 percent. During the same period, the percentage of Ph.D. and Ed.D. clinical directors increased from 10 percent to 13.4 percent overall; these degrees are most common among clinical directors in corrections (25.0 percent) and social services/other (18.8 percent) facilities.

Among facility administrative directors, master's degrees in fields other than social work are the most common, reported by 48.8 percent of all respondents. Baccalaureates are the second most common degree for administrative directors. Among facility superintendents, the distribution of highest degree differs substantially across auspices. Within mental health facilities, where the superintendent is frequently the highest level administrator, the M.D. was the most commonly reported degree—46.2 percent. Within corrections, where the superintendent is normally the chief security officer, M.D. superintendents are nonexistent, as one might expect. Among correctional respondents, 43.4 percent of respondents report master's–level superintendents and 26.1 bachelor–level. Among social services/other respondents, 60 percent of all superintendents hold master's degrees; the remainder hold M.D. or other doctoral degrees.

Among clinical/program directors, table A–14 indicates a clear trend toward increased specialization. While the reported frequency of degrees in medicine dropped 29 percentage points (from 38 to 9) between 1972 and 1981, the frequency of specialties in psychiatry or forensic psychiatry increased by 26 percentage points, from 33 to 59. Among clinical/program directors, the same period also saw relative declines in the numbers of psychology, counseling/guidance, and social work specializations, but increases in social science/business and public administration degrees.

Among administrative directors, public administration, social sciences, and business degrees are the most common. Among superintendents, the most common academic field depends on auspices, presumably because of the previously noted differences in character of the position. Within mental health facilities, 46.1 percent of superintendents report fields in medicine, psychiatry, or forensic psychiatry, while 21.5 percent report public administration degrees. Within corrections, a majority of specializations (52.9 percent) are within social sciences or business, with public administration degrees only 11.8 percent and medical degrees nonexistent. Within social services/other facilities, specializations are split predominantly between public administration (36.4 percent), psychology (27.3 percent), and psychiatry (27.3 percent).

Staff Training and Other Staffing Issues

Responding facilities were asked to describe the frequency and content of staff training provided by in–house personnel, consultants, and outside sources such as conferences, symposia, and specialized schools. As shown in table 4–17, substantial training occurs in most facilities, with only 1.6 percent of respondents reporting that in–house training never occurs, 25.2 percent reporting no training by consultants, and 12.6 percent reporting no outside training. In–house and consultant training usually occurs on a regular basis, with only 22.9 percent describing the in–house frequency as "irregular," or failing to specify the intervals; the corresponding rate for training by consultants is 39.4 percent. In contrast, 71.7 percent of respondents either failed to specify the frequency of outside training or described the frequency as irregular.

In–house training generally occurs at frequent intervals, with 63.0 percent of all facilities reporting at least monthly frequency. Among correctional facilities, in fact, 46.7 percent report in–house training at least weekly. Consultant training occurs regularly in only 32.2 percent of all facilities, with "at least monthly, but less than weekly" being the most common interval.

Table 4–18. Staff training subject areas, by auspices and provider

Subject area	Percent of facilities											
	Corrections (N=30)			Mental health (N=79)			Social services/other (N=18)			All (N=127)		
	In-house	Consultant	Outside	In-house	Consultant	Outside	In-house	Consultant	Outside	In-house	Consultant	Outside
None	23.3%	43.3%	33.3%	16.5%	38.0%	35.4%	11.1%	33.3%	44.4%	17.3%	38.6%	36.2%
MDO treatment (general)	40.0	20.0	33.3	25.3	25.3	19.0	44.4	27.8	16.7	31.5	24.4	22.1
Clinical	33.3	23.3	40.0	41.8	29.1	26.6	44.4	22.2	22.2	40.2	26.8	29.1
Medical	33.3	16.7	23.3	30.4	25.3	16.5	33.3	27.8	16.7	31.5	23.6	18.1
Legal issues	26.7	10.0	23.3	17.7	20.3	16.5	38.9	22.2	16.7	22.8	18.1	18.1
Security matters	26.7	10.0	26.7	20.3	13.9	13.9	33.3	22.2	16.7	23.7	14.2	17.3
Management/ Administration	33.3	23.3	23.3	35.4	20.3	19.0	27.8	22.2	16.7	33.8	21.3	19.7
Not specified	26.7	20.0	23.3	6.3	24.1	26.6	27.8	33.3	33.3	14.2	24.4	26.8
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0

Use of consultants is most common among mental health facilities, of which 32.9 percent report consultant training occurs at least monthly. Regular outside training occurs in only 12.7 percent of all facilities but in 20 percent of correctional facilities. Outside training on an irregular basis was reported by 53.6 percent of facilities, however.

Table 4–18 reports the relative frequency of various subject areas covered in staff training. For in–house training, the most common area was "clinical," i.e., specialized topics in psychiatric nursing and therapeutic procedures; clinical subjects were reported by 40.2 percent of all facilities. Management and administrative topics are the second most common subject area, reported by 33.8 percent of facilities. Treatment topics (e.g., diagnosis/testing, treatment planning and methods) and medical topics (e.g., first aid, CPR, medication) were both reported as subjects of in–house training by 31.5 percent of facilities. These four topics are the predominant subjects of in–house training among mental health and corrections facilities. Among social services/other facilities, training on legal and security matters took precedence over management/administration. Consultant and outside training topics were less frequently specified by respondents; however, clinical and treatment topics predominated among those facilities that did specify topics.

Experience in treatment of the (predominantly male) population of mentally disordered offenders suggests that inability to relate to females is frequently associated with mental illness and inappropriate behavior. Moreover, presence of females is an essential component of a therapeutic community intended to resemble the real world. An emerging staffing issue, therefore, is the employment of females in facilities for mentally disordered offenders. Responding facilities were asked to provide sex distributions for various categories of staff having frequent contact with residents. Based on the responses, table 4–19 reports, by auspices and age jurisdiction of referring court, the mean female percentage of staff in each category. On average, 43.8 percent of treatment and other professional staff were reported to be female, with little variation by auspices. A slightly higher female percentage—48.1 percent—was reported for administrative and clerical staff; this difference is slightly more noticeable in mental health facilities than others. In the security staff category, only 18.4 percent were reported female, with little variation across auspices.

With respect to age category of population served, differences in female staff concentrations are not marked. However, adult–only facilities reported the lowest concentrations of female treatment/professional staff (43.0 percent) and administrative/clerical staff (45.5 percent) but the highest female concentrations of maintenance staff (24.7 percent). Juvenile–only facilities reported the highest female proportions of security staff (22.3 percent) and volunteers, interns, and students (64.0 percent). The highest female concentration, 79.2 percent, appears among volunteers in juvenile–only social services/other facilities. No female maintenance employees having contact with residents were reported in correctional facilities serving juveniles, and none were reported among administrative/clerical staff in correctional facilities serving both adults and juveniles.

A related question is whether the prevalence of female staff is statistically associated with the prevalence of female residents. To examine this issue, responding facilities were classified into three female–population groups: none, low proportion (i.e., not zero but less than the mean proportion of females across all facilities), and high proportion (i.e., greater than the mean proportion). Within each female–population group, facilities were subclassed into female–staff groups in an analogous manner, separately for each staff category. The resulting distributions of facilities are reported in appendix table A–15.

With respect to treatment/professional staff, results are approximately what one would expect. Among the 75 facilities with no female residents, 2.7 percent report no female treatment/professional staff, and only 44 percent report high concentrations of female treatment/professional staff. Among the 28 facilities with a high proportion of female residents, however, none reported a complete absence of female treatment staff, and 89.3 percent reported a high proportion of female treatment staff. Similarly, high female staff concentrations occur more frequently with high female

Table 4–19. Prevalence of female staff interacting with residents, by auspices and age jurisdiction of referring court

Staff category	Mean percent of category staffed by females															
	Corrections				Mental health				Social services/other				All			
	Adults and juveniles (N=2)	Juveniles only (N=2)	Adults only (N=26)	All (N=30)	Adults and juveniles (N=8)	Juveniles only (N=9)	Adults only (N=62)	All (N=79)	Adults and juveniles (N=2)	Juveniles only (N=6)	Adults only (N=10)	All (N=18)	Adults and juveniles (N=12)	Juveniles only (N=17)	Adults only (N=98)	All (N=127)
Treatment, education, other professional	45.2%	43.8%	39.8%	40.4%	49.4%	46.9%	45.3%	45.9%	53.0%	40.9%	37.0%	40.1%	49.3%	44.4%	43.0%	43.8%
Security	10.0%	44.2%	15.4%	17.0%	3.5%	19.1%	21.2%	19.2%	10.0%	19.7%	17.9%	17.6%	5.7%	22.3%	19.3%	18.4%
Maintenance	0.0%	0.0%	12.6%	10.9%	21.3%	23.3%	27.4%	26.3%	23.5%	12.5%	39.3%	28.6%	18.1%	16.7%	24.7%	23.0%
Administrative and clerical	0.0%	29.9%	43.6%	39.8%	70.5%	53.4%	49.7%	52.2%	46.0%	53.6%	23.0%	35.8%	66.2%	50.7%	45.4%	48.1%
Volunteers, interns, students	71.4%	56.5%	38.0%	41.5%	45.0%	55.6%	54.0%	53.3%	75.0%	79.2%	56.9%	66.3%	54.4%	64.0%	50.1%	52.4%

population concentrations for both the administrative/clerical and volunteer/intern categories. For both security and maintenance staff, however, the predominance of facilities with high female staff proportions is greater in facilities with low rather than high proportions of female residents.

The results in table A–15 suggest that female staff are frequently found in facilities with rather high concentrations of male residents. Facilities were asked to document their practices concerning the assignment of female staff to male wards, and the results are tabulated in appendix table A–16. Practices in this area differ substantially by auspices and population served. Among adult–only correctional facilities, 17.4 percent do not assign female staff to male wards; this policy was reported by only 6.7 percent of adult–only facilities under mental health auspices, and none under social services/other auspices. No facilities serving juveniles, under any auspices, have this policy.

Among correctional facilities, 18.5 percent report assigning female staff to male wards without special precautions, while among other facilities, the corresponding proportion is about 33 percent. Among precautions, the most commonly used are to assign female staff in pairs or with a male escort (59.8 percent of all facilities) and/or to provide female staff special security or self–defense training (18.8 percent). Less common precautions are security devices (in 10.7 percent of facilities) and restrictions on procedures or access areas (4.1 percent).

Security Practices

Facilities were asked to provide information on their security practices, including their designated security levels, criteria for assigning residents to different security levels, physical security measures, and security procedures during visits by family and friends.

As shown in table 4–20, approximately one–third of the respondents classified themselves as maximum–security facilities. Overall, another 18.9 percent were classified as medium security, 10.2 percent as minimum security, and 16.5 percent stated that all three levels existed. Twenty–two percent of social services/other facilities consider the question nonapplicable, while no correctional facility did so.

With respect to ward procedures, 60.6 percent of respondents reported having all closed wards, with some variation by auspices (67.1 percent of mental health facilities, 53.3 percent of correctional facilities, and 44.4 percent in social services/other). Overall, 26 percent used a combination of open and closed wards, with only 4.7 percent reporting all open wards.

Facilities were asked to list the criteria used in assigning residents to units providing various levels of security. As shown in table

Table 4–20. Security levels, by auspices

Security levels	Percent of facilities			
	Corrections (n=30)	Mental health (n=79)	Social services/ other (n=18)	All (n=127)
Maximum	36.7%	32.9%	33.3%	33.9%
Medium	20.0	17.7	22.2	18.9
Minimum	3.3	15.2	0.0	10.2
Maximum/medium	6.7	0.0	0.0	1.6
Maximum/minimum	0.0	1.3	0.0	0.8
Medium/minimum	6.7	3.8	11.1	5.5
Maximum/medium/minimum	26.7	13.9	11.1	16.5
Does not apply	0.0	10.2	22.2	9.5
Not ascertained	0.0	5.1	0.0	3.1
All	100.0%	100.0%	100.0%	100.0%

Table 4–21. Security assignment criteria reported, by auspices

Assignment criteria	Percent of facilities reporting use of criteria to assign security levels			
	Corrections (n=30)	Mental health (n=79)	Social services/ other (n=18)	All (n=127)
Prior escape history	0.0%	6.3%	11.1%	5.5%
Assaultive behavior	33.3	21.5	27.8	25.2
Time in facility/program adjustment	23.3	21.5	33.3	23.6
Psychiatric/clinical determination	16.7	15.2	5.6	14.2
Legal status/convicted charge	10.0	6.3	16.7	8.7
Admissions/evaluation unit	0.0	7.6	5.6	5.5
Other	3.3	5.1	11.1	5.5
No criteria reported/ one level only	63.3	68.4	55.6	65.4

4–21, 65.4 percent listed no criteria, for the most part because they provide only one level. Among the criteria listed, the emphasis was clearly on behavior during the present period of institutionalization, rather than on historical or predictive criteria. Under all three auspices, the most commonly cited criteria were assaultive behavior (25.2 percent overall) and time in the facility, adjustment to the program, or a combination of the two (23.6 percent). Substantially less common is a psychiatric or clinical determination (14.2 percent), and still fewer respondents cited historical factors such as legal status (including offense charged) and prior escape history.

For each of a variety of physical security measures, respondents were asked to indicate whether the measure was employed in at least one of their levels of security. The results are reported by auspices in appendix table A–17. Perimeter security measures are substantially more prevalent in correctional facilities than in facilities under other auspices. This pattern is apparent with respect to security towers, security fences/ walls, armed guards, and unarmed guards. Perimeter surveillance devices are used within grounds of approximately one–fourth of all facilities.

Physical security measures within buildings show a somewhat different pattern. Locked wards, security windows and doors, surveillance devices, and nontelephone alarm systems are all as prevalent in mental health facilities as correctional facilities.

Within buildings, the reported prevalence of unarmed guards differs noticeably by auspices: 83.3 percent of corrections facilities, 53.2 percent of mental health facilities, and 44.4 percent of social services/ other facilities. The differences may be in part semantic, however, since many mental health and social services/other facilities employ persons with titles such as ward aide or psychiatric technicians, who combine the security functions of an unarmed guard with a treatment role.

Table A–18 in the appendix suggests differences across auspices in the approach to security during visits of family and friends. Correctional facilities more frequently employ intrusive procedures, such as physical presence of a security guard (83.3 percent of corrections facilities, compared with 57.5 percent overall), strip search of the resident (70.0 percent compared with 43.3 percent), and metal detectors (66.7 percent compared with 51.2 percent). Less intrusive measures, such as TV monitoring, locking the visiting room, and searching the visitors, are used in a minority of facilities under all auspices; but the less intrusive measures are used least often with corrections.

Management Issues

Among the concerns frequently raised by those involved in treatment of the mentally disordered offender are the extent of crowding; the occurrence rates of three types of "critical incidents"—suicide, other deaths, and escapes; and the segregation of minors from adults. These issues are briefly examined in this section, together with facility administrators' reports of the management problems they perceive as most important.

Facility Crowding, Critical Incidents, and Youth/Adult Separation

Table 4–22 describes population/capacity ratios, by auspices and organizational level. As expected, the ratio clusters near unity, with more than half (53.4 percent) of all facilities reporting population/capacity ratios between 91 percent and 110 percent. Such a ratio indicates that the average daily census during the last annual reporting period (normally calendar or fiscal year 1981) was within 10 percent of capacity. The table also shows that 10 percent of all respondents reported population exceeding 110 percent of capacity.

Substantial unutilized capacity is shown in table 4–22 with 35.9 percent of all respondents reporting average daily censuses at 90 percent or less of capacity. It is known that at least two of the five respondents reporting ratios of 50 percent or less were in the first year of operation, so that their populations were still increasing rapidly. Such facilities were not sufficiently numerous, however, to explain the rather high incidence of underutilization at a time of widespread concern about overcrowding in correctional facilities generally. The data in table 4–22 are consistent with the hypothesis that case law governing institutionalization to restore competency and penal transfers to mental health facilities has given those facilities more control over the sizes of their populations than correctional facilities enjoy. Combining institutions and units, only 24.1 percent of all correctional facilities, but 39.2 percent of mental health facilities, reported population/capacity ratios of 90 percent or less. At the same time, 13.8 percent of correctional facilities, but only 10.8 percent of mental health facilities, report ratios exceeding 110 percent. Figures reported by Eckerman suggest that underutilization of capacity also existed a decade ago, when the mean population was 84 percent of mean capacity for security hospitals and 83 percent for mental health facilities among his respondents.

Appendix table A–19 examines the relationship between facility population and the incidence of suicides, other deaths, and escapes. Suicides and escapes occur disproportionately more frequently in the smaller facilities among respondents in the survey. Examining cumulative percentage distributions, the table reports that while the smallest facilities—those with populations of 25 or fewer—contained only 1.1 percent of the total population of responding facilities, they accounted for 10.5 percent of reported suicides and 5.9 percent of reported escapes. Similarly, facilities with populations of 100 or fewer reported only 14.0 percent of the population but 23.7 percent of suicides and 31.3 percent of escapes. The largest facilities—those with populations exceeding 500—housed 42.6 percent of the population but reported only 26.3 percent of suicides and 28.0 percent of escapes. In contrast, other deaths were reportedly concentrated most heavily—78.2 percent—in the over–500 category.

The 41 facilities reporting that they housed both minors and adults were asked whether they separate the two groups for delivery of various services. The percentages reporting separation are shown in appendix table A–20 by percentage of minors in the population. Separation occurred more frequently for education (in 37.5 percent of facilities) than for other services. Public Law 94–142 requires maintenance of a minimum ratio of teachers to youngsters of school age in order to receive Federal financial assistance for education. While facilities are less likely overall to separate minors from adults for housing, treatment, and recreation, separation is more likely where minors exceed 10 percent of the facility population than in other facilities. This pattern is most marked with respect to housing, for which 41.7 percent of all facilities in which minors exceed a tenth of the population separate them. Only 12.5

Table 4–22. Population/capacity ratios, by auspices and organizational level

Percent of Capacity Utilized	Percent of facilities								
	Corrections		Mental Health		Social Services/ Other		All		
	Institution (N=12)	Unit (N=17)	Institution (N=28)	Unit (N=46)	Institution (N=5)	Unit (N=12)	Institution (N=45)	Unit (N=75)	All (N=120)
50% or less	0.0%	11.8%	0.0%	4.3%	0.0%	8.3%	0.0%	6.7%	4.2%
51% - 90%	16.7	17.6	42.9	32.6	20.0	41.7	33.3	30.7	31.7
91% - 100%	33.3	58.8	35.7	50.0	60.0	50.0	37.8	52.0	46.7
101% - 110%	25.0	5.9	3.6	6.5	0.0	0.0	8.9	5.3	6.7
111% - 150%	25.0	5.9	17.9	0.0	0.0	20.0	20.0	1.3	8.3
More than 150%	0.0	0.0	0.0	6.5	0.0	0.0	0.0	4.0	2.5
All	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

percent of the facilities in which minors constitute less than a tenth of the population house them separately from adults.

Problems Perceived by Administrators

In a series of closed questions, respondents were asked to report whether they experienced administrative problems in their facilities due to the ethnic mix of their populations, due to the presence of suicidal/homicidal residents, due to the presence of both males and females, and due to staff turnover. In open-ended followup questions, they were also asked to explain the problems they experienced. In general, because the closed questions provided opportunities to skip the more burdensome open-ended questions, the true incidence of problems probably exceeds that shown in table 4-23. The most widely reported problems shown there are due to suicidal/homicidal patients and to the presence of males and females.

In open-ended comments, respondents indicated that suicidal/homicidal patients require more staff time for monitoring, specially designed areas for safety, and special training and recordkeeping for staff. Simultaneous presence of male and females reportedly promotes sexual contacts and "acting out," as well as the need for devices to protect privacy. In addition, fluctuations in the relative proportions of males and females force facilities to leave some sleeping space unused; while total capacity is underutilized, female or male wards individually may be filled to capacity with a waiting list developing. In general, all types of problems were reported more frequently among large facilities than small ones. This is especially clear with respect to problems due to the population ethnic mix. It is not clear, however, whether this is purely a population effect, or whether it reflects the fact that some of the largest States, such as California, New York, and Florida, tend to have both the largest facilities and the most ethnically diverse populations.

The precise nature of problems due to facility ethnic mix is examined in more detail in tables A-21, A-22, and A-23 in the appendix. Table A-21 indicates that such problems were reported in 15 percent of facilities overall, that they are more common in mental health facilities than others, and that problems are distributed approximately evenly between residents and staff (11.8 percent). Both types of problems were reported by 7 percent of facilities. The incidence of such problems did not vary substantially by region.

Although only 8 of 13 facilities provided more description of the problems among residents, table A-22 reports discrimination charges to be the most common (30.8 percent of those facilities), with fights and acting out next most common (23.1 percent), and language barriers and cliques reported by 15.4 percent of facilities. As shown in table A-23, the most commonly reported resident/staff ethnic problems were the need for bilingual staff (by 40 percent of facilities) and the need for additional staff (by 33.3 percent). Although staff/resident language (communication) problems were mentioned by only 1 facility, informal comments by facility administrators suggest that such problems occasionally hinder the verbal therapy process, even if they do not present a management problem.

When respondents were asked to list any management problems other than those raised previously in the questionnaire, 82.7 percent reported "none." Among the problems most commonly reported were major treatment decisions, control vs. rights of residents, and preparation for release. These issues emerged in far greater prevalence and richness during followup interviews and site visits than from the questionnaire; they are discussed in detail throughout chapter 5.

Legal Issues

To examine the salience of legal issues for facility administrators, respondents were asked to describe the status of the facility as a subject of court orders and legislative controversies, and to describe the impact of certain court decisions on their operations. Also, results of a 50-State statute search were used to examine whether laws defining the category guilty but mentally ill and statutes governing the commitment of defendants found not guilty by reason of insanity actually affected the legal-status distribution of mentally disordered offenders. The results of these analyses are discussed in this section.

Table 4–23. Management problems cited by facility administrators, by facility population category

Population range	Percent citing population ethnic mix	Percent citing suicidal/homicidal residents	Percent citing presence of males and females*	Percent citing staff turnover	Percent citing other problems
Less than 10 (n=5)	0.0%	40.0%	0.0%	20.0%	20.0%
11–25 (n=21)	4.8	42.9	33.3	30.0	9.5
26–50 (n=25)	8.0	60.0	38.5	19.2	12.5
51–100 (n=23)	17.4	60.9	18.2	39.1	25.0
101–250 (n=31)	19.4	54.8	33.3	25.8	25.8
251–500 (n=12)	25.0	75.0	42.9	41.7	8.3
More than 500 (n=8)	37.5	62.5	66.7	50.0	25.0

*Percentages based only on facilities housing both males and females.

Court Orders and Legislative Controversies

As shown in appendix table A–24, the vast majority of facilities (89.7 percent) reported that they were not under court order at the time of questionnaire completion. Of the 10 under court order, 4 reported the substance to be upgrade of treatment, 2 reported overcrowding, 1 reported standards compliance, and 3 reported other issues.

Similarly, as shown in table A–25, a high proportion (82.7 percent) of respondents did not report their facilities to have been the subject of a legislative controversy within the year preceding questionnaire completion. Among those citing a controversy, funding was the most common subject (reported by 9.4 percent of facilities), followed by upgrading of security, treatment, or both (named by 6.3 percent).

Impact of Major Court Decisions

A decision widely considered to have affected the care and treatment of incompetents to stand trial was rendered in 1973 in *Jackson* v. *Indiana*, a case involving a mentally retarded defendant accused of the theft of $9. Because of his handicap, Jackson had been found incompetent to stand trial and held in an institution for 4 years. In its decision, the U.S. Supreme Court said that Jackson could not be held indefinitely in the hope that he might regain competency, and that because a "reasonable" period had elapsed, he had either to be released or civilly committed. Although Jackson was not mentally ill, the decision has been interpreted to mean that a defendant found incompetent for any reason who is considered unlikely to regain competency, must be considered for release or civil commitment at a hearing to be held after a "reasonable" period of time.

Respondents were asked to list any changes made in their States in response to *Jackson*, to explain any impacts that those changes had had on their programs, and to describe any responses that their programs had made. The first three changes, impacts, and responses listed by each respondent were coded and tabulated. The results of those tabulations are shown in table 4–24.

Because defendants in all States whose incompetency is due to mental illness must be committed to a mental health facility rather than a correctional facility, it is not surprising that table 4–24 shows "no State changes" reported by a higher proportion of the latter (80.0 percent) than the former (41.8 percent). Among mental health facilities, 21.5 percent of all respondents reported State-level changes that were related to civil commitment. More specifically, many States that were not previously in compliance with *Jackson* have instituted a practice of competency hearings, to be held following examination and at regular intervals thereafter. Typically, following the hearing, the court may order the State to proceed with trial or may order the defendant returned to the institution for treatment to restore competency. If considered unlikely to regain competency, the defendant must either be released or civilly committed. Under many State statutes, the defendant cannot be civilly committed unless he or she is dangerous as well as mentally ill, and the 1975 Supreme Court decision in *O'Connor* v. *Donaldson* is widely considered to mandate a dangerousness standard for civil commitment in the remaining States.

Thus, the "new laws/regulations" in response to *Jackson* reported by 13.9 percent of mental health and 22.2 percent of social services/other respondents in table 4–24 are presumably codifications of the procedures described here. The changes in population size/mix reported by 8.9 percent of mental health respondents could be expected to reflect a decline in the number of nondangerous defendants being held for long periods in the hope that competency will be restored, and an increase in the number of "dangerous" defendants who have been civilly committed. Among mental health facilities, 11.4 percent report responses classified as "programmatic change." At least a few of these new programs were found in telephone followups and site visits to be more aggressive therapy/instruction programs aimed at restoration of competency.

At least three reasons exist to believe that the figures in table 4–24 understate the true impact of *Jackson*. First, a respondent could reduce the burden of completing the questionnaire by writing "no change" instead of a description of a change. Second, the individual completing the questionnaire may have been aware of a new statute requiring competency rehearings at regular intervals

but unaware that it stemmed from the *Jackson* decision. Third, such changes may have predated the respondent's tenure at the institution.

As already mentioned, a low percentage of respondents reported that population mix was affected by the nature of statutes governing commitment of persons found incompetent to stand trial (IST) or not guilty by reason of insanity (NGI). To explore further the nature of this effect, States were grouped into four categories: group 1, in which commitment is mandatory for both NGIs and ISTs; group 2, in which commitment is mandatory for NGIs but discretionary for ISTs; group 3, in which commitment is discretionary for NGIs but mandatory for ISTs; and group 4, in which commitment is discretionary for both categories. It was hypothesized that NGIs and ISTs would be proportionately more numerous in States requiring mandatory commitment than in States with discretionary commitment.

The results reported in appendix table A–26, are consistent with this hypothesis. In State groups 1 and 2, where commitment is mandatory for adult NGIs, this category comprises, respectively, 36.6 percent and 28.0 percent of facility populations; in the two State groups—3 and 4—with discretionary NGI commitment, this group comprises only 13.3 percent and 16.1 percent of the respective populations. Similarly, in State groups 1 and 3, where commitment is mandatory for ISTs, this group constitutes 8.4 percent and 16.1 percent of the respective facility populations. In the two State groups—2 and 4—with discretionary IST commitment, this group comprises only 3.7 percent and 4.0 percent, respectively. Thus, in States where discretion in commitment is permitted, judges appear to limit the use of commitment.

A 1980 Supreme Court decision expected to affect correctional facilities directly and mental health facilities indirectly was rendered in *Vitek* v. *Jones*. In that decision, the

Table 4–24. Prevalence and nature of reported effects of *Jackson* v. *Indiana*, by auspices

Effects of decision	Percent of facilities citing effect			
	Corrections (n=30)	Mental health (n=79)	Social services/ other (n=18)	All (n=127)
State changes				
Due process	0.0%	21.5%	5.6%	14.2%
Civil commitment	6.7	21.5	16.7	17.3
New laws/regulations	3.3	13.9	22.2	12.6
Population size/mix	6.7	8.9	0.0	7.1
Already in compliance	3.3	1.3	5.6	2.4
No impact	80.0	41.8	61.1	53.5
Impact on program				
Due process	3.3	16.5	0.0	11.0
Civil commitment	0.0	10.1	0.0	6.3
Programmatic changes	0.0	5.1	0.0	3.1
Population size/mix	0.0	6.3	11.1	5.5
Already in compliance	0.0	7.6	5.6	5.5
No impact	96.7	58.2	83.3	70.9
Program response				
Due process	3.3	10.1	5.6	7.9
Civil commitment	0.0	5.1	5.6	3.9
Programmatic changes	3.3	11.4	0.0	7.9
Already in compliance	0.0	10.1	5.6	7.1
No impact	93.3	65.8	83.3	74.8

Table 4–25. Reported impact of *Vitek* v. *Jones*, by auspices

Effects of decision	Percent of facilities citing effect			
	Corrections (n=30)	Mental health (n=79)	Social services/ other (n=18)	All (n=127)
State policy change				
Due process	13.3%	26.6%	22.2%	22.8%
Requirement for program change	0.0	12.7	16.7	10.2
Already in compliance or N/A	10.0	2.5	0.0	3.9
No impact	76.7	58.2	61.1	63.0
Problems for program				
Delay, reduce treatment	3.3	5.1	11.1	5.5
Strain resources	0.0	1.3	5.6	1.6
Other	0.0	2.5	0.0	1.6
No problems	96.7	91.1	88.9	92.1
Program communicating to legislature				
Yes	0.0	8.9	11.1	7.1
No	76.7	65.8	83.3	70.9
Not ascertained	23.3	25.3	5.6	22.0

Court held that the superintendent of a Nebraska correctional institution could not transfer a prisoner to a mental health facility for treatment of mental illness without a hearing at which the prisoner was accorded representation, the opportunity to present testimony, and the opportunity to cross-examine witnesses. Because the decision was announced only a year or so before the questionnaires were completed by most respondents, it is somewhat surprising that, according to table 4–25, more than 30 percent of all respondents reported a policy change at the State level.

The report from only 3.9 percent of respondents that their States were already in compliance is difficult to interpret. Based on the statute research, it appears that 56.7 percent of correctional respondents and 34.2 percent of mental health respondents are located in States that were in compliance at the time the decision was rendered. The 3.9-percent figure may be partially explained by ignorance at the facility level of legal matters, as well as respondent reluctance to investigate very carefully for *Vitek* impacts to record on a questionnaire. In addition, it is likely that some of the "no impact" responses should be interpreted as "no impact because already in compliance." It is also true, however, that the impact on mental health facilities is indirect, in the form of requirements on staff psychiatrists in some facilities to testify at transfer hearings and, presumably, eventual declines in the rate at which prisoners are transferred to their facilities. The staff requirements were noted as delaying or reducing treatment, or straining resources, by 6.4 percent of all mental health respondents. It is also noteworthy that, despite the indirect nature of impact, 8.9 percent of all mental health respondents reported that their facilities planned to communicate views on *Vitek* implementation to their State legislatures. No corrections facilities, where the impact should be felt directly, indicated plans to do so.

Respondents were asked to describe other court decisions affecting the operations of their facilities and the nature of the effect. The results are reported in table 4–26. Of the 127 respondents, 65.4 percent reported no court decisions having an impact on their facilities. The most commonly reported area of court impact was the right of residents to refuse treatment, with 17.3 percent of facilities reporting an impact from such court

Table 4–26. Percent of facilities reporting impact of other court decisions, by auspices

Effects of decision	Percent of facilities citing effect			
	Corrections (n=30)	Mental health (n=79)	Social services/ other (n=18)	All (n=127)
Right to refuse treatment	16.7%	21.5%	0.0%	17.3%
Right to hearings/advocacy	0.0	3.8	0.0	2.4
Right to least restrictive alternative	0.0	6.3	0.0	3.9
Juvenile issues	0.0	1.3	5.6	1.6
Dangerousness	0.0	3.8	0.0	2.4
Security	0.0	2.5	11.1	3.1
Environment	0.0	5.1	5.6	3.9
Other/nonspecific	3.3	16.5	16.7	13.4
None having impact	83.3	55.7	77.8	65.4

decisions. This is not surprising, in light of the judicial activity in this area during the past decade. In 1972, a Federal district court held that patients had the right to refuse "unusual or hazardous" treatment procedures, such as lobotomy, electroshock therapy, and aversive reinforcement conditioning. A year later, a Michigan county court, in *Kaimowitz* v. *Department of Mental Health*, refused to permit a particularly risky and intrusive form of psychosurgery, and concern developed among practitioners that extension of the *Kaimowitz* ruling might eventually prevent use of beneficial but unpleasant forms of treatment.

In *Rennie* v. *Klein*, this concern was realized as a Federal district court ruled that an involuntarily hospitalized mental patient had the constitutional right to refuse psychotropic medication. A similar issue was raised at about the same time in *Rogers* v. *Okin*, a Massachusetts case. In June 1982, the Supreme Court remanded both *Rennie* v. *Klein* and *Rogers* v. *Okin* to lower courts, avoiding rulings on constitutional issues. At this writing, both cases are still pending at the U.S. district court level. Therefore, the absence of legal guidelines is expected to continue for the foreseeable future on the question of the mentally disordered offender's right to refuse treatment, even in emergency situations involving violence or the threat of violence. This area thus may be expected to remain a source of concern for facility administrators.

A related area of concern reported by a few respondents (3.9 percent) was the right of mentally disordered offenders to be treated in the least restrictive alternative environment, including the community. The principle of least restrictive alternative, which has been recognized for civilly committed persons in a number of State courts and legislatures but has not been considered by the U.S. Supreme Court, raises the general question of balance between community security and the rights of mentally disordered offenders.

Early Impacts of Guilty but Mentally Ill Statutes

Because of recent calls for enactment of statutes providing the guilty but mentally ill (GBMI) verdict, it is of interest to compare the legal-status distributions for mentally disordered offenders in States with and without such statutes at the time of the statute search. As shown in appendix table A–27, facilities in the 13 States with GBMI laws reported that GBMI individuals represented only 3.0 percent of their populations, indicating a rather small effect. Facilities in GBMI States, however, also reported substantially fewer insanity acquittees than did those in non–GBMI States (6.5 percent to 16.5 percent), as well as fewer persons being evaluated for criminal responsibility (1.3 percent to 3.9 percent). These results are

Table 4–27. Areas of significant facility research, by auspices

Research area	Percent of facilities reporting research			
	Corrections (n=9)	Mental health (n=14)	Social services/ other (n=6)	All (n=29)
Characteristics of mentally ill offenders	11.1%	21.4%	33.3%	20.7%
Treatment/diagnosis/outcome relationship	44.4	42.9	50.0	44.8
Determinants of length of stay	0.0	14.3	0.0	6.9
Correlates of violence to self or others	44.4	14.3	16.7	24.1
Other/unspecified	33.3	50.0	16.7	44.8

consistent with GBMI advocates' claims that the availability of GBMI verdicts discourages use of the insanity defense.

Facilities in GBMI States also report relatively more penal transfers (28.6 percent of their population) than do facilities in non–GBMI States (20.0 percent of their population). Finally, table A–27 shows a smaller proportion of sex offenders in facilities in GBMI States (7.9 percent) than in other facilities (14.2 percent), a result consistent with the comment of the director of a Michigan facility that GBMI was being used in his State as a plea bargain to avoid the stigma of conviction for sex offense.

Research and Statistical Activity

Interest in facility–based research and statistics on mentally disordered offenders has increased steadily over the past 15 years. Scheidemandel and Kanno reported that, in 1967, only one facility was conducting research, and one facility suggested that an evaluation program would help staff judge how successfully mentally disordered offenders were treated. Later, Eckerman (1972) reported that 10 of his 68 respondents suggested "more research" as a desirable program change.

Table A–28 in the appendix, indicates that such activity had become commonplace by 1981. Overall, 94.5 percent of facilities perform routine data collection and reporting, typically as part of regular annual or quarterly reporting to State government. In addition, 46.5 percent of respondents report outcome evaluation, 31.5 percent report a management information system in operation, and 22.8 percent report ongoing "significant research/demonstration activities." In all categories except routine data collection and publication, social services/other facilities report more activity than do facilities under corrections or mental health auspices.

The nature of this statistical activity is described more fully in tables 4–27 and 4–28. The 29 facilities reporting "significant research/demonstration activity" were asked, in open–end format, to describe the activity more fully. The usable and specific descriptions were grouped into four categories, and table 4–27 reports the prevalence of each category. Research relating treatment modalities and diagnosis to each other and/or to the outcome of institutionalization was reported by 44.8 percent of the facilities reporting any type of research. The prevalence of work in this area does not appear to vary substantially by auspices. The next most common research area, reported by 24.1 percent of respondents, is correlates of behavior dangerous to self or others. The major emphasis on this topic, however, occurs within correctional facilities, 44.4 percent of which reported topics in this area compared with 24.1 percent overall. Characteristics of mentally ill offenders were being analyzed by 20.7 percent of facilities reporting any significant research activity. Unfortunately, 44.8 percent of the facilities reporting research did not describe it in sufficient detail to permit classification and tabulation.

Table 4–28. Type of statistics routinely reported

Type of statistics	Percent of facilities regularly reporting statistics (n=127)
Population counts	16.5%
Admission/discharge flows	41.7
Length of stay	9.4
Resident demographics	22.0
Resident diagnoses	13.4
Resident legal status/ crime/history	9.4
Service provision/quality	15.0
Critical incidents	11.8
Staffing	3.9
Competency/responsibility evaluation outcomes	7.9
Release outcomes	9.4
Cost/financial data	3.1
Other/nonspecific	19.7

Similarly, respondents who regularly report and collect statistics were asked to describe them precisely. Table 4–28 reports the percentage of facilities publishing various categories on a regular basis. The three most common data categories are admission/discharge statistics, collected by 41.7 percent of facilities; resident demographics, collected by 22.0 percent; and population/census counts, by 16.5 percent. The prevalence of these topics is not surprising, since they are both relatively easy to produce and usually noncontroversial. It is of interest, however, that 15 percent reported disseminating statistics on indicators of service provision/quality (e.g., frequency of medication, resident-hours in therapy, assignment to treatment programs by resident characteristics). In addition, 13.4 percent compile data on resident diagnostic categories, and 11.8 percent on "critical incidents" such as medication errors/refusals and injuries to staff and residents.

Two other categories of data require further discussion. First, the length-of-stay statistics compiled by 9.4 percent of facilities appear to refer to residents released during the reporting period. For most facilities, this figure is thought to be much smaller than average length of stay among persons in residence as of a given date. The former statistic can be compiled from examination of records of releasees only, while the latter statistic requires tabulation of admission dates on all records on file as of a given date—a time-consuming task where manual records are involved. Attempts to collect the latter data for the present survey were successful for very few facilities.

Second, it is somewhat surprising that cost/financial data were reported to be available by only 3.1 percent of facilities. While various observers had suggested prior to this survey that these data were generally unavailable, 8 of the 11 programs visited for case studies were able and willing to provide at least approximate estimates of cost per resident-day. These 8 alone represent more than double the 3.1 percent of 127 facilities reporting regular collection of this item. This fact suggests a reluctance to advertise the existence of cost data, rather than a lack of such information.

Finally, respondents were asked to nominate data for regular publication on a national basis. Because the question was asked twice—in one section usually completed by the facility administrator and in another section usually completed by the records or research director—table 4–29 reports desirability as expressed separately by these two respondent types. Not surprisingly, two of the most commonly requested data items, admissions/discharge flows (38.6 percent of administrators) and resident demographics (27.6 percent) are among those reported most commonly available in table 4–28. However, regular data on resident diagnoses and on criminal/mental health/substance abuse history were also requested by substantial numbers (29.1 percent and 21.3 percent of administrators, respectively), despite the fact that they are not commonly compiled by facilities at the present time. This suggests that satisfying these requests at the Federal level would necessitate substantial upgrading of statistical activity at the facility level.

Summary of Statistical Description

This chapter has described basic organizational and population characteristics of the 127 facilities responding to the national

Table 4–29. Data desired for regular publication, by auspices and respondent type

Type of Data	Percent of respondents requesting regular publication							
	Corrections (N=30)		Mental Health (N=79)		Social Services/ Other (N=18)		All (N=127)	
	Administration	Records Chief	Administration	Records Chief	Administration	Records Chief	Administration	Records Chief
Resident Demographics	26.7%	13.3%	29.1%	13.9%	22.2%	11.1%	27.6%	13.4%
Diagnostic Data	20.0	23.3	32.9	16.5	27.8	11.1	29.1	17.3
Criminal/ Mental Health/ Substance Abuse History	16.7	6.7	24.1	10.1	16.7	0.0	21.3	7.9
Admissions/ Discharge Flows	46.7	16.7	39.2	22.8	22.2	16.7	38.6	20.5
Critical Incident Rates	6.7	3.3	2.5	3.8	5.6	0.0	3.9	3.1
Staffing Levels/ Needs	20.0	16.7	7.6	6.3	5.6	0.0	10.2	7.9
Program Character-istics	16.7	6.7	13.9	12.7	11.1	11.1	14.2	11.0
Per Diem Costs	3.3	0.0	.3	0.0	5.6	0.0	2.4	0.0

survey. In addition, within the limitations of mail survey methodology, it has presented the status of treatment, staffing, and security practices in the facilities. Finally, it has quantified the prevalence of major categories of administrative problems posed by the legal and organizational systems of which the facilities are a part. The next chapter explores specific instances of such problems and facility responses, based on first-hand observations in 11 of the facilities. Specific areas examined include staffing, release, legal issues, State system reorganizations, and linkages to universities.

Chapter 5

Analysis of Site Visits

This chapter examines in some detail a number of legal and administrative issues and program responses that were found (through legal, library, and mail survey research) to characterize selected institutions and programs. Chapter 3 reported on some general legal issues that have helped to shape administrative, organizational, and programmatic activity. The survey results, shown in chapter 4, reported statistical distributions of institution and program characteristics, as well as the frequency with which broad categories of problems are perceived by administrators. This chapter narrows and deepens the focus from those general categories of legal and administrative problems and quantifiable facility characteristics to a more specific topic: how institutions and programs have responded to or dealt with particular legal, political, and professional pressures and constraints that were identified in the previous chapters.

Information for this more intensive examination of institutions and programs was obtained from 2-day site visits to 11 facilities, chosen on the basis of therapeutic and organizational activities reported in their survey responses and legal activities in the State as ascertained from survey legal analysis. Using responses to the survey instrument and the indepth telephone probes, researchers selected facilities that seemed to address similar organizational or therapeutic problems in what appeared to be desirable ways. Where possible, facilities were selected to provide comparisons of alternative approaches to a single problem, or comparisons of a single approach implemented in alternative settings.

Some of the programs are designed primarily for special populations in terms of legal status. For example, one institution was set up solely for sex offenders. Penal transfers comprised the predominant group at another. The majority of facilities visited serve individuals in a number of different legal statuses, however.

This chapter discusses issues, constraints, and program adaptations in 10 topical areas: organization and administration, size of facility and patient management, security and related physical plant, treatment programming, staffing issues, research and linkages with universities, prerelease and release activities, litigation and legal issues, and State agency reorganization and budget issues. As noted earlier, this set of issues was gleaned from legal research and analysis of survey-reported issues and problems mentioned by facility administrators and program staff.

Organization and Administration

Of the 127 facilities responding to the national survey, 79 were under mental health auspices, 30 under corrections, and 18 under social services/other, an amalgamation including youth authorities and joint corrections/mental health authority. Regardless of auspices, however, facilities for mentally disordered offenders perform both the security services of prisons and the treatment services of mental hospitals, thus raising general concerns about the mix and balance of these two functions. The general issue is compounded by professional specialization. Administrators with state-of-the-art knowledge of security procedures and technology may lack indepth understanding of treatment techniques. Similarly, highly trained clinicians may be insufficiently aware of security needs and procedures. The site visits provided an opportunity to observe four organizational approaches to the problem of balancing treatment and security concerns in day-to-day facility operation: one institution with bifurcated corrections/

mental health chains of command; a correctional facility that augmented its treatment capability with a vendor's clinical staff; a facility in which a mental health administrator conducted day-to-day operations within policy guidelines set by a joint corrections/mental health board; and one mental health program in a statewide network of such programs located within prisons.

Bifurcated Chain of Command

The first type of organizational structure studied, the bifurcated administration, was found in a facility operated simultaneously under two State agencies—the department of mental health, which is responsible for the treatment program, and the department of corrections, which is responsible for the physical plant, the security functions, and the corrections officers. The organization was based in a State statute calling for a mental health program within a correctional facility. The statute, which served as the blueprint for operation of the facility, defined the type of population to be served by the program as "sexually dangerous" and prescribed the procedures for voluntary entry into the facility, release criteria, and dates of court reports on progress.

One characteristic of the bifurcated administration was the presence of two different orientations to security and treatment within the institution. As with most facilities, training and experience tend to orient guards toward security concerns and treatment staff toward treatment concerns. However, unlike many facilities where treatment staff are located in secure areas during the entire day (even while performing paper work), in this facility treatment staff, as mental health employees, were on ward only for a set period each day to conduct treatment. In contrast, residents were always near or in the presence of guards.

The combination of bifurcation and the constant presence of security officers from a correctional background raised some management problems. For example, if treatment staff felt that a guard was disruptive to the treatment milieu or abusive to a resident, the program director could do nothing more than bring the problem to the attention of the superintendent of the correctional facility. The mental health program director lacked the control over guards he would have had in a unified administration through influence in personnel matters.

The simultaneous existence of two chains of command also resulted in problems at other levels of administration. It appeared that the staff had difficulty in separating various responsibilities for the residents. Because the facility performed two functions—security and treatment—and each function was administered by a separate agency, the problem of balancing security and treatment was more apparent than at other facilities visited. Line staff felt neither corrections nor mental health directives clearly separated the day-to-day responsibility for resident care from the responsibility for security. At many other facilities visited, such separation was unnecessary, because both duties were performed by psychiatric technicians. Bifurcation made this impossible. In turn, the facility corrections administration seemed to feel that direction from the department of mental health was lacking.

One illustration of the problems faced by staff because of bifurcation was that of seclusion policy. The decision to seclude a resident was not made as an administrative or clinical determination; rather, it was a security decision. The decision to release a resident from seclusion, however, was the responsibility of the clinical director. The two decisions were guided by directives from two different agencies.

One senior clinician perceived a definite "difference between the department of mental health's and the department of corrections' approach to patients." In addition, subtle animosity between the two staffs was reported. Residents had knowledge of these interdepartmental differences and attempted to play staff members against each other. Although that happened in many—if not most—facilities, bifurcation aggravated the tension between security and treatment staff. Discussions with administrative staff on bifurcation revealed no single point at which these interstaff conflicts could be resolved.

The problems associated with this type of split administration resulted in the establishment of an interdepartmental task force to identify the major issues of conflict and to develop compromises. The task force did

not believe it could resolve the issues, although its members felt the disagreements should be settled once and for all. The group realized that establishing one central position or agency responsible for all aspects of the program would require amending the pertinent State statute. Facility administration and staff did not believe this was likely to occur in the foreseeable future.

Vendorship of Clinical Services

Another type of relationship between two organizations dealing with mentally disordered offenders was that of a correctional facility with a contractual agreement for its mental health services. The vendor was a psychiatric hospital, many of whose staff had joint appointments at a major university. The contract with the hospital arose from a Federal court order that treatment must be available during confinement so that residents would not be victims of indefinite commitments. At the time of the site visit, 9 psychiatrists (4 full-time), 10 psychologists (6 full-time), and 2 part-time social workers from the hospital were working at the facility. The department of corrections continued to employ its own guards and nursing staff, as well as social workers and psychologists.

This program had been in place approximately 6 years by the time of the site visit. On paper, the vendor staff were responsible for all clinical treatment and programming, while corrections staff performed all other functions. Staff comments suggested, however, that the organizational components were still being negotiated. Some saw it as an "organizational mess...with no clear-cut definition of where one system ends and the other begins." One corrections employee expressed pride in working with the staff from the hospital and felt that she was learning a lot about therapeutic interventions from them. The superintendent acknowledged that the corrections staff and the hospital staff were "two highly divergent groups" in terms of approach to the residents. He reported that, during the first year of the contract, the clinical staff were "suspicious and misunderstood the corrections department's handling of patients." The clinical director of the hospital staff appeared to be quite supportive of the work being done by the corrections staff. Although not explicitly stated, his clinical endeavors appeared to receive more support from the corrections line staff than from the administration.

The hospital clinical staff did not seem to feel like "interlopers" when inside the facility, however, and were treated with respect by the guards. The site visitors thought that conflicts and solutions were less complex under the vendorship arrangement than in the relationship between two different State agencies.

Corrections/Mental Health Joint Policy Board

Another approach to the issue of some administrative separation between treatment and security functions was examined in a treatment program in a State hospital established to serve inmates transferred to the hospital for long-term treatment of mental illness. The treatment program began in 1975 as a collaborative effort by the corrections and mental health divisions of the State to provide long-term mental health services to men and women committed to the division of corrections. Short-term stabilization of acutely psychotic inmates in prison was performed by another State facility.

To establish policy guidelines for this two-pronged effort, the legislature established a policy board made up of assistant administrators of both the corrections and the mental health divisions, institutional superintendents, and representatives from field services and from community corrections. Other members of the board included a representative from the State community mental health program directors association and the director of the correctional treatment program. This board develops broad policy governing the operations of mental health programs in correctional institutions, including the administrative rules of transfer, which set forth the conditions and process of transfer.

The short-term treatment program for stabilizing acutely psychotic inmates operates as a community mental health system within the three corrections institutions. Its units screen those needing intensive treatment into the inpatient long-term program,

while providing day treatment for other less seriously disturbed or ill inmates.

Interviews with the correctional treatment program director did not reveal any of the major problems experienced under the bifurcated chain of command or the vendorship relationship discussed earlier. The absence of such problems may well result from the assignment of overall administrative responsibility to one individual with the support of a joint corrections/mental health policy board. Responsibility for day-to-day management is fixed at a single point, rather than as an outcome of continuous negotiation and dispute resolution.

Statewide Network of Mental Health Services in Corrections

The forensic services division of one State's mental health department was operating 10 programs within correctional facilities. The division operated 7 outpatient clinics within prisons, 2 day-treatment programs based on a community mental health center concept, and 1 medical security unit. Within these programs, both mental health employees and contract services were used. This decentralized structure was too new to permit much assessment. However, responsibility for administration of both treatment and security resided in one agency, headed by the commissioner of mental health.

The four programs examined revealed a variety of problems having to do with the constant tensions and competing demands between security needs and treatment needs. These problems were reported to be least acute in the program with a single point of authority, operating under policy guidelines set with sufficient sensitivity to both sets of considerations. The decentralized State system was still in its formative stages, however, and may prove effective.

Size of Facility and Patient Management

Facilities responding to the national survey displayed a wide range of both populations and ratios of population to capacity. Reported populations ranged from nearly 1,200 in an institution set aside for mentally disordered offenders to only 3 in a special unit for juveniles. With respect to utilization, 5 facilities reported populations to capacity ratios of 50 percent or less, while 12 reported ratios exceeding 110 percent. Thus, responding facilities faced a wide variety of pressures, from high per-patient costs associated with small populations and underutilization, to special management problems involved in handling large populations, to adverse effects of overcrowding. All of these phenomena and administrative responses were observed during site visits.

Overcrowding

Overcrowding was an issue at two of the facilities visited. One had a population of 1,100 patients housed on 27 wards in a two-story building, with a capacity for 1,254. Although the facility was not formally "overcrowded" (its ratio of patients to capacity was 88 percent), its resources were strained. As seen onsite, this facility appeared to have a definite need for more treatment rooms. A proposal had been submitted that would reduce the capacity from its current 1,254 to 973, opening up much-needed room for staff offices and treatment areas.

At the time of the visit, this facility had approximately 517 persons committed under sex offender statutes. These statutes were repealed in 1982 but continued to apply to individuals already under commitment. Those individuals found guilty of a sex offense who entered the custody of the department of corrections after the statute changed would be offered a transfer to the facility only within the last 2 years before their expected release date. Therefore, based on the current rate of admissions, length of stay, and releases, administrators felt that this change would free about 100 beds during 1983. Should the capacity reduction petition be granted, it would help control the rate at which these beds were filled. The facility administrators were well aware that the department of corrections was experiencing overcrowding and hoped to be able to control the speed with which these 100 transfers would be received at the hospital.

In such a large facility, with a mix of both mental and legal statuses, patient manage-

ment was a major issue. All residents were clothed in uniforms provided by the State, unlike patients in most other hospitals in the State, who were granted the right to wear their own clothes. Uniforms allowed officials to determine who belonged in the facility, in case of emergency.

Freedom to move about in the halls was earned by proper behavior. As in many large institutions, hall monitors saw that traffic flowed in the proper direction and dawdling was kept to a minimum

Although experienced in managing large numbers of offenders, administrators were aware of the potential impediments to treatment associated with overcrowding. They hoped to ensure that their hospital would not import the overcrowding problem that existed in the State's corrections department.

The other hospital visited was experiencing overcrowding. Due to its statutory mandate and position as "an end of the road facility" it had to accept all individuals sent to the facility. At the time of the visit, the average daily census had peaked at 465 and hovered around 400; 310 was considered a safe level. As the only maximum security psychiatric facility in the State, it received referrals from over 70 sources; inappropriate admissions from some of these sources were considered to be a major contributor to overcrowding. Although many of the individuals were admitted for short-term treatment or stabilization, the rapid turnover of patients did not help the problem. More often than not, the hospital was not notified that a person was coming. As one administrator said, "He just shows up at the door."

As the density of patient population grew, the mental health workers at the facility began to question why they were there, as in the statement made to us, "If I can't perform treatment, I'm not aiding people." The Clinical Director was very concerned with the overcrowding situation in two ways. It was a problem for him both as an administrator—staff morale was low—and as a clinician—if "violence is situational," what chance does a treatment plan needing a secure structured environment have to succeed when space for persons is at such a premium?

Thus, while neither facility appeared entirely successful in ameliorating the antitherapeutic effects of overcrowding, one was attempting to eliminate the overcrowding through a reduction in official capacity. For a variety of reasons, many facilities are not afforded the opportunity to cap capacity levels.

Population Fluctuations

A facility's interest in operating an optimally sized, manageable, efficient institution is balanced by the State's interest in providing secure custody and treatment for designated mentally disordered offenders, regardless of variations in the size of that population. Due to the maximum security section closing at the State mental hospital, one of the forensic mental health facilities we visited had been preparing for over a year to receive approximately 85 patients from there. At the time of our visit, the program had 89 medium and minimum security patients. To accommodate the large influx of patients, construction was underway on a new maximum-security treatment and residential building. Hospital administrators worried that the new building would give a foreboding aspect to this placid appearing civil hospital.

In addition, this forensic program was reorganizing its internal administration to accommodate the doubling of its population. At the time of the visit, the forensic program was administered by a program director to whom unit chiefs reported. As of January 1983, the new organization chart showed that three of the four existing unit chiefs would continue to report directly to the program director for forensics. The existing Forensic Assessment Unit and the three new maximum security units would report to the assistant program director, who was, at the time of the visit, the unit chief of the Forensic Assessment Unit. Most of the staff seemed positive about the additional patients and staff changes. The director of the hospital, however, seemed somewhat apprehensive about a large, active, viable forensic program detracting from a civil hospital.

Another facility had substantial decreases in its average daily census. In response to deinstitutionalization, the census dropped from 1,670 in 1965 to 1,200 in 1972 to 300 in 1977, triggering an internal reorganization.

In 1972, units were organized by catchment areas, i.e., patients were assigned to units based on their county of residence. Concurrent with the drop in resident population, the maximum security section was closed. Until then, the mentally disordered offenders were housed in the maximum security section. The 12 men from section were integrated into the general hospital population, under the condition that they report hourly on the their whereabouts.

Another reorganization took place in 1978 that placed patients within the hospital on the basis of their functional status. This resulted in one unit being designed for patients presenting a high risk of escape or danger to self or others. This forensic unit was more protective and restrictive than other units. In addition, this one unit was responsible for diagnostic testing ordered by the courts. The standards were therefore more uniform than if treatment teams throughout the hospital were performing court evaluations, as was the case prior to the reorganization.

Although there was one small forensic unit, many of the forensic patients were scattered throughout the population. The goal of the forensic unit was to stabilize these patients so they could receive more treatment in other, less restrictive areas of the hospital. The fact that the director of the forensic program was the clinical director for the institution made this a fairly smooth, and by staff accounts, successful endeavor. In fact, the result was to make more and different types of treatment available to mentally disordered offenders as improvements in functional level permitted them to progress into other units within the hospital. Thus, where one might have expected a population decline to narrow the range of services available (or at least to reduce the ability to tailor treatment plans to individual patient's needs) the reorganization from geography-based to function-based assignment actually had the opposite effect.

Security and Related Physical Plant Issues

In dealing with the population of mentally disordered offenders, a common objective is to mix "just right" amounts of security and treatment. However, "just right," "too much," and "not enough" are difficult concepts to define operationally, much less achieve. Is it too much or just enough security to have armed guards at the sallyports or on perimeter patrol? Is it not enough or just enough security to allow these residents to use leather craft tools, barber shears, and various other arts and crafts equipment?

On a day-to-day basis, all 11 programs observed on site were treating the patients in a humane therapeutic program within a secure facility. Indeed, several administrators with security responsibility expressed the view that while visually obtrusive security hardware might retard treatment, effective security procedures were a prerequisite to treatment. Staff members were less effective if frightened, and patients who believed escape was possible or feared violence from other patients were less receptive to treatment. However, each facility had at least one story of an escape, escape attempt, or staff injury that resulted in a policy change. For example, one facility had a series of incidents in which patients injured staff seriously enough so that time off from work was needed. The program was then the subject of an extensive policy and activity review by the State legislature. This examination resulted in a redesignation of one of the units for the more violent patients, keeping them separate from the others. Staff were more aware that these patients were violence-prone and were more judicious in their handling of them. Based on this reorganization, serious staff injuries dropped considerably and were no longer considered a problem.

Two of the programs visited were quite new, both the treatment programs and the physical plants. One program was housed in a small 30-bed building built in 1975. The building was kept locked. Entrance, even into the administrative offices, was cleared through the control room. The treatment and living quarters were entered through a double door locked sallyport. No bars or fences were visible. All the windows and window frames had sensors which set off alarms. In addition, staff carried security pens that when aimed at fixtures on the walls, emitted an emergency siren. Because the treatment and living areas were relatively small, it was fairly easy to locate all

residents. While the hardware was unobtrusive, the facility was security conscious, as demonstrated through adherence to thoroughly documented security procedures.

Both mental health and corrections officials helped design the physical structure of another facility built in 1981. Although some of the staff felt that space was inadequate for the needs of the program, the array of electronic equipment was impressive. The unit was wrapped in microwave and electronic fields that triggered alarms on intrusion. The central control room had direct line emergency telephones from the nursing stations, an intercom system with direct communication to the nursing stations, a sound disturbance system monitor that permitted automatic or selective monitoring of patient areas, and 22 closed circuit television cameras that monitored the interior, exterior, and all approaches to the facility.

However, even with all the advanced electronic technology, there was still a major problem with the glass window panes. Residents were able to break the glass and hold it to employees' necks. Much of the glass was replaced with nonshattering polycarbonate. However, the control room remained glass enclosed.

To summarize, the range and variety of security mechanisms and approaches were as varied as the number of programs visited. In all facilities visited, treatment appeared to be conducted effectively in a highly secure environment. Within buildings, there were no appreciable discernible differences in physical security measures in the facilities based on auspices, mental health and corrections, a result consistent with the survey findings reported in chapter 4. Nor did security procedures seem to vary with variations in resident legal-status composition. What seemed to convey a more prison-like than hospital-like atmosphere were the procedures and hardware needed to manage large populations. However, the smaller facilities were newer, and it did seem that visible hardware was less obvious in the more recently constructed buildings. There also appeared to be an emerging operating tenet that advanced hardware and concertina wire are not as effective as individuals looking out for each other and constant monitoring of the patients. However, this approach is likely to be much more feasible and effective in a smaller institution than at a large facility.

Treatment Programming

Responses to the national survey indicated that individualized treatment planning and case conferences were nearly universal and that some form of group or individual therapy was usually available to supplement medication as a mode of treatment. However, only through observation on site was it possible to gain impressions of the quality of treatment planning and verbal therapy, and of the degree of discretion in use of medication.

The measurement of treatment success is difficult, and the separation of treatment effects from population effects is even more difficult (Cressey 1960). No attempt was made to determine which treatment programs were successful, consistent with the nonevaluative orientation of the study. However, even with this limitation, some of the treatment activities seen in the facilities are worth reporting.

Two characteristic attitudes toward treatment were noted in those facilities having a wide range of treatment programs and a heavy concentration of individual one-to-one therapy. The first was that staff seemed more committed to being treatment professionals in facilities where they felt the administration was supportive and encouraged their efforts. For example, in programs where line staff had the opportunity to develop treatment groups on topics they thought would benefit the residents, the amount of unstructured time of the patients was less than that in some other facilities.

Another equally prevalent staff attitude was that successful treatment was difficult to achieve in programs that could not control admissions. Control over admissions was perceived to serve at least two functions, avoiding overcrowding and its adverse impact on treatment, and screening for treatability.

In one facility, amenability to treatment was not a criterion for admission—a person must be admitted if found to be sexually dangerous. At another facility, sex offenders, as well as all other penal transfers, came voluntarily. In addition, this treatment

facility transferred recalcitrant individuals to another unit within the hospital. The difference in staff morale and the range of treatments in the two units were readily apparent during the site visit. Much more activity characterized the second facility's units, and its staff seemed much more motivated and excited by their treatment assignments than those in the first facility.

Also related to treatment amenability is treatment participation. One juvenile treatment facility could transfer those youth who consistently refused treatment back to the juvenile justice system. The ability to transfer out nonparticipants makes treatment and the establishment of a therapeutic community more likely. Motivation was possible, and esprit de corps was not disrupted by residents who refused to participate. Furthermore, the removal of disruptive patients made the therapeutic community function more smoothly and staff felt more like clinicians than warehousers.

In discussing treatment programming, it is important to note that the goals of the facilities were not uniform and were determined in part by the legal-status composition of the population. The goal of the program at one facility was "behavioral stabilization—not treatment." One of the predominant goals at another facility was a "total restructuring of personality" to curb criminal behavior.

With the exception of units solely for sex offenders, drug therapy was used in all programs. The percentages of patients on psychotropic drugs varied widely. Prescribing psychotropics was usually intended to increase receptivity to treatment and sometimes to maintain control over behavior.

While the survey provided data on the availability and participation level for broad categories of treatment, site visits provided the opportunity to view a variety of methods of providing this treatment. Treatment techniques that seemed to be the most structured and generated the most staff enthusiasm were of four types: intensive and individual (one-to-one) treatment for adults, programs designed to teach and treat individuals found incompetent to stand trial to competency, ancillary therapies that were integrated into the treatment process, and programs meeting the special needs of the juvenile mentally disordered offender.

Intensive and Individual Programs for Adults

The treatment program at one facility visited was divided into four units—one for assessment, two for inpatient treatment (rehabilitation service and program for sex offenders), and one a cottage-style dorm that housed persons on work release from the facility.

The rehabilitation service placed a heavy emphasis on "psychotherapeutic and rehabilitative efforts under controlled conditions." Considerable variability was seen in the premorbid patterns and backgrounds of individuals under treatment, requiring highly individualized treatment. (All patients had been assessed as able to conduct themselves in a minimum security setting, i.e., adjudged to be low risks in the areas of potential escape, aggression, violence, or severely disturbed behavior.)

Psychopharmacologic measures were used when appropriate; many or most of the patients at any given time were undergoing a regimen of carefully controlled and monitored psychotropic drugs, reviewed regularly to improve symptomatic remission. Continuous reassessment was offered, both to ameliorate and control severe psychotic disorders and to maintain remission of major psychic symptomatology while the patient progressed in other therapeutic modalities.

The psychotherapeutic and rehabilitative programs had four basic components: continuing psychotherapy, an emphasis on patient responsibility, the provision of psychoeducational classes, and increased community involvement and reintegration.

Various forms of therapy were scheduled on an individualized basis to facilitate each patient's self-awareness, self-control, and social skills. Individual and process-oriented group psychotherapy were provided on a weekly basis by the clinical staff. Patients also met regularly with assigned nursing staff to discuss their individual problems with daily living. Social discussion groups, led by psychiatric aides, facilitated social skills development and heightened the patient's awareness of the world outside the hospital. Selected patient's also participated in a peer contact program in which patient dyads shared their thoughts, feelings, and experiences.

While in treatment, patients were expected to act in a responsible manner. All

unit policies were explicitly stated and consistently applied. Patients helped review unit policies, planned weekend activities, acted as liaisons to the treatment team, and were partly responsible for orienting new patients to the unit.

Didactic and experiential psychoeducational courses, based on social learning theory were provided. Every 3 months, new courses in the areas of psychological adjustment, social skills development, patient education, activities of daily living, and recreational skills were initiated. Course selection was based on current patient needs. Patients volunteered and were assigned to participate in groups from which they might benefit most.

As patients progressed in treatment, steps were taken to enhance community reintegration. When clinically indicated, the treatment team would refer patients to the work release program.

This prerelease program focused on consumerism, stress management, vocational skill development, and forming an understanding of community resources. The patient work coordinator kept in contact with community work placement programs and the department of vocational rehabilitation. When appropriate, patients could participate in community work release and/or community schooling.

The sex offender program put emphasis on acquisition of personal and socially adaptive behaviors and control of the sexual aggressive tendencies that had resulted in the problem offense. In designing the program, the clinical staff had examined, either in person or through the literature, other sex offender programs. The staff felt their program was unique, however. According to the unit chief, they were "incorporating what the other programs do but not in the ways they (the other programs) do it."

Patients diagnosed as character disorders, antisocial type, are generally less amenable to treatment than others. Accordingly, efforts were made to bring each patient the maximum amount of treatment exposure but in proportion to the patient's motivation to change himself.

The sex offender program offered a confrontational approach to treatment. The program used group therapy skills, provocative therapy, and covert sensitization. The program was experimental and had been changing in the 3 months prior to the visit. All 21 patients on the unit received 16 hours of mandatory group therapy each week. These groups were process-oriented. Their major goal was to develop a therapeutic community and explore group dynamics, sense of belonging, and the development of attachments to others. This group helped develop the milieu necessary for the provocative therapy that was open to 8 of the residents. At the time of the site visit, there was a waiting list to participate. The residents not involved in provocative therapy were involved in other groups related to their special needs as sex offenders.

The purpose of the provocative therapy was to cause the residents to expend a great deal of emotional and physical energy in trying to achieve personal development and maturity. This approach combined psychodrama, behavior provocation, and physical activities. The therapy was conducted one time a week for 8 hours. The session usually began with a Synanon-type encounter in which all members of the group ganged up on one person (a different one each week). This individual had to deal with his own feelings as well as the situation at hand. Discussions of the sex offenses of the group, as well as their emotions before, during, and after the crime, also were included.

As would be expected, a tremendous amount of physical and emotional energy was raised in these sessions. For that reason, as part of the cooling down period, some form of intense physical exercise closed the session. The session leader stayed on the unit following this session until normal patterns of interaction were reestablished and the unit had regained stability. Persons in the sex offender program received between 20 and 35 hours of intensive treatment weekly.

The covert sensitization aspect of the treatment program aimed to diminish sexual arousal to deviant stimuli and replace it with arousal to appropriate stimuli. Arousal was measured and then controlled through a behavior modification/biofeedback program.

The sex offender therapeutic program was seen as instrumental in bringing about the "necessary" personality change. It was stated that one "can't change personality meaningfully without a drastically shocking experience. The patients need a reward for these new feelings and behavior." Staff and

patient commitment on this unit was reported to be high. Staff were willing to conduct large amounts of treatment, and patients were asking for more therapy. On the basis of onsite interviews, staff and patient motivation did not appear to be a problem.

The patient's progress was determined by his participation in his treatment plan and his behavior on the unit. Progress was documented through the clinical record, which was kept in a problem-oriented medical record format. Charting included reporting by all staff members from each discipline. This included documentation of contacts with nursing staff, therapeutic sessions, therapy groups, and psychiatric and psychological testing. Documentation had to be in the form of individual progress notes, multidisciplinary progress notes, or daily progress reports.

Specific behaviors were monitored, i.e., consistency in following program involvement, relating facts about his crime, motivation and attitude toward program involvement as well as motivation to change self, concern for others as reflected in feedback to peers, trust level between self and staff members, development of empathy for victim, development of service attitude, and evidence of progress toward treatment goals.

Team meetings were held regularly, in which multidisciplinary progress notes were formulated at least monthly, evaluating progress or lack of progress. Patients were invited to participate in this process in order to provide direct feedback.

During this monthly review, the patient's privilege status was evaluated. The results of this process were reflected in the institutional summary prepared for the special review board or the court hearing.

The fourth unit, the work-release program, received patients from the sex offender and the psychotherapeutic programs prior to release. Many of the residents worked in the community for 8 hours a day. Because this was such a confusing time for the residents—controls were loosened, the individual was away from the structured and secure environment—treatment programming was seen as still extremely important. Individual treatment was available to all residents, and three mandatory groups were offered, centered on social skills, interpersonal issues, and community reintegration. Much teaching was done in these groups to prepare the men "for going it alone." The staff had developed a community preparation program pre-test. This instrument was designed to alert the staff to problems residents might have on discharge, as well as to alert patients to gaps in their "self-care" knowledge.

Another program that offered an intensive treatment approach to adult mentally disordered offenders operated four units within a large State hospital: the mentally and emotionally disturbed unit, the sex offender unit, the social skills unit, and a drug and alcohol program. The treatment in the four units was derived from Yochelson and Samenow's *The Criminal Personality* (1976) within the context of a therapeutic community. The conceptual basis of this treatment approach rests on the assumption that criminal behavior is the result of deeply established maladaptive patterns of thinking and behavior. The program therefore required that the resident commit himself to altering thoughts and perceptions as well as lifestyle. Thirty-five "thinking errors of the criminal" were targeted for self-identification and elimination. An emphasis was placed on self-revelation and intensive confrontation by peers, as well as gradual assumption of responsibility for self and group. Other techniques designed to facilitate change were based on behavioral principles, as well as modalities of a more didactic nature. Treatment was conducted by all levels of staff.

Residents kept detailed journal accounts of their thoughts by time segment and presented these to their therapeutic community as a means of facilitating problemsolving, self-revelation, and ultimately change. The therapeutic community was highly structured, and programmatic values reflected an emphasis on what was described as unconditional respect, accountability, and integrity. Behavior contracts were also used to elucidate and change habitual patterns of response. These were negotiated and reinforced by the therapy group members. Although each resident was assigned to an aide who coordinated treatment, individual treatment per se was virtually nonexistent and the establishment of individual relationships with staff was not encouraged. The rationale for this seemed to be that the

group needed to be aware of, and assist with, individual issues that might otherwise remain as well-kept secrets between staff and patient. Thus, residents were encouraged to break into dyads to provide self-help and support for each other.

The programs for sex offenders and the mentally and emotionally disturbed seemed to be a confrontational therapeutic milieu within a community setting. The social skills unit was less confrontational but did stress that the individual assume responsibility for his or her actions. It seemed that much of the therapy centered on activities that required skills such as reading, writing, and well-developed self-expression. According to the director, should an inmate not have the skills necessary, he or she would be assisted by a ward aide.

Programs for Individuals Found Incompetent to Stand Trial

Several of the programs visited had special programs or groups for those individuals found incompetent to stand trial. These activities focused on teaching these persons proper courtroom behavior, as well as some conceptual notions of the judicial systems and the meanings and possible outcomes of conceivable pleas. The programs employed various methods, such as role plays of courtroom situations, mock trials, and group discussions of the legal process.

Only one program utilized its education department for this effort, however. Most of the other facilities used members of the treatment staff, such as social workers or nurses, to conduct these groups. Although other treatment personnel are involved in the comprehensive treatment of persons found incompetent, one facility's education department was used to teach the judicial aspects component of the treatment. The program was divided into five modules: a general overview of the State criminal justice system, courtroom procedures, dealing with an attorney, sentencing, and preparation for return to court. The use of the education staff in this way freed treatment staff to conduct groups not strictly educational in nature.

Ancillary Therapies

Two programs had extremely strong ancillary programs. The staff at one of these facilities believed that these programs, especially recreational therapy, were important in reducing frustration among patients whose concentration capacities and tolerance of frustration were severely limited. For this reason, the facility had a well-trained five-member recreational therapy staff, and other staff members viewed the department's programming as excellent.

The recreational therapy goals at the other facility were similar—staff reported them to be "helping the individuals structure time and tolerate frustrations." The recreational program was an integral part of the treatment plan—not a "tack on" as a time filler. In addition to planned recreational activities, the recreation director oversaw the recreation committee. Composed of patients, this group decided the activities for the month, allocated the budget, and helped determine the equipment necessary to be purchased. An activities therapy program worked in conjunction with the recreation program and the treatment units. The activities program utilized industrial therapy, macrame, and community activities such as baseball tournaments and YMCA memberships to provide release from frustration, to teach constructive use of unstructured time, and to improve peer-group social skills.

Many of the facilities were experiencing problems with their occupational therapy programs. Various rulings have made it mandatory that patients be paid for their work at rates that varied from approximately 40 cents an hour up to minimum wage. This had severely limited the number of hours patients could work, as well as the number of patients who could be employed. In other programs, patient work had been totally eliminated due to budget constraints.

The importance of education for the mentally disordered offender is beginning to be noticed. With the exception of Public Law 94-142, making education mandatory for juveniles, educational achievement has not been a major issue. The programs were starting to recognize that educational level is important once the individual is stabilized. It would appear, however, that some of the programs were not using their education staff to capacity. Educational programming was done primarily in response to requests from individual residents.

Programs for Juveniles

The two treatment programs for juveniles that were visited were quite different from the adult programs. Both programs seemed more nurturing, and a more relaxed atmosphere was apparent in interactions between staff and the youth. The other extremely obvious characteristic was the attitude of the staff—the level of commitment, care, and concern seemed extremely high.

The two programs, however, had different screening and admissions procedures. Young men in the first program were screened for appropriateness of admission to the intensive treatment program. The diagnostic process began with a 4–6–week testing and evaluation period at a reception center clinic. If referral was made to the intensive treatment program, the referral was reviewed by an admissions committee at the facility. The facility also accepted requests for screening from other juvenile justice institutions when they identified a youth believed in need of the program.

The program saw itself as providing services to "the neediest of the needy." To identify them, a global assessment scale was used to rate the level of individual functioning. Additional information used in screening consisted of: evaluations from the clinic; psychological and psychiatric evaluations; a historical statement of treatment attempts, identified problems, and desirable outcomes from the referring individual; and, almost always, a personal interview. Treatability was a factor taken into consideration during the on–the–lodge evaluation but was not a determination in accepting or rejecting the youth for a full evaluation.

The second juvenile treatment program admitted youngsters from several sources. Five percent of the youngsters were court–ordered, 30 percent were transfers from two correctional facilities for adolescents in the State, and 65 percent were there with court sanction of the placement signed by the administrator of children's services division. This administrator had responsibility for the care and custody of the youngster.

Individuals who petitioned and were found appropriate for hospitalization were transferred for a period not to exceed 14 days. Should the individual need continued hospitalization, they could extend their stay beyond 14 days by voluntarily giving written consent. If they refused to do this, the treatment staff could initiate a civil commitment proceeding, or if they did not require continued hospitalization, they were sent back immediately to the correctional facility.

Some of the similar characteristics of the children and adolescents served included extreme deprivation; physical, sexual, and emotional abuse; histories of violence toward others, including homicide, firesetting with the intent to do bodily harm, and physical and sexual assaultiveness toward others; and histories of self–destructive behavior, including severe suicide attempts and extreme self–mutilating behavior. It was not uncommon for the majority of individuals in the program to have histories that included numerous out–of–home placements. The criteria for admission to the regular treatment beds were prioritized to ensure secure treatment to those children and adolescents most in need. The criteria required a recognizable degree of psychiatric impairment, with priority given to those individuals who were demonstrating behavior that was extremely dangerous to self and others. A second priority was given to those children and adolescents who were repeatedly involved in life–threatening situations with little concern for the consequences of their behavior. This priority also included individuals involved in firesetting that was not intended to bring about bodily harm but did result in severe property damage.

The crisis component of the program also had very selective criteria for admission and focused specifically on individuals who presented acute life–threatening behavior to self or others. The crisis component did not intend to duplicate existing local community emergency services and was not available for respite, evaluation, or holding. The average length of stay in the crisis component was 3 days, with a maximum length of stay of 14 days. Generally, if an individual required longer than 3 days care in a crisis bed, it was because the agency, and not the individual child or adolescent, was continuing in crisis.

One of the more interesting treatment interventions at the first juvenile treatment facility described above was the use of audiovisual equipment in the therapeutic program. Staff have devised treatment

techniques utilizing Interpersonal Process Recall (IPR). IPR was developed by Dr. Norman Kagen of the University of Michigan, who had trained the staff on the use of the technique. This process allows both the counselor and the patient to do self-exploration through visual feedback procedure. An audiovisual tape was made of a 3–5–minute session between a counselor and a patient by a senior treatment person who had the role of inquirer. After taping, the counselor left the room and the patient was asked by the inquirer, at strategic moments as the tape was played, the thoughts he was having. Then the counselor was similarly queried. Finally, the two of them were led through the interaction together. Questions were asked to explore feelings and thoughts during the interaction. As there was almost immediate recall, suppression was minimized and expressed responses were thought to be close to actual responses.

The main thrust of IPR is not to judge either the treatment skills of the therapist or the receptivity to treatment of the patient. Rather, it is an exploratory process for both participants. With the skill of the inquirer, a 3–5–minute taping runs into an hour of intense treatment. This facility tried to involve eight youth in the IPR interaction each month. The role of inquirer needed approximately 2 days of initial training and followup focus to ensure that the inquirer did not drift into "counseling or critique" but remained in the role of inquirer.

Both juvenile treatment programs utilized medication very conservatively. The second program had a strong behavioral management component using limit setting to control acting-out behavior. Identification with the primary therapist was encouraged, and exploration of family conflict was viewed as critical. Both programs emphasized relationship building and intensive one-to-one counseling. A "phase system" was used to define privileges. The gain of privileges was dependent on commitment to treatment, and loss occurred as a consequence of exhibiting predefined inappropriate behaviors.

The major difference in the treatment components of the two programs was community integration. The second program conducted numerous field trips and recreational outings into the community and, when possible, placed residents in the public school system for part or full days prior to actual discharge from the program. The first program provided recreational and educational services on the facility campus.

Staffing Issues

Four major areas of concern pertaining to staff organization and administration were observed in the facilities during the site visits. These were training and the licensing of paraprofessionals; dual treatment and security roles for "line staff," i.e., staff having patient contact; burnout prevention; and supervision of direct care staff.

Training and Licensing

Training programs in facilities for mentally disordered offenders are both widely prevalent and important institutional activities, especially training for line staff. All but about 3 percent of responding facilities offered in-house training. Moreover, about 70 percent provided at least occasional training by consultants or at outside facilities. Professional staff, by virtue of their academic disciplines, had received training in their respective areas. Many facilities, however, depended on aides and technicians to provide professional treatment such as various group therapies, one-to-one interaction with residents, and treatment team meetings to determine goals and evaluate goal attainment for the residents. Although some of the facilities had individuals with college degrees in these line staff positions, the minimum criterion for these jobs was usually only a high school diploma. Both the content and the extent of training for this type of staff were therefore likely to affect the quality of the therapeutic process.

Sources of training for these aides/technicians varied from one program to another. Some forensic units of mental hospitals utilized the training department of the parent facility as a whole; others provided an extensive curriculum of ongoing training for which all staff in the program were eligible. For example, one program had extensive training available to the staff, provided by both the facility staff and the State juvenile services department. Money was available for outside workshops. Experts

were brought into the facility fairly frequently to conduct training. Staff—both line and clinical—requested certain seminar topics relating to care and treatment, and the administration was willing and able to respond. Because this staff did not have excessive turnover, training did not have to repeat basic care and security issues but could explore more sophisticated treatment ideas such as utilizing the IPR techniques discussed earlier.

At another facility, the technicians received training at the State prison. Although some inservice mental health training took place at the facility, most of it was for orientation of new staff. Training had been an area of budget consideration at the center, and the overall impression was that "training was primarily gotten on the job."

At a third facility, all staff were eligible for 20 hours of inservice training per year. In addition, psychiatric technicians had to be licensed by the State, and this licensure kept up to date. These requirements served to operationalize the standards to be met by the new technician and those to be maintained by the more experienced technician. This facility also provided extensive on-the-job training. A new psychiatric technician received one-to-one supervision by a more seasoned senior technician. Both senior technicians and trainees agreed that this was a workable plan and that both trainee and trainer benefited from it.

The policy of licensing technicians seemed an especially good idea. In the era of budget cutbacks, the requirement to meet certain minimum qualifications for licensure would seem to ensure training as a fairly secure budgetary line item. In addition, the need to maintain licensure would help ensure that training was more than a one-time orientation of the staff member to the facility.

Dual Treatment/Security Roles

At least one correctional facility and several mental health facilities had the aides/technicians in the dual role of providing both a treatment and a security function. In two of these facilities, training for the security function dominated training for the therapeutic function. In one of these, as mentioned earlier, the technicians receive 5 weeks training at the State prison. At the other facility, the aides received 80 hours of medical/psychiatric training and 160 hours of general corrections training.

The dual role of clinician and custodian was not generally mentioned as being a major administrative issue. However, comparing the facilities with dual roles for line staff with those in which clinical and custodial functions are separated implicitly highlighted a major problem. Establishing a therapeutic relationship involving the sharing of confidences is difficult when the resident is uncertain as to the role of the technician at any given moment, as in the case when clinical and custodial roles are in the same individuals. At only one facility was this dual role mentioned by the psychiatric security aides as an issue of some concern. The unit staff expressing this concern, however, also expressed the feeling of "being unsupported by the administration." The unit also seemed to be experiencing a conflict among various staff members as to whether the unit should function "as a prison or a hospital." It seemed that the dual line staff role was adding to, not helping to solve, the conflict. On the other hand, where resources limit the availability of professional therapists, use of technicians in a dual role may be the only feasible way to provide any form of therapeutic contact on a regular, frequent basis.

Prevention of Staff Burnout

A third staffing issue raised frequently during site visits was burnout prevention. At a recently opened forensic psychiatric unit that was visited, administrators were aware of its future potential and were beginning to examine ways to deal with it. At another facility, staff participated in a weekly "Me Time." During this period, staff on the unit team expressed the various problems and frustrations associated with their work situation. These frustrations were vented and ideally either solved or put to rest. The staff felt that, because of these structured sessions, "backbiting was at a minimum" and the multidisciplinary approach to treatment was enhanced. In addition, discussions about problems such as dealing with child molesters or violent patients helped sort out staff feelings and ultimately contributed to their enhancement as treatment practitioners.

It was interesting that in programs where this type of staff interaction was not part of the work week, staff would gather informally (offduty) for what seemed to be rather similar reasons and participate in similar discussions. Staff morale seemed lower, however, and staff in these facilities did not express the same feelings that the administration supported their efforts.

Supervision of Direct Care Staff

Varieties of structure for supervision of direct care personnel were evident during the site visits. These variations addressed the problems caused by the multidisciplinary nature of the direct care staff, who perform therapeutic, security, and medication functions. Since any one line staff supervisor is typically specialized in one of the three areas but must provide supervision for all three functions, his or her supervisory role extends beyond the scope of academic training and also possibly outside his or her primary function within the facility. Consequently, some supervisory staff face potential conflicts arising from the limitations of their own training and the areas in which they must serve as supervisors.

At one facility, the forensic specialists (ward aides) were organized under and supervised by the nursing department. This structure was reported to work satisfactorily, while the same procedure at another facility—aides report to the charge nurse—was not considered as favorably. This was attributed to supervision of aides having a dual security/treatment function by nurses who were concerned primarily with medication. At a third facility, where licensure required the technicians to be competent in many areas, senior psychiatric technicians headed many of the units. In addition, the highest level of psychiatric technician supervised the line nurses. The line nurses therefore could concentrate on medication administration and perform a more typical nursing function. The senior psychiatric technicians were more experienced in other forms of direct patient care and treatment. Therefore, the technicians were supervising individuals working in one area of their own training.

Staff morale varied greatly by institution. In facilities where morale was highest, however, the reason most commonly given was respect and support for line staff. Such respect and support by the administration of line staff seemed to be the single most important contributor to the positive staff attitude and high level of professionalism observed in these facilities.

Research Activities and Linkages with Universities

As reported in chapter 4, statistical and research activities were common in facilities for mentally disordered offenders. Of the 127 responding facilities, 46.5 percent reported outcome evaluation activity, 22.8 percent reported other significant research, and 31.5 percent reported operating a management information system. As with treatment activities, the site visits presented an opportunity to describe more fully the substance of the research efforts.

Several of the programs had developed various informal methods of self-evaluation. The youth at one facility, on exit from the program, completed a questionnaire on the usefulness of various aspects of the program. The questionnaire measured the way in which the youth leaving the program perceived various components to have helped them. The facility also participated in a State juvenile services data collection effort. Much of the analysis was done on the State level, but administrators at the facility made substantial use of the analysis in planning upgrades and enhancements of their treatment programs. The research was available to all staff, and for topics on which staff requested more information, efforts were made to bring in specialists to conduct seminars.

Another program was conducting a followup study of 151 youth discharged from the program. The study, which was initiated in 1981 and was being updated every 3 months, was examining success/failure on discharge as it related to many independent variables such as age, sex, length of stay in program, behavior management while in program, and acting-out behavior. The staff had written several articles on the results of the continuing study.

A third facility had a well-developed research program that had brought it

nationwide recognition. The number of staff publications attests to the level of sophistication of the research. In addition, close affiliation was maintained with a large university in the same area.

One State hospital did not have an ongoing research program. The hospital did have an automated program evaluation and patient tracking system, however, which recorded 137 data items on each patient. These items included details on the patient such as date and place of birth, language of home, education; information on commitment such as number of prior commitments, commitment offense, data on previous incarcerations; information on mental problems, diagnoses, and activities; information on behavior in the institution; and exit information.

The hospital began computerizing its records in 1978. Clinicians were given input into the data items selected, and active records were coded as of July 1977. Approximately one-eighth of 1 percent of the hospital budget was used for system maintenance. The file was updated daily. Although ongoing extensive research using the data collected was not apparent, the data would appear capable of supporting rather extensive analysis of historical and therapeutic potential determinants of behavior within the institution.

Besides the two facilities mentioned already, at least two other facilities visited had established working relationships with nearby universities. One facility was located near a major university. This proximity made it possible to use forensic psychiatric interns and legal-aid attorneys. Staff felt that their presence helped improve the services residents received at the facility. In addition, the facility benefited from a State program that allowed social workers and nurses to receive educational benefits in return for working for the State for 1 year. The facility had employed several of these persons.

A program in another State had developed a reputation as a teaching facility, with students from 17 disciplines such as psychiatry, nursing, social work, law, activities therapy, and guidance counseling as interns. Many came from the professional schools at the nearby campus of a large State university, while others came from colleges and universities across the State.

Prerelease and Release Activities

As reported in chapter 4, more than 90 percent of all facilities responding to the national survey released residents to the community, at least occasionally. Of these, most provided such prerelease services as counseling and negotiation of postrelease services treatment plans with community agencies. About 85 percent of the facilities reported some form of partial release (e.g., release for work or school). About one-third of facilities provided postrelease followup with either the releasee or the responsible community agency. In planning and operating such programs, the facilities had to maintain a delicate balance between benefit to the resident and protection of the community. The site visits provided an opportunity to observe several approaches to prerelease, transitional release, the release decision itself, and postrelease programs.

Release to the street was routine in 8 of the 11 visited facilities, at least for residents with certain legal statuses. Often, this release was done on the authority/approval of an outside board such as a parole board. Release to less restrictive institutional settings was common for about one-half of the visited facilities. In addition, many of the facilities had individuals sent to them for short-term treatment or stabilization. Once the individual was stabilized, he or she was returned to the referring institution.

Regardless of the individuals' release destination, the major gap named by nearly all the site visit participants was followup of residents. No matter how "well" the individual was at the time of release, should he or she not continue to follow the treatment regimen that had been successful, deterioration was considered likely to occur. The importance of followup has been frequently overlooked for this population. No matter how successful the institution is in stabilizing residents or putting the symptoms of mental illness into remission, the residents must continue the regimen set up by the institutions. For a great many, this involves simply continuing on psychotropic medication. Others need the stability of group therapy once they are in a community setting.

The site visits presented an opportunity to view several types of phased prerelease, in which residents are moved to progressively

less restrictive living arrangements prior to release. One facility had a community preparation service as one of its treatment units. At another facility, forensic patients were eligible for a modified release treatment program. This was an incremental release program in which the resident progressed from an offgrounds supervised pass to somewhat independent living supervised by the facility. Progress to each successive stage required court approval. To support this program, the facility maintained 40 beds in one-quarter, one-half, and three-quarter way houses. At any point during this prerelease period, the facility could revoke the privilege and bring the individual back into the fully supervised program.

Another treatment program had a community access program that was also a phased program. The individual began by making supervised outings into the community and could work up to 6-day unescorted passes. As stated by one staff member, "The community access program requires high-risk decisionmaking by the administrative and clinical directors" of the treatment program. While the individuals were in prerelease status from both these facilities, the facility administrators could revoke this status. The individual would then be returned to a more restrictive program in the facility and have to re-earn the prerelease status.

Prior to release from another facility, a State sanity commission must corroborate the program's finding that individuals who were found either incompetent to stand trial or not guilty by reasons of insanity were ready for release. The sanity commission convened at 6-month intervals and was composed of three doctors chosen randomly by the judge from a roster of approved doctors. When convened to determine the release readiness of a person found incompetent to stand trial, at least one of the doctors had to be a psychiatrist. When convened to determine release readiness of a person found not guilty by reason of insanity, all three members had to be psychiatrists. The commission members came to the center and observed and interviewed the patient. At least two of the three members had to find the individual either competent or sane—depending on the resident's legal status—for the individual to be released.

The staff at the facility had mixed feelings about the value of the commission. There was a feeling of some pride that a very high percentage of those individuals recommended for discharge by the facility staff had those findings corroborated by the sanity commission. Others felt that, because of this track record, the sanity commission was unnecessary. The additional fact that more than $12,000 of the facility budget had to be reserved for sanity commission hearings was irritating to some members of the clinical staff.

A unique system for handling release of those individuals who had been found not guilty by reason of insanity was found in another State. Upon such a finding, the trial judge then committed those "who continue to be affected by mental disease or defect (active or in remission) and continue to be dangerous" to a psychiatric security review board. This was a five-member independent board comprising a psychiatrist, psychologist, attorney, parole officer, and a lay citizen. Insanity acquittees were under the jurisdiction of the board for as long as the maximum prison sentence would have been following a finding of guilty. This moved this State's system for insanity acquittees closer to a criminal sentencing model, as opposed to the approach more similar to civil commitment found in other States. However, the two systems were kept separate and "there is a clear respect for the legal and medical-psychiatric perspective." The actual time on conditional release was longer than in most other States, and the board could revoke the status, without a court hearing, for any violation of the conditions of release.

Within the State hospital, insanity acquittees were housed on the Forensic Psychiatric Services Unit. The director of that unit expressed no concern about the releasing authority being assigned to the board. However, it may be pertinent that some treatment staff on this unit felt that it functioned more as a hospital than as a prison. It was possible that this feeling was stimulated, at least in part, by lack of authority over the release decision.

Litigation and Legal Issues

Based on responses to the survey questionnaire and recent activity in the Supreme

Court, administrators feel the most vulnerable to challenge on the legal issues surrounding the rights to receive and refuse treatment.

Right to Receive Treatment

The right to receive treatment is an important new legal right asserted on behalf of the institutionalized, albeit with certain conditions and stipulations. According to Brooks (1980), the objectives of this right are twofold. The first is to "significantly improve the atrocious conditions that prevailed in many mental hospitals." The second objective is deinstitutionalization. The State, it was thought, could only accommodate the high costs of treatment by releasing large numbers of patients. Therefore "the right to treatment became a part of the overall deinstitutionalization strategy."

Brooks also noted that the implementation of these right-to-treatment orders has been difficult. He stated that the "changes have been taking place, if slowly and begrudgingly."

Our site visits took us to three programs established in response to court-ordered right-to-treatment mandates. The first program appeared to have met the treatment mandates and stabilized its organizational structure. The two other programs appeared to be still evolving. Therefore, although for all three programs, the right to treatment was an historical issue, the organizational changes and evolution were more apparent at the latter two facilities.

The first program opened in 1975 in response to a Federal mandate. Prior to this time, the mentally disordered offenders had been housed on death row at the State prison. The program was mandated to provide services to those found incompetent to stand trial or not guilty by reason of insanity, and to selected offenders at the prison.

In another State, a court decision found basically that the treatment available at the State hospital was not adequate and had to be improved. In addition, the care and living environments were not adequate. The State agency decided to decentralize the provision of forensic services and was developing a plan to close the hospital facility. However, the rights granted to the patients under the court ruling went with them into the new system.

A contractual relationship between a private psychiatric hospital and the State psychiatric hospital was established in another State in response to a Federal court decision. The thrust of the decision was that unless these patients were provided with treatment services which would help improve their conditions, the facility and the State were guilty of allowing indefinite commitments.

None of these court orders mandated the specific structure or amount of treatment to be provided, as in the Alabama case of *Wyatt* v. *Stickney*. Thus, across the facilities observed on site, "adequate treatment" was seen to include a range in amount and type of group therapies, a wide variation in the use of psychotropic medication, and a variation in the types of treatment personnel conducting the treatment. However, treatment—both verbal therapy and medication—was available in all 11 facilities, and the administrators appeared to be following both the spirit and the letter of the laws governing their respective facilities.

Right to Refuse Treatment

The site visits took us into States exemplifying three types of right-to-refuse treatment practices: (1) facility residents had no right to refuse treatment, (2) at least some residents had the right to refuse some forms of treatment, and (3) residents could refuse any and all treatment. Statutory variations in right to refuse treatment are described in more detail in chapter 3. In one State, it was statutorily defined that forensic patients had no right to refuse treatment. In other States, the statutory language was less clear, creating management concerns when patients were thought by professional staff to need certain forms of medication or treatment. Thus, in one State, patients diagnosed as needing medication signed a consent form. This form was also signed by the doctor and witnessed by the staff. When the right to refuse treatment was denied, e.g., if electroconvulsive therapy was thought necessary for a schizophrenic with a seizure disorder that was nonresponsive to traditional treatment, the procedure was firmly defined. A form had to be initiated that involved a discussion of the rationale, treatment, and background of the

patient. The form was processed to the Advisory Committee of the Department of Mental Health. In an emergency when a patient was exhibiting extremely dangerous behavior, the form was filed subsequent to medication.

Another State facility had no legal precedent for the right to refuse treatment. Reportedly, resistance was worked through on a case-by-case basis, with the staff member closest to the patient attempting to coax him into participation. Legally different options existed for the patients based on commitment status.

Each facility visited had detailed regulations on medication procedures during an emergency. Most procedures were similar to the following: a physician was on call, medication was prescribed and administered, and the appropriate forms were completed subsequent to the treatment actions.

Several facilities required patients to sign a consent form. It is interesting to note that in some facilities when the patient refused medication, he released the facility from responsibility for his medical welfare. Most of the programs indicated that medication refusal was not a frequent problem. They were more concerned that the administrative regulations on overriding a medication refusal would not be upheld by a court of law. Therefore, the issue was not one of frequency but of nondirection when the problem presented itself.

Staff knowledge of the governing statutes and cases was observed to vary by level. However, staff at all levels were clear on the regulations in their respective facilities regarding the right to refuse treatment, as well as seclusion and restraint policies.

Effects of Litigation on Facility Operation

The major toll that litigation imposes on the institutions, according to facility staff, is the hours it takes the clinician away from treatment and into case-related paperwork. Shortly before the site visit, a senior clinician at one facility had received 16 pages of questions to be answered for one case. The amount of paperwork on each resident is usually quite extensive for routine clinical notes; when additional time is required to prepare input to legal briefs, the amount of treatment time is severely curtailed.

To help reduce the volume of litigation, two facilities had clients' rights advocates. In both facilities, each resident complaint was investigated by the advocate, who attempted to solve the matter internally, so that it did not reach the litigation stage. Some of the staff saw patients' rights as a "fly in the ointment—it is intrusive to the therapeutic relationship at times to have to figure out your legal relationship to the patient." However, the majority of staff at both facilities felt that having a patients' rights advocate helped keep minor problems just that. If a patients' rights advocate kept one complaint from becoming a legal case, then the time clinicians were spared from preparing litigation support material and thus able to devote to treatment made the advocate an effective resource for the entire treatment program.

State Agency Reorganization

A particularly complex result of litigation was occurring in one State where the entire system for dealing with mentally disordered offenders was undergoing an extensive reorganization. This reorganization was prompted by a judicial decision that the care, conditions, and treatment at the State hospital must be improved.

The court held that the "State upon committing an individual until he regains his sanity, incurs a responsibility to provide such care as is reasonably calculated to achieve that goal." Based on the court's evaluation of all patients then at the State hospital as to their mental illness or mental retardation, and the potential threat of harm to self or others if released, the court set forth the rights of the patients.

The decision detailed the qualifications of staff including the academic background and necessary years of experience. In addition, the decision defined "the minimum constitutional standards for adequate treatment for patients" committed to the hospital. These standards were detailed and included: placement in the least restrictive setting; individual treatment plans detailed as to goals, development, review, rationale, and individuals formulating the plan; treatment in the "most humane psychological and

physical environment;" patients' rights; personal possessions; diet and food services; and physical facilities.

The State was in the process of complying with these regulations. In an interview, the Commissioner of Mental Health explained that the plan involved phasing out the State hospital and replacing it with three security units in regional hospitals. Besides saving transportation costs to and from court, these three facilities would put the State system more in harmony with the philosophy of the community mental health concept of treatment close to home. Whether the State hospital would actually be closed was under debate. At the time of the visit it was housing all male prisoner transferees within the State, while the regional hospital housed persons adjudicated incompetent to stand trial or not guilty by reason of insanity. In addition, the regional hospitals served the female prisoner transferees. The department was still deliberating about the alternatives of having an entire facility for male prisoner transferees or the integration of prisoner transfers with other forensic patients throughout the system.

In addition to managing the security units of these State hospitals, the Bureau of Forensic Services, which was within the Department of Mental Heath, was also responsible for community-based service delivery to mentally disordered offenders though 16 Community Forensic Centers and satellite units within the corrections system that were dispersed throughout the State. Their purpose was primarily to do court-ordered evaluations. This way, the patients could be kept closer to their homes and not occupy precious bed space in the hospital for the evaluation. In addition, these centers did some parole supervision and continued treatment on an outpatient basis following release.

Within corrections, the Bureau of Forensic Services ran 10 satellite programs: 7 outpatient clinics within prisons, 2 day treatment approaches run under a community mental health center model, and a medical security unit. Within these satellite units, both mental health employees and contract services were used.

It was claimed that mentally disordered offenders would not be victims of warehousing in this State again. This was independent of where the services were provided, because, as explained by a State administrator, "All patient rights attached under [the court decision] go with them to the satellite units." The decentralization process was still very new. One facility was not yet complete. It was impossible to measure success in terms of impact on recidivism. However, the commissioner noted that he was "hoping to set up a tracking system" to determine success and recidivism rates among inmates.

This type of reorganization of forensic services and the use of satellite centers within corrections was also taking place in two other States. Based on the visit to one of these States, it appeared that the system was operating smoothly. The utilization of mental health personnel in the satellite units within the corrections facility working under the same auspices as those of the inpatient programs contributed to this smoothness of operations. The design of these programs put these systems more in harmony with the current emphasis on community-based treatment in mental health care.

Budget Issues

Obviously, during the current period of public-sector resource constraints, program costs are of concern to administrators. Some of the programs had been cut back, and these cuts had reportedly hampered training efforts, in particular. Outside training was usually the first item cut, perhaps because the effects of such cuts are both delayed and difficult to measure. Most of the programs did not experience large year-to-year turnover; this staff stability meant that staff were drawing on past training efforts.

Besides the budget level, a related problem faced by most administrators is the year-to-year nature of funding. Programs are funded one year to the next, without any knowledge of the availability and level of continued funding until the 11th hour. This causes problems in staff morale, treatment continuity, and administrative burnout due to excessive lobbying. In addition, it creates a turf problem as to who should lobby—the Director of the State Agency; the Administrator of the Facility; or the Clinical Director of the Program.

Summary

As stated in the introduction to this chapter, the site visits were not conducted to evaluate any of the programs. Rather, the purposes were to ascertain from those programs activities that other program might want to incorporate; to identify features of State agency reorganization that other States may be facing in the near future; and to further highlight both the problems faced by these administrators and the approaches being utilized in an attempt to solve them.

Because of variations in legal structure, population mix, resource availability, and public attitudes, to compare the whole of any one program to the whole of another would be a great injustice. However, each facility has comparable administrative problems in dealing with the mentally disordered offender population while grappling with security constraints, budgetary problems, State bureaucracies, the legal system, and individuals collecting information on the populations. Even in the absence of rigorous evaluation, it was possible to observe that the programs whose administrators were supportive and astute in terms of relations with the legislature and oversight authority were the same programs where the most staff excitement was found. Staff seemed more professional and committed, and morale was higher. Although no residents were interviewed, it could logically be assumed that they profited from this feeling.

Chapter 6

Conclusions and Recommendations

This chapter draws on the analyses contained in the preceding chapters to reach conclusions in five major areas of inquiry.

- In what kinds of facilities are mentally disordered offenders institutionalized for treatment of their mental disorders?
- What are the legal, diagnostic, and demographic characteristics of the residents of these facilities?
- What forms of treatment, levels of staffing, and security practices are common to these facilities?
- What are the predominant problems faced by facility administrators with respect to case management, facility administration, and representation of the facility to other constituencies, and what approaches are being used as solutions?
- What have been the major legal initiatives affecting these facilities in recent years, and how have they affected treatment and administration?

In the next five sections, results on these topics are summarized and compared with previous research. Then, based on the research reported here and on the expressed needs of facility administrators, recommendations are presented for future periodic data collection and publication and for future research.

Organizational/Structural Characteristics of Responding Facilities

As was the case more than a decade ago, care and treatment of mentally disordered offenders is primarily the responsibility of State mental health departments. Of 127 respondents to the present survey, 79 reported themselves to be mental health facilities, 30 under correctional auspices, and 18 under other auspices, primarily social services agencies, youth authorities, or joint mental health/correctional authority. This distribution is quite similar to that reported by Scheidemandel and Kanno (1969). The resident populations were even more heavily concentrated in mental health facilities, with approximately 70 percent housed there, 23 percent in correctional facilities, and only about 7 percent in social services/other facilities. Approximately 60 percent of responding facilities under all auspices are units of larger institutions. Moreover, the overwhelming majority of facilities—121—were under State auspices, with only five Federal facilities and one local one. Fifty-eight percent of the entire population served by the responding facilities was concentrated in just 14 percent of the facilities—the 18 facilities with populations exceeding 250. Thus, large security hospitals remain the primary source of treatment for mentally disordered offenders.

Only four of the responding facilities were dedicated to female mentally disordered offenders, although females were eligible for admission to 46 others—a distribution similar to that reported by Eckerman in 1972. Halleck (1987) has noted that the paucity of specialized facilities usually exists because the State has not perceived sufficient numbers of females to justify the construction of a special unit. Therefore, female mentally disordered offenders in most States were housed with males, or with mentally ill female nonoffenders, or with other female prisoners.

Another effect of the lack of institutions for women, which has generated substantial

litigation against corrections departments, is that incarcerated women are frequently held in facilities far distant from their homes. In the case of mentally disordered female offenders, excessive distance may preclude involvement of family in diagnosis and treatment, prevent partial release to the home community, and exacerbate the difficult problem of effective postrelease followup in the home community.

Of the 127 responding facilities, only 17 were dedicated to "juveniles," i.e., persons detained by order of a juvenile court. Another 12 facilities accepted both juveniles and persons sentenced by adult court, while the vast majority—98—limited admissions to adults. The existence of any juvenile-only facilities at all is a change from 1969, when Scheidemandel and Kanno, despite intensive efforts, were unable to locate any.

Facility design capacities varied widely —from three units with capacities of 10 or fewer to one facility dedicated to the mentally disordered offender having a capacity of 1,254. For separate institutions such as security hospitals, the median capacity category was reported to be 101–250, while the corresponding category for separate units of larger institutions (e.g., psychiatric units of prisons, forensic units of mental hospitals) was 51–100. In general, institutions with capacities exceeding 101 were slightly more predominant within corrections than other auspices.

Based on analysis of the national survey data, as well as observations during site visits, several facility characteristics seemed to be related to size. First, estimated length of stay among released residents was only about 2 months in facilities with capacities of 10 or fewer and increased rather steadily with capacity, reaching approximately 16 months in facilities with capacity exceeding 501. Thus, the large facilities tended to provide more long-term housing and treatment. Possible explanations for this relationship may be that some of the smaller facilities are geographically dispersed institutions performing not only treatment of adjudicated mentally disordered offenders but also many psychiatric evaluations, which require less time than does treatment of mental illness, producing shorter overall lengths of stay, on average. Other smaller facilities are psychiatric units of prisons, with the goal of stabilizing behavior sufficiently to permit the inmate to function in the general prison population, a more limited and less time-consuming goal than fundamental behavioral change preceding release to the community.

Among the adult facilities selected for site visits, the large facilities seemed to offer a wider array of treatment options —an understandable result, since a large population is likely to contain more special-need subgroups of sufficient size to warrant special programming.

Facility Population Characteristics

The legal-status distribution among adjudicated adult mentally disordered offenders residing in the 127 responding facilities generally resembled the distribution reported by Steadman et al. (1982) for all such persons in the United States as of 1978. According to both surveys, this population is approximately equally divided among the following categories: those found incompetent to stand trial, persons not guilty by reason of insanity, persons sentenced under special statutes defining mentally disordered sex offenders, and mentally ill inmates of correctional facilities transferred to special prison units or mental health facilities for treatment of mental illness. The two most notable differences between composition reported in the present survey and reported by Steadman et al. are consistent with hypotheses related to recent legal changes: a smaller proportion of incompetents, which could reflect increasing success of treatment-to-competency programs established in response to the mandate of *Jackson* v. *Indiana*, and an increase in the proportion of mentally ill inmates held in corrections rather than mental health facilities, perhaps related to the tightening of due process standards for transfer to mental hospitals mandated by the decision in *Vitek* v. *Jones*.

In addition to the adjudicated adult categories, responding facilities housed a smaller, but still substantial, population of residents undergoing evaluation for competency and/or insanity. For this group, while medication might be necessary to control acute episodes of acting-out behavior, the primary goal was to complete the evaluation

and return the individual to court jurisdiction. Finally, the responding facilities housed a smaller number of juvenile offenders, for whom education and training in life and social skills are important components of the treatment program, in addition to treatment of the mental illness.

Diagnostically, the mentally disordered offenders in responding facilities presented a picture of diversity. While all major DSM–II and DSM–III categories were reportedly found among the population, the most widely reported diagnoses were schizophrenia, substance abuse, and conduct disorders. In addition, 16 percent to 19 percent of residents had also received secondary diagnoses of mental retardation. This composition of diagnoses does not appear to have changed significantly since the survey by Scheidemandel and Kanno (1969).

Demographically, the entire set of responding facilities housed a population containing about twice as many youths under 17, more residents aged 65 and over, and somewhat more whites than did the general Federal and State prison systems. The prevalence of youths disappears when juvenile–only facilities are excluded from the comparison; in fact, youths constituted only 1.6 percent of the population of adult–only facilities for mentally disordered offenders, compared with 2.6 percent in the general prison population. The predominance of elderly residents occurred in adult–only facilities under all auspices, however.

With respect to minors, it is worth noting that separation of persons 17 and under from older mentally disordered offenders was the exception, rather than the rule. Of the 46 facilities housing both minors and adults, only 22 percent housed them separately. As one might expect, however, that percentage is about twice as high among facilities where minors were a smaller fraction of the population. Separation was slightly more common in treatment, substantially more common in education, and slightly less common for recreation.

The high representation of whites in facilities for mentally disordered offenders resembles the distribution within mental health facilities. The ethnic composition of correctional facilities for mentally disordered offenders is virtually identical to the ethnic composition of corrections facilities generally.

Facility Treatment, Security, and Staffing Practices

Among responding facilities, some form of individualized treatment planning is generally institutionalized, with more than 90 percent of responding facilities reporting preparation and regular review of individual treatment plans. Psychotropic medication is the most universal form of treatment, being available in 97.6 percent of responding facilities and reportedly administered to a median of 61 percent of residents. According to staff interviews performed during site visits, psychotropic medication was administered for immediate crisis intervention, short–term stabilization of inappropriate behavior, and long–term control therapy. In addition, antidepressant and anticonvulsants were administered as needed. Reports suggest that discretion is used in administration of all medication, however. None of the sex offender treatment programs observed on–site reported use of medication as a means of therapy.

About 90 percent of responding facilities reported offering group and individual therapy at least weekly, to medians of 60 percent and 34 percent of residents, respectively. Compared with earlier surveys, use of electroconvulsive therapy (ECT) and other somatic therapies (e.g., Indoklon and insulin shock) had virtually disappeared. Although ECT was reportedly available in 19.2 percent of facilities, the median participation rate is 0 percent; other somatic therapies are reportedly available in only 3.2 percent of facilities but are used extensively in those few facilities.

Three issues related to quality of treatment emerged: instances of oral treatment planning and review, conduct of group therapy by psychiatric technicians and similar nonprofessional staff, and staff responsibility for both treatment and security. In general, staff were supervised by social workers and/or psychologists, and facilities frequently provide some level of inservice training in the necessary skills. Several facility administrators cited this training as a leading candidate for elimination in response to financial pressures, however.

Several examples of structured, intensive treatment programs in which progress toward predefined goals was measured and evaluated were described. These included:

competency testing and individualized treatment-to-competency programs, based in whole or in part on the work of McGarry (1972); integrated social skills training and behavior modification for sex offenders; programs integrating recreation into the therapeutic process; programs of individualized and intensive education and treatment for juvenile mentally disordered offenders; and several prerelease programs incorporating special living units, trips or temporary release into the community, and other prerelease planning. Several other characteristics of treatment programs were manifest as well. First, in general, facilities with populations larger than about 50 seemed to offer more highly structured treatment programs than did smaller facilities. This might be expected, because the larger facilities were likely to house sufficient numbers of residents with a given need so that a special program to meet that need became cost-effective.

Second, in the one facility observed in which psychiatric technicians faced a licensure requirement, several desirable effects were noted that did not appear in other facilities visited. The technicians articulated uniquely high levels of understanding of the treatment process and an awareness among senior technicians of their roles as trainers and examples for more junior technicians. In addition, they demonstrated initiative in establishing therapeutic groups to meet the needs of special subsets of residents and expressed high morale as a result of respect demonstrated by facility administrators. These observations suggest that "professionalization" of technicians produces desirable effects.

Third, because of geographic distances and reluctance by families to become involved, families and friends very seldom participated in either the treatment or diagnostic processes. Although staff of the facilities visited recognized the constraints, many of them commented that such involvement would improve the effectiveness of treatment.

Fourth, a similar lack was noted by many treatment staff with respect to postrelease followup. Consideration of distance, as well as organizational and resource limits, mitigated against followup to ensure ongoing adherence to the treatment plan following release, even when release was to the general prison population. Informally, a number of staff members expressed the view that this lack would lead to the eventual return of releasees to the institution.

Fifth, statutes in some States permitted mental hospitals to reject potential penal transferees on a "treatability" criterion. This was seen as an important aid to effective treatment, not only because it provides a safety valve for controlling population size but also because it permitted the facility to reject those who might later disrupt or refuse group therapeutic processes, thereby lowering the effectiveness of the programs for other residents.

With respect to security practices, approximately one-third of responding facilities classified themselves as "maximum security." Another 19 percent were classified as medium security, 10 percent as minimum security, and 16 percent stated that all three levels existed. About 60 percent of all facilities house all residents in closed wards.

Among the 35 percent of responding facilities that operated under multiple levels of security, the security-level assignment criteria emphasized patient behavior and elapsed time during the present institutionalization, rather than historical or predictive criteria of violent behavior. The most commonly cited criteria were assaultive behavior (25.2 percent of facilities) and time in facility, adjustment to program, or both (23.6 percent). Substantially less common (14.2 percent) was a psychiatric or clinical determination, and still fewer respondents cited historical factors such as legal status, offense charged, and prior escape history.

With respect to physical security measures, most facilities reported security fences or walls around the perimeter, and half reported unarmed guards on the perimeter. Security gates controlling access to the grounds, and unarmed guards patrolling the grounds, were reported by just over half the responding facilities. Within buildings, more than 85 percent of facilities reported security windows and doors, as well as at least one locked ward. More than half reported availability of a telephone alarm system and the presence of unarmed guards, and sallyports and/or metal detectors were reported by more than 40 percent of facilities. Armed guards are located on the perimeters

of 19 percent of facilities, on the grounds of 10 percent, and in the buildings of 6 percent.

Correctional facilities employed relatively intrusive measures during visits by family and friends. A security guard was present during visits in 83 percent of correctional facilities, compared with 57.5 percent overall; residents were strip-searched following the visit in 70 percent of correctional facilities, compared with 43 percent overall; and metal detectors were used in 66.7 percent of correctional facilities, compared with 51.2 percent overall. In contrast, less intrusive measures, such as TV monitoring, locking the visiting room, and searching the visitors, were less common within corrections than within the other systems, though used in a minority of facilities under all auspices.

Responding facilities reported a median of 136.5 staff members per 100 residents, a ratio that varied from 121.5 in facilities housing both adults and juveniles, to 133 in adult-only facilities, to 219 in juvenile-only facilities. By auspices, the number of staff per 100 residents was reportedly 65.5 in correctional facilities, 175.5 in mental health facilities, and 147.5 in social services/other facilities. Besides these differences in levels of staffing, differences were also apparent with respect to the mix of staff. Within correctional facilities, treatment staff outnumbered security staff by a ratio of about 1.75 to 1. Among mental health and social services/other facilities, the corresponding ratios were about 11 to 1 and 13 to 1, respectively.

Staffing levels differed in rather interesting ways with respect to population. For administrators, treatment personnel, and ancillary therapists, economies of scale seemed to exist, in the sense that their numbers per 100 residents generally declined as facility population increased. In contrast, the number of security staff per 100 residents increased with population, possibly because security problems were more acute in larger facilities, or because the larger facilities were more likely than others to be correctional facilities, which were considered to be more security-conscious.

In-house training took place in virtually all facilities, at least monthly in about 60 percent of them. Smaller facilities made use of outside training or consultants, and such training occurred more frequently at irregular or unspecified intervals. For in-house training, the most commonly specified subject area was "clinical," i.e., specialized topics in psychiatric nursing and other special therapeutic procedures.

Areas of Management Concern

Responses to the national mail survey identified the most prevalent areas of management concern among the administrators of facilities for mentally disordered offenders as management of suicidal/homicidal residents, problems due to the simultaneous presence of male and female residents, results of staff turnover, and the general problem of balancing treatment and security concerns. The management concerns may be grouped into three general types: (1) case management involving the provision, assessment, and regulation of treatment activities; (2) facility management including staffing, training, and operations; and (3) outside representation of the facility to other constituencies including State-level administrators, the research community, and the general public.

Administrative support of case management includes the areas of facility admissions, the provision of treatment services, and release decisions. The concern of inappropriate admissions was raised as an issue quite often onsite. Some facilities had accepted inappropriate admission as a fact of life. Other facilities had overcome problems with inappropriate admissions through the policies of the administration and clear definitions of admissions criteria, e.g., mentally ill and a danger to self or others. None of the facilities had completely resolved the inappropriate admissions issue. Matching population flows with treatment needs and availability while maintaining treatment integrity and quality is an exceedingly difficult job, especially when referral sources and the delivery systems operate under different authorities and the delivery system has no means to control inflows.

The administration of treatment programming included both the provision and assessment of treatment activities. The mail survey data showed that about 90 percent of the facilities responding to the mail

questionnaire prepared individual treatment plans. Onsite, however, it was learned that some of these plans were developed and maintained orally in at least a few institutions. In other facilities, staff noted that the degree of differences in the actual treatment plans was not of sufficient detail to warrant their being deemed "individual." In other facilities, however, the individual treatment plans were reviewed comprehensively in case conferences, with goals and success measures negotiated by the treatment team. This was then presented to the resident, and his or her willingness to participate in treatment was negotiated. Such a procedure is likely to have led not only to more complete and individualized treatment plans, but also to more acceptance of treatment by residents. As shown by the survey data, the types of treatment available were predominantly psychotropic medication, group therapy, and individual psychotherapy. Observations onsite found that some facilities classified ward meetings that discuss general living arrangements to be "group therapy." In other facilities, the groups had a structured syllabus with topics and rationale for the group as well as measures of success. In most of the facilities, due to budget pressures, the groups were led by ward aides or psychiatric technicians.

Another aspect of treatment programming administration is the evaluation of ongoing treatment and the use of evaluation results to suggest improvements in the treatment program. Based on information obtained from the site visits, it appears that several facilities have established research departments within the facility. Although the structures and procedures exist for the conduct of research, very few facilities had established a feedback loop for utilizing research results to improve actual treatment programming.

Another case management concern related to the therapeutic activities within a facility is that of control of critical incidents. These critical incidents include patient suicides, homicides, and escapes. Interestingly, although both suicides and escapes were reported to occur with disproportionate frequency in smaller facilities, administrative concern about suicide, at least, was more widespread in the larger facilities. All facilities visited onsite had experienced at least one such critical incident and had established directives for dealing with these occurrences.

Another type of patient management concern voiced by one-third of the respondents housing both males and females includes problems associated with that mix. Specific examples cited by respondents include both sexual acting-out and the need for procedures to protect privacy.

The concerns of managing the organizational aspects of the facility were observed onsite to be related to, although separate from, treatment monitoring. It did not appear to be coincidental that in programs where the organization and administration were supportive of staff, more hours of treatment programming were being conducted than in those facilities that experienced an "us against them" feeling between line staff and management.

Many programs combine the dual therapeutic/corrections mandate of the facility by training line staff to function as both security guards and therapists. The major problem associated with this dual role of line personnel, however, is that sometimes a conflict is felt between the two roles of therapist and guard. Traditional roles of therapist and guard are almost antithetical to each other—the former is based on interaction, and the other discourages interaction.

Another concern of facility management is the prevention of staff burnout. Some of the programs visited had instituted structured times for staff to discuss problems with residents and/or other staff. It was recognized that these facilities can be highly charged and that dealing with persons both "mad" and "bad" is extremely stressful. In addition, the multidisciplinary nature of the staff sometimes contributed to "interprofessional" conflicts in dealing with certain types of residents. This structured time not only portrayed to staff that the administration was supportive to them but it allowed the administration to be aware of potential problems and bring them to closure before the problems escalated.

During site visits, facility administrators reported devoting increasing amounts of time to representing their programs outside their local communities. This is done through meetings with the cognizant State agency and other facility administrators,

releases to the media, and published research by the staff.

The primary focus of representation is to the authority responsible for funding—either the State legislature or the cognizant State agency. Many of the programs were concerned about potential budget cutbacks and knew that lobbying State legislatures for their programs was the only viable method of survival.

In addition, many of the programs had at least one "horror story" that they were aware the general public would remember for a long time. To improve the public images of their programs, the directors of several facilities had developed working relationships with the media. The media in these localities would publish feature stories on the facilities in addition to other articles.

Impact of Legal Changes on Facility Operations

This section discusses the impact of court decisions on confinement and treatment of mentally disordered offenders.

Limitation of the Period of Confinement for Persons Found Incompetent to Stand Trial

As noted by Wexler (1976), those found incompetent to stand trial have long constituted a substantial share of the population of facilities for mentally disordered offenders. Prior to 1973, he notes, the usual procedure for defendants whose competency was called into question was confinement for 30 to 90 days in a maximum security facility for evaluation. Defendants found incompetent were then automatically committed to a mental hospital for indefinite periods.

The traditional procedure of holding these individuals indefinitely was overturned by the U.S. Supreme Court decision in *Jackson* v. *Indiana,* which ruled that defendants found incompetent to stand trial could be held a "reasonable period" to determine the likelihood of regaining competency. Following the reasonable period, the decision required either release or civil commitment with periodic review. Continued commitment could be justified only by progress toward regaining competency. As noted by Wexler (1983), such progress, in turn, required an ongoing program of treatment to restore competency and evaluation of progress. It is important to note that because the defendant Jackson was not considered dangerous, the mandate did not apply to dangerous persons, and no subsequent case has thus tested the requirements.

As of 1981, 23 States had statutorily defined maximum period of confinement for defendants found incompetent to stand trial. The statutory maximum periods range from 3 months to 10 years. During the 1970s, many State commitment statutes were revised to deal separately with the civil commitment of defendants considered permanently incompetent. Meanwhile, a number of States have generally tightened their standards for commitment, usually to incorporate a "dangerousness" requirement.

A predictable impact of the *Jackson* decision is a decrease in average length of confinement for incompetents. Holding a rate of admissions of incompetents constant, this would cause a decrease in the population of institutionalized incompetents at any point in time. Wexler suggests, however, that compliance with the decision could cause merely a "shuffling" of defendants from status as incompetent to status as persons civilly committed. Moreover, he suggests that any decrease in the number of institutionalized incompetents due directly to the *Jackson* limitation may be indirectly offset by more frequent use of the plea, encouraged by the limitation itself.

Incompetents constituted only 18.5 percent of the adjudicated adults housed in facilities responding in 1981 to the present survey, compared with the 24 percent reported for 1978 by Steadman et al. (1982). While the difference may be due to methodological reasons, it could reflect increasing success in programs for restoration to competency established in response to the *Jackson* mandate.

In addition to impacts on population and length of stay, the *Jackson* mandate could be expected to stimulate more active treatment programs for restoration of competency and attempts to predict restoration to competency. The telephone followup identified some facilities using instruments based more or less closely on the work of McGarry (1972) to assess competency, to identify particular areas of the individual's

incompetency, and to develop a plan for treatment to restore competency.

Another predicted impact of the *Jackson* decision is additional litigation, requesting implementation of *Jackson* where the State has not done so, challenging certain implementation methods as not conforming to the mandate, and challenging the statutory requirements of 10 States for judicial approval before release of civilly committed incompetents. To our knowledge, none of the responding facilities in the present research had been the subject of such litigation.

Limitation of Right to Confine Indefinitely Persons Found Not Guilty by Reason of Insanity

Release decisions for convicted sex offenders and mentally ill inmates generally fall within the purview of parole authorities, rather than mental health professionals. When an incompetent has been restored to competency, the disposition decision is shifted to the courts and eventually, unless the defendant is found not guilty, to parole authorities. The release decision for civilly committed persons whose incompetency has been judged unrestorable remains dependent on input from staff of a facility for mentally disordered offenders. A successful insanity defense can lead to commitment to a secure mental hospital. Thus, for both persons whose competency is unrestorable and persons found not guilty by reason of insanity, responsibility for recommending release is likely to remain with staff of a facility for mentally disordered offenders.

Wexler (1976) notes that legal activity, beginning in 1968, has started to undermine the tradition of automatic and indefinite commitment. The decision in *Bolton* v. *Harris* recognized that an insanity acquittal establishes, at most, *prior* insanity at the time of the illegal act, and therefore found unconstitutional statutes authorizing automatic commitment of insanity acquittees. Since initial and continued commitment should be premised on a finding of *present* mental illness and dangerousness, courts have begun to assert that equal protection requires commitment standards roughly conforming to those for civilly committed patients. State legislatures have responded by statutorily according to these persons due process procedures and confinement limits that are comparable to civil commitment procedures.

The national survey results indicate that problems associated with release to the community are nearly universal, and that impacts are observable in the establishment of prerelease services, transitional release, and efforts to provide postrelease followup. More than 90 percent of responding facilities reported releasing residents directly to the community, and 83 percent of facilities reported offering prerelease services.

The most common forms of prerelease service were counseling and testing and negotiating terms of treatment with community agencies. In addition, 74 percent reported operating one or more transitional release programs—partial release, release for work or education, or some other special release program. Administrators and treatment staff expressed substantial concern over the conflict between transitional release programs and community security. Administrators saw themselves confronted with a public relations problem: reducing community fear, perhaps unwarranted, concerning such programs. Several facilities visited had received occasional adverse publicity about their transitional release programs and had initiated public information activities to counter this publicity.

Nearly half the facilities releasing to the community reported postrelease followup with the releasee, and about 60 percent reported followup with community agencies. Followup with the releasee was usually to provide support and information about community adjustment and to evaluate adjustment to the community. Followup with agencies was typically to monitor referrals and to evaluate adjustment. A common concern of facility treatment staff was the lack of supervision in the community, especially with respect to maintenance of medication. This gap is apparently seen as a frequent cause of "failure" or recidivism by the releasee. It is worth noting that this lack of control over followup extends to mentally ill inmates returned to the general prison population following stabilization.

With respect to the decision to release mentally disordered offenders (particularly insanity acquittees) to the community, Wexler (1976) wrote that "psychological studies suggest that if a legal decisionmaking structure could be designed in which release

responsibility is *shared* or *diffused*, the decision to release might be made with fewer inhibitions." To remove the inhibitions, he suggested the court as an appropriate locus for the decision. Vesting the release decision responsibility in the judge, however, would appear to *diffuse* the responsibility of treatment staff in formulating release recommendations, thereby reducing their accountability. At one facility, a five-member review board independent of the institution was responsible for the individual once a defendant was acquitted by reason of insanity, was responsible for the release decision, and retained authority to return the releasee to the facility. This authority was maintained for a period comparable to maximum sentence length for the given charged offense. Because the board contained both a psychiatrist and a psychologist, clinical recommendations were perhaps considered with more expertise than they would be by a judge. The hospital staff was relieved of both responsibility for the release decision and the conflict between roles as a provider of treatment and evaluator of treatment progress versus decisionmaker concerning readiness for release.

Right of Institutionalized Mental Patients to Treatment

As explained by Stone (1975), the right of the institutionalized mentally ill to treatment has been the subject of a longstanding legal controversy. By 1960, the decisions in *Miller* v. *Overholser* and *Commonwealth* v. *Page* had established the right of sex offenders to treatment under the statutes of Massachusetts and the District of Columbia. The decision in *Rouse* v. *Cameron* by the D.C. Circuit Court of Appeals was the first to give the right to treatment constitutional standing for insanity acquittees. While the decision explicitly excluded resource constraints as an admissible excuse for denying treatment, it did not articulate specific criteria defining treatment, requiring only a "bona fide effort to provide an individualized treatment program with periodic evaluation." Two years later, a Massachusetts decision, *Nason* v. *Superintendent of Bridgewater State Hospital*, threatened to release an incompetent patient not receiving treatment, on the constitutional grounds of due process and equal protection.

In 1973, the fifth circuit decision in *Wyatt* v. *Stickney* . reiterated the constitutional standing of the right to treatment and set out extremely detailed standards, including staffing levels by category necessary for adequate treatment. This decision thus pressed the issue of how far the Federal judiciary can go in setting standards that may have substantial fiscal impact on States. In addition, the opinion in *Wyatt* was largely adopted in *Davis* v. *Watkins*, a Federal district court case brought in Ohio that led to a statewide reorganization of the State's mental health care system.

Cases refining the definition of treatment, extending the right to treatment, and challenging the authority of courts to mandate specific treatments without regard to resource requirements have continued. Moreover, such cases have had a clear impact on statutes, as the number of States with a statutorily guaranteed right to treatment increased from none to 21 between 1961 and 1981.

The present research suggests that this legislative and judicial activity has had some impact on facilities for mentally disordered offenders in terms of awareness of treatment responsibility, treatment modalities, and staffing. Ninety-four percent of responding facilities reported preparation and regular review of individual treatment plans, even though only 48 percent of respondents reported awareness of a legal requirement for this activity. Telephone followup and onsite interviews revealed wide variation in the operational meanings of treatment planning and review.

No general picture emerges of the degree of specificity, individuality, or measurability of written goals and plans. It is not clear whether treatment planning is seen as good practice, or merely a means of forestalling litigation. It does seem clear, however, that some form of individual treatment planning is institutionalized, under all auspices, in facilities for mentally disordered offenders. Moreover, case conferences have also become common practices, with 93.5 percent of responding facilities reporting that they occur at least weekly.

With respect to treatment modalities, facilities responding to the present survey reported widespread availability of group

and individual therapy. "At least weekly" group and individual therapy was reportedly available in 90 percent and 88 percent, respectively of responding facilities. It should be noted that participation rates are relatively low, with a median of 34 percent of residents participating in individual therapy and 60 percent in groups. Moreover, as mentioned previously, much of the therapy is provided by nonprofessionals under professional supervision and with some training. During site visits, some administrators indicated such training would likely be cut in response to fiscal pressures, an action that could be expected to reduce further the quality of available therapy.

It may be of interest to compare staff-to-resident ratios reported by responding facilities with the standards mandated in *Wyatt* v. *Stickney* for certain categories of staff. The *Wyatt* standard of 0.8 psychiatrists per 100 residents is far exceeded by the median ratio of 2.5 reported by the responding facilities, indicating that far more than half the responding facilities exceed the *Wyatt* standard. The same is true for all subcategories defined by auspices and size, except for facilities with populations exceeding 501, which reported a median of 0.5 psychiatrists per 100 residents. Similarly, the *Wyatt* standards for psychologists and social workers combined total 4.4 per 100 residents. This standard is exceeded by more than half the facilities responding to the present survey, which report a median of 7.3 overall; the *Wyatt* standard for these groups is exceeded by the medians for all categories except the two largest population groups. The *Wyatt* standard for psychiatric aides (36.8 per 100 residents) exceeds the median reported by correctional facilities and the medians reported among all population categories above 251.

A general absence of outcome evaluation of treatment success, even in the most innovative treatment programs, is worth noting. This may be due in part to lack of the necessary followup data; moreover, the process of evaluation is complicated by the fact that some innovative treatment seems to occur in facilities having statutory or administrative authority to reject potential admittees on grounds that they are not treatable. This authority introduces a selection bias that complicates the evaluation process.

No universally accepted definitions for treatment came out of this survey. Based on this research, it is thus impossible to reach conclusions about the impact of statutory and case law in the right-to-treatment area on the quality of treatment. It does seem possible, however, to conclude that some form of treatment is in place in most facilities for mentally disordered offenders, though at widely varying levels of resources and staff professionalism.

Right of Institutionalized Mental Patients to Refuse Treatment

Concern with the right to refuse treatment among institutionalized mental patients (a group including some but not all mentally disordered offenders) seems to have emerged during the early 1970s. Society became increasingly aware that such patients were being subjected to certain experimental, painful, and sometimes irreversible forms of treatment, such as psychosurgery and drugs causing uncontrollable vomiting or sensations of suffocation or drowning. In cases such as *Mackey* v. *Procunier* and *Knecht* v. *Gillman*, such treatments were ruled unconstitutional as forms of cruel and unusual punishment. The decision in *Wyatt* v. *Stickney* explicitly ruled that involuntarily committed patients have a right to refuse certain "intrusive" and "risky" forms of treatment. Implicitly, Wexler (1976) argues, the treatment standards in *Wyatt* automatically confer a right to refuse participation in token economies or tier systems in which the mandated essentials of "a humane psychological environment" are available only as contingent reinforcers.

More recently, the right to refuse treatment has been raised under a broader rubric—the rights to bodily integrity, personal security, and the protection of one's mental processes. Arguments concerning these cases raised such issues as the appropriate means used to inform patients of their right and the conditions under which the right could be overridden, e.g., in emergency situations involving potential personal injury or property damage.

Statutorily, 7 States provided mentally disordered offenders a right to refuse treatment, while 9 additional States granted the right either to incompetents to stand trial or to persons found not guilty by reason

of insanity. Another 18 States, in which mentally disordered offenders were civilly committed, provided the right by extension.

Perhaps because of the decisions promulgating the right to refuse treatment, the use of somatic therapies has declined substantially since the survey of Scheidemandel and Kanno (1969). Electroconvulsive therapy was used for "some, most, or all patients" in 34 percent of the facilities responding to the 1969 survey, compared with availability in 19.2 percent of the facilities responding to the present survey. Similarly, availability of other somatic therapies declined from 6 percent of facilities to 3.2 percent of facilities during the same period.

Only about 2 percent of responding administrators mentioned the right to refuse treatment as a significant problem to them, perhaps because existing regulations are being used as guidelines until challenges are resolved. Telephone followup and site visits reveals that some facilities used consent forms signed at the time of admission, with respect at least to certain types of treatment. Some of these consent forms, however, also stated that refusal to consent to any particular type of medication released the facility from "all liability with respect to the patient's welfare." While some of the forms notified the incoming resident that refusal to consent could be overridden in emergency circumstances, they frequently failed to inform him or her of the process for appealing such overrules.

Impact of Legal Changes on Facilities Handling Juveniles

Changes in State laws governing juveniles who commit criminal offenses have created new assessment and treatment problems for corrections and mental health personnel. The formalization of the juvenile system, which began with *In re Gault* in 1967, has caused approximately 10 States to specify by statute, court rule, or judicial decision that competency to stand trial is an issue and insanity is a defense in juvenile court proceedings.

The national survey determined that 10 States have developed programs for juveniles. Legislatures are handicapped in developing new programs, however, by the lack of available data enumerating the numbers of mentally ill juveniles. It is obvious that, without firm definitional criteria for determining what is mental illness and what is simply violent behavior, many of the mentally ill juveniles are "slipping through the cracks" between adult corrections, mental health programs, and juvenile detention centers.

The problem of age segregation was mentioned in several mental health facilities serving adults and juveniles. This problem is apt to worsen as juveniles in more States become able to raise the incompetency issue and the insanity plea; youngsters raising these issues will probably be placed in adult mental health facilities. In addition, facilities serving both adults and juveniles note that treatment programming for the two groups differed, particularly regarding extensive educational programming for juveniles. Under Public Law 94–142, staffing levels for educational personnel for juveniles must meet or exceed a predetermined minimum ratio of staff to residents. This ratio is not required for institutionalized adults. This requirement, coupled with fluctuations in juvenile admissions, at times results in an excess of educational staff. Obviously, this overstaffing in one area results in a drain of resources from other areas of need.

It would appear that the formalization and criminalization of the juvenile court are beginning to affect the States that have not yet provided treatment facilities for mentally disordered juveniles. A time lag can be expected, however, before new court procedures have an impact on facilities. As more studies are done on the relationship between a violent or mentally disordered juvenile criminal career and future adult criminality, one would expect the mentally disordered juvenile to become an area of increased importance.

Recommendations for Further Research

As indicated in the preceding sections, the phased quantitative and qualitative research conducted in the present study provides a fairly comprehensive picture of facilities for mentally disordered offenders —their organizational structure, size, treatment and security practices, and staffing levels. In addition, it provides a series

of descriptions of facility residents—in terms of legal status, psychiatric diagnosis, age, and ethnicity. Considerations of respondent burden and resource constraints, however, placed a number of limits on both the detail of the data and the resulting achievable depth of the analysis. Because of these limits, a number of interesting research questions remain.

While the national survey data do quantify the availability of treatment and the average resident participation rate, the survey could not attempt to determine the quality of treatment. Apparently this can be assessed only, if at all, by systematic observation of patient/staff interactions in host institutions. For example, during site visits to a nonrepresentative subset of facilities, group therapy was defined by some administrators to include the weekly ward meeting where the issues were ward management and maintenance, a type of interaction not widely considered therapeutic. Variation in the definitions accorded to treatment was a major impediment to the survey's attempting to assess the status of treatment nationwide. As another example, collecting detailed national data on the credentials of the group leaders proved to be impossible. Again, based on site visits and followup telephone calls to 60 facilities, the majority of the group leaders appeared to be psychiatric technicians or, at most, psychiatric nurses or social workers.

Further, researchers involved in this survey were not able to determine the type and quality of individual treatment planning. Responses to questions posed onsite were mixed as to whether a review of individual charts would show individualized approaches to treatment. Data collected do not represent the thoroughness or extent of treatment plan review. An important research question not addressed by the current effort therefore involves the quality of treatment planning and factors associated with quality.

Another limitation of the data concerns lack of quality measures for staff training. Survey analysis does report whether training is primarily orientation at the time of hiring, ongoing at regular intervals, or only occasional. Data were not gathered, however, on number of staff attending, credentials of trainers, or the currency and depth of what was actually covered. Training, especially for line staff, is an especially important area, due to the treatment duties frequently assumed by line staff in these facilities. Thus, an assessment of the quality and effectiveness of training remains a research issue of importance.

Finally, a number of interesting questions relating individual residents' criminal histories, legal status, diagnoses, and treatments to institutional and postrelease behaviors cannot be examined using survey data. To limit respondent burden, survey questions concerning residents were limited to those that could be answered from existing reports, rather than those requiring micro-level analysis of individual records. Questions could not be addressed, therefore, on matters such as the extent of use or success of a given treatment mode for residents of a particular diagnostic subset, or an analysis of the relationship between psychiatric diagnosis and the probability of violent behavior. These remain important topics for future research.

Another research gap not filled by the present effort is the measurement of average length of stay. Apparently, no facility regularly computes or reports average length of stay for the population in residence as of a given day. This is understandable, as the computation would require extraction of admission dates from the entire set of patient records, an arduous task with a manual records system. Some facilities do periodically report average length of stay for releases during the period, a somewhat easier task. Because any cohort of releasees will overrepresent short-stay residents (e.g., persons being evaluated) relative to the facility population, however, the average for releasees will understate the average for the population. These underestimates, when misinterpreted by the media, legislatures, or general public, may provide unwarranted support for claims that mentally disordered offenders are treated relatively leniently.

In comparing the population of mentally disordered offenders with the general prison population, researchers were constrained in their analysis of crimes charged. This limitation arose through the use of broad supercategories in order to accommodate the substantial variation in crime classification and reporting systems in different facilities. Precise comparisons between mentally disordered offenders and the general prison

population, by individual crime type, comprise a question for future research.

Analysis of the true legal status of civilly committed residents of responding facilities was also limited. Numbers of individuals committed through the criminal courts and those committed through civil commitment procedures can be determined. Statistically separating those persons voluntarily or involuntarily civilly committed through other routes (e.g., dangerous mental patients or unrestorable incompetents), however, would necessitate a detailed individual record analysis—another issue for further research.

Topics for Additional Research

The present effort identified two kinds of topics to which researchers' attention should be drawn. First, analysis of existing data bases could shed additional light on several empirical questions of longstanding importance. Second, several fiscal and legal trends that were identified are thought to have the potential for major impact on facility operations. Neither the research designs nor occasionally the data bases exist for measurement of the anticipated impact, however.

As an example of the first type of issue, the relationship between mental illness and violent crime is an area in which additional research is needed. The continued utilization of some automated data bases could provide additional information on this topic.

As a second example, amalgamation of mental illness and offense data with historical "rap sheet" data on mentally disordered juveniles could provide input on the question of juvenile criminal careers and histories of emotional disturbance and mental illness predictors of adult criminality.

Third, survey data suggested the possibility of a relationship between the frequency of critical incidents (e.g., death, suicides, and escapes) and facility size. This area needs additional research to test the suggested hypothesis, controlling for such potential rival explanations as facility auspices, population, legal status, and other population characteristics.

Fourth, the prevalence and practices of postrelease followup programs, and the relationship between such followup and success, are questions that need additional research. The success or failure of different types of followup programs should be examined. In addition, comparisons should be made between recidivism rates of patients released from facilities that rely on community mental health centers and those released from facilities that maintain their own halfway houses.

The responses of facility administrators to proposed or enacted budget reductions is an area of change that requires monitoring in order to determine how administrators are coping with this threat, what kinds of program changes occur in response to budget reductions, and how these changes affect patient care and program outcomes. For example, one might surmise that, given strong public sentiment against the mentally disordered offenders, cutbacks would occur in treatment staff more readily than in security staff. If so, then treatment staff might be forced to use medication more frequently to control patients.

Other trends and levels may be affected by the impact of certain proposed legal changes. For example, laws establishing guilty but mentally ill verdicts are being considered in a number of States, sometimes with simultaneous abolition of the insanity defense. Some of the proposed laws specify that treatment for persons found guilty but mentally ill be conducted in correctional facilities, a requirement that would affect the extent of facility utilization. Other such statutes prescribe that treatment be conducted in mental health facilities. Because most of the maximum security mental heath facilities in this study do not meet the maximum security standards of correctional facilities, such laws could generate requirements to upgrade physical security and procedures, with likely adverse consequences for other program components.

Many States are also repealing or modifying their sex offender laws. As punishment is more the intent of these changes, this activity may stimulate more admissions of sex offenders to correctional facilities. Thus, the psychiatric units of these facilities could eventually face pressures to house and treat sex offenders in addition to their emergency stabilization patients. The mix of these two types of offenders on one ward, one assumes, would create new behavior management problems for the facilities.

Information Needs of Facility Administrators

Facility administrators have become increasingly concerned with research, statistics, and other information in recent years. More than 90 percent of respondents to the current survey performed routine data collection/reporting, almost half reported ongoing outcome evaluation, almost a third operated a management information system, and almost a quarter reported ongoing "significant research/demonstration activities." The three most commonly reported research topics were aspects of the diagnosis/treatment/outcome relationship, correlates of violence, and characteristics of mentally disordered offenders. The survey did not attempt to examine the dissemination of research results.

In addition to their own efforts to gather information through research and statistical activity, facility administrators expressed a desire for collection and publication of a number of statistics on a regular basis. Two of the most commonly requested statistics are admissions/discharge flows and the demographics of mentally disordered offenders. Because of the administrators' expressed interest in these topics, it is not surprising that these data are the two series most commonly collected and routinely reported by facilities. However, because the flow data are currently reported by only 41.7 percent of facilities, and demographics by 22 percent, meeting the administrators' needs in these areas with national statistics would require substantial upgrading of statistical activity at the facility level.

The need for such upgrading is even more apparent with respect to two other types of data mentioned by administrators as desirable for publication. Regular diagnostic statistics were requested by 29.1 percent of administrators but are currently routinely reported by only 13.4 percent of facilities. Similarly, statistics on criminal/mental health/substance abuse history were requested by 21.3 percent of administrators but are currently routinely reported by only 9.4 percent of facilities.

In addition to their statistical information needs, many facility administrators and staff members expressed needs for in-house legal advice from attorneys with specialized grounding in mental health law, as well as up-to-date information on emerging case law, new trends in treatment programming, and staffing levels in comparable facilities. Also, needs were expressed for the opportunity to exchange views and experiences concerning nonclinical problems such as contacts with State legislatures and the media, negotiation with labor unions, and effective use of State personnel systems. Several administrators in States where facility specialization is by function rather than geographic catchment area noted their uniqueness within their States. These persons felt that, on many issues, administrators of similar facilities in other States could provide more assistance than other administrators in their own States. Consequently, they expressed interest in identifying such contacts in other States.

Conclusion

It is likely that mentally disordered offenders will continue to comprise a distinct population within both the mental health and corrections systems. The legal definitions of this type of offender are changing, however. Individuals found guilty but mentally ill, for example, were found in only one State when this research began. As analysis was completed, however, at least eight States had adopted guilty but mentally ill provisions, and two of them had eliminated the plea of not guilty by reason of insanity.

Legal and clinical definitions of mental illness are also changing. For example, 25 States have either repealed or modified their sex offender statutes, reflecting the belief that these individuals need not treatment but punishment as criminal offenders. The majority of those classified as mentally ill by mental health professionals and offenders by the judicial system, however, will still need specialized care and treatment during their incarceration.

The treatment services needed to assist this population already exist. What is currently needed is more effective administrative support. It is hoped that this and related research and other efforts will add to the base of knowledge concerning problems and needs of the mentally disordered offender, as well as the institutional responses of those needs.

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Appendix

Table A–1. Distribution of DSM–III diagnoses, by prevalence of violent crime charges

DSM III Diagnostic Category	Mean percent of diagnosis in category (DSM-III Facilities)		
	Facilities With Less Than Half Violent Crimes (N=22)	Facilities With Half or More Violent Crimes (N=56)	All (N=78)
Disorders usually first evident in infancy, childhood and adolenscence			
• mental retardation	3.7%	4.5%	4.3%
• conduct disorders	6.8	8.9	8.3
• other disorder usually first evident in early childhood or adolescence	1.1	0.9	1.0
Organic mental disorders	3.8	3.8	3.8
Substance abuse disorders	10.3	8.9	9.3
Schizophrenic disorders	41.9	34.4	36.5
Paranoid disorders	2.2	5.4	4.5
Psychotic disorders not elsewhere classified	3.4	2.4	2.7
Affective disorders	6.5	6.4	6.4
Anxiety disorders	1.9	2.1	2.0
Somatoform disorders	0.5	0.4	0.4
Dissociative disorders	0.3	0.9	0.7
Psychosexual disorders	6.0	7.1	6.8
Factitious disorders	1.0	0.7	0.8
Disorders of impulse control not elsewhere classified	2.7	2.3	2.4
Adjustment disorder	4.4	5.7	5.3
Psychological factors affecting physicial condition	0.3	0.5	0.5
V codes for conditions not attributable to a mental disorder that are a focus of attention or treatment	1.4	2.4	2.1
Additional codes	1.9	2.0	2.0
All Categories	100.9	100.0	100.0

Table A–2. Distribution of DSM–II diagnosis, by prevalence of violent crime charges

DSM-II Diagnostic Category	Mean Percent of Diagnoses in Category (DSM-II facilities)			
	Group 1: Facilities With Less Than Half Personal Crimes (N=4)	Group 2: Facilities With Half or More Personal Crimes (N=14)	All (N=18)	1972 Comparative Data*
Mental retardation	3.5%	4.4%	4.2%	8%
Psychoses: organic brain syndromes	5.7	3.2	3.8	6
Psychoses: not organic brain syndromes				
• Schizophrenia	47.9	51.3	50.6	
• Affective psychoses	1.4	4.2	3.5	
• Paranoid states	2.1	3.6	3.3	33
• Other/unspecified	0.0	0.8	0.7	
Other psychotic disorders	0.7	1.1	1.0	
Neuroses	2.6	4.2	3.8	9
Personality disorders	25.4	19.6	20.9	42
Psychophysiologic disorders	0.8	0.1	0.3	
Transient situational disturbances	5.8	0.6	1.7	3
Childhood/adolescent behavior disorders	1.9	4.9	4.2	
No definite psychiatric disorder	2.3	1.9	2.0	1
All Categories	100.0	100.0	100.0	100.0

*Source: Weighted averages computed from data by facility type reported in Eckerman (1972): Table VI-4, p.37. Weights are 19 security hospitals, 23 mental health facilities, and 26 correctional institutions.

Table A–3. Incidence of mental retardation diagnosis, by auspices and age jurisdiction

Facility Auspices and Age Jurisdiction	Estimated Proportion of Mentally Disordered Offenders Diagnosed Mentally Retarded	
	Unweighted Mean	Median
Corrections		
Adults and Juveniles (N=2)	16.6%	16.6%
Juveniles Only (N=1)	24.6	24.6
Adults Only (N=21)	17.5	7.3
All (N=24)	17.7	7.4
Mental Health		
Adults and Juveniles (N=6)	12.5	6.1
Juveniles Only (N=8)	19.7	13.2
Adults Only (N=52)	16.7	10.0
All (N=66)	16.7	11.0
Social Services/Other		
Adults and Juveniles (N=2)	10.0	10.0
Juveniles Only (N=6)	58.8	44.4
Adults Only (N=8)	14.1	7.4
All (N=16)	26.5	9.4
All Auspices (N=106)	19.0	11.0

Table A-4. Age of youngest resident, by auspices and jurisdiction of referring court

Age category of youngest resident	Percent of facilities in category															
		Corrections			Mental health				Social services/other				All			
	Adults and juveniles (N=2)	Juveniles only (N=2)	Adults only (N=26)	All (N=30)	Adults and juveniles (N=8)	Juveniles only (N=9)	Adults only (N=62)	All (N=79)	Adults and juveniles (N=2)	Juveniles only (N=6)	Adults only (N=10)	All (N=18)	Adults and juveniles (N=12)	Juveniles only (N=17)	Adults only (N=98)	All (N=127)
10 or younger	0.0%	0.0%	0.0%	0.0%	0.0%	44.4%	0.0%	5.1%	0.0%	0.0%	0.0%	0.0%	0.0%	23.5%	0.0%	3.1%
11 - 14	50.0%	50.0%	0.0%	6.7%	25.0%	33.3%	1.6%	7.6%	50.0%	83.3%	0.0%	33.3%	33.3%	52.9%	1.0%	11.0%
15 - 17	50.0%	50.0%	23.1%	26.7%	62.5%	22.2%	21.0%	25.3%	50.0%	16.7%	20.0%	22.2%	58.3%	23.5%	21.4%	25.2%
18 - 21	0.0%	0.0%	76.9%	66.7%	0.0%	0.0%	69.4%	54.4%	0.0%	0.0%	80.0%	44.4%	0.0%	0.0%	72.4%	55.9%
22 or older	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	4.8%	3.8%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	3.1%	2.4%
Not ascertained	0.0%	0.0%	0.0%	0.0%	12.5%	0.0%	3.2%	3.8%	0.0%	0.0%	0.0%	0.0%	8.3%	0.0%	2.0%	2.4%
Total	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

Table A–5. Availability and use of diagnostic assessments

Diagnostic Service	Percent reporting availability and routine use							
	Corrections (N=30)		Mental Health (N=79)		Social Services/ Other (N=18)		All (N=127)	
	Routine	Available	Routine	Available	Routine	Available	Routine	Available
Physical Examination	93.3%	93.3%	97.5%	97.5%	100.0%	100.0%	96.9%	96.9%
Psychological Tests	66.7	86.7	72.2	92.4	61.1	88.9	69.3	90.6
Psychiatric Examination	90.0	90.0	89.9	89.9	77.8	77.8	88.2	88.2
LABORATORY TESTS								
• Venereal Disease	83.3	83.3	84.8	84.8	72.2	88.9	82.7	82.7
• Sugar	83.3	83.3	84.8	84.8	55.6	94.4	80.3	85.8
• Blood Count	86.7	86.7	88.6	88.5	77.8	88.9	86.6	86.6
• Electrolytes	60.0	83.3	65.8	88.6	50.0	94.4	62.2	88.2
• Other Chemistries	73.3	86.7	65.8	79.7	55.6	83.3	66.1	81.9
• Substance Screeners	36.7	86.7	25.3	81.0	33.3	83.3	29.1	82.7
• Pregnancy	10.0	16.7	20.3	48.1	22.2	33.3	18.1	38.6
• Pap Smear	13.3	16.7	26.6	44.3	16.7	27.8	22.0	35.4
X-RAYS								
Chest	80.0	86.7	77.2	83.5	61.1	66.7	75.6	81.9
Other X-rays	33.3	83.3	31.6	83.5	27.8	83.3	31.5	83.5
Fluoroscope	13.3	90.0	10.1	82.3	11.1	83.3	11.0	84.3
CAT Scan	10.0	93.3	6.3	79.7	11.1	88.9	7.9	84.3
Tuberculin Test	63.3	83.3	62.0	82.3	77.8	77.8	64.6	81.1
EEG	13.3	86.7	31.6	91.1	27.8	83.3	26.8	89.0
EKG	16.7	93.3	29.1	89.9	33.3	83.3	26.8	89.8
Neuro-behavioral Tests	10.0	93.3	29.1	83.5	16.7	94.4	22.8	87.4
DENTAL EXAMINATION								
Visual	70.0	93.3	74.7	93.7	66.7	83.3	72.4	92.1
X-rays	53.3	86.7	39.2	92.4	44.4	88.9	43.3	90.6

Table A–6. Availability of ancillary services, by auspices and age jurisdiction of referring court

Ancillary services	Percent of facilities offering ancillary services															
	Corrections				Mental health				Social services/Other				All			
	Adults and juveniles (N=2)	Juveniles only (N=2)	Adults only (N=26)	All (N=30)	Adults and juveniles (N=8)	Juveniles only (N=9)	Adults only (N=62)	All (N=79)	Adults and juveniles (N=2)	Juveniles only (N=6)	Adults only (N=10)	All (N=18)	Adults and juveniles (N=12)	Juveniles only (N=17)	Adults only (N=98)	All (N=127)
Academic																
Tutoring	100.0%	100.0%	69.2%	73.3%	37.5%	88.9%	71.0%	69.6%	50.0%	100.0%	90.0%	88.9%	50.0%	94.1%	72.5%	73.2%
G.E.D. preparation	100.0	50.0	88.5	86.7	50.0	88.9	82.3	79.8	100.0	100.0	90.0	94.4	66.7	88.2	84.7	83.5
English as a second language	50.0	0.0	19.2	20.0	12.5	11.1	25.8	22.8	50.0	0.0	10.0	11.1	25.0	5.9	22.4	20.5
Other elementary/ secondary education	100.0	100.0	84.6	86.7	50.0	77.8	61.3	62.0	50.0	83.3	60.0	66.7	58.3	82.4	67.3	68.5
Postsecondary correspondence education	50.0	50.0	42.3	43.3	25.0	22.2	46.8	41.8	0.0	33.3	60.0	44.4	25.0	29.4	4.0	42.5
Recreational																
Gymnasium	100.0	100.0	69.2	73.3	37.5	88.9	77.4	74.7	50.0	100.0	70.0	77.8	50.0	94.1	74.5	74.8
Other indoor facilities	100.0	50.0	69.2	70.0	50.0	44.4	74.2	68.4	0.0	83.3	90.0	77.8	50.0	58.8	74.5	70.1
Outdoor sports	100.0	50.0	88.5	86.7	62.5	100.0	93.5	91.1	100.0	100.0	90.0	94.4	75.0	94.1	91.8	90.5
Movies	100.0	100.0	88.5	90.0	62.5	100.0	93.5	91.1	100.0	100.0	90.0	94.4	75.0	100.0	91.8	91.3
Swimming pool	100.0	100.0	0.0	13.3	25.0	77.8	37.1	40.5	0.0	83.3	10.0	33.3	33.3	82.4	24.5	33.1
Vocational																
Job training	100.0	100.0	42.3	50.0	25.0	33.3	38.7	36.7	50.0	0.0	40.0	27.8	41.7	29.4	39.8	38.6
Vocational aptitude evaluation	100.0	50.0	69.2	70.0	25.0	77.8	61.3	59.5	50.0	66.7	50.0	55.6	41.7	70.6	62.2	61.4
In-patient job programs	50.0	50.0	57.7	56.7	37.5	77.8	66.1	64.5	100.0	50.0	60.0	61.1	50.0	64.7	63.3	62.2
Outside job placement	50.0	0.0	7.7	10.0	37.5	44.4	25.8	29.1	100.0	33.3	60.0	55.6	50.0	35.3	24.5	28.4
Life skills training	100.0	100.0	57.7	63.3	50.0	66.7	50.0	51.9	50.0	83.3	50.0	61.1	58.3	76.5	52.0	55.9
Civil legal services	50.0	50.0	69.2	66.7	62.5	66.7	71.0	69.6	100.0	33.3	60.0	55.6	66.7	52.9	69.4	66.9

Table A–7. Community organization relationships, prevalence by auspices and age jurisdiction of referring court

Community agency type	Percent of facilities reporting agency relationship															
	Corrections				Mental health				Social services/Other				All			
	Adults and juveniles (N=2)	Juveniles only (N=2)	Adults only (N=26)	All (N=30)	Adults and juveniles (N=8)	Juveniles only (N=9)	Adults only (N=62)	All (N=79)	Adults and juveniles (N=2)	Juveniles only (N=6)	Adults only (N=10)	All (N=18)	Adults and juveniles (N=12)	Juveniles only (N=17)	Adults only (N=98)	All (N=127)
Public vocational rehabilitation agency only	0.0%	0.0%	0.0%	0.0%	25.0%	0.0%	1.6%	3.8%	0.0%	16.7%	10.0%	11.1%	16.7%	5.9%	2.0%	3.9%
Postsecondary educational institution only	0.0	0.0	26.9	23.3	0.0	0.0	8.1	6.4	0.0	0.0	0.0	0.0	0.0	0.0	12.2	9.4
Alcohol abuse program only	0.0	50.0	3.8	6.6	12.5	0.0	1.6	2.5	0.0	0.0	0.0	0.0	8.3	5.9	2.0	3.1
Other agency only	0.0	0.0	3.8	3.3	0.0	11.1	3.2	3.8	0.0	0.0	0.0	0.0	0.0	5.9	3.0	3.1
Two or three agency types	50.0	50.0	42.4	43.4	62.5	77.8	66.2	67.1	100.0	50.0	70.0	66.7	66.7	64.7	60.2	61.6
All types of agencies	50.0	0.0	15.4	16.7	0.0	11.1	14.5	12.6	0.0	33.3	10.0	16.7	8.3	17.6	14.3	14.2
No agencies	0.0	0.0	7.7	6.7	0.0	0.0	4.8	3.8	0.0	0.0	10.0	5.6	0.0	0.0	6.1	4.7
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0

Table A–8. Prevalence of transitional release programs, by auspices and age jurisdiction of referring court

Transitional release programs	Percent of facilities providing program*															
	Corrections				Mental health				Social services/Other				All			
	Adults and juveniles (N=2)	Juveniles only (N=2)	Adults only (N=18)	All (N=22)	Adults and juveniles (N=5)	Juveniles only (N=8)	Adults only (N=48)	All (N=61)	Adults and juveniles (N=2)	Juveniles only (N=6)	Adults only (N=8)	All (N=16)	Adults and juveniles (N=9)	Juveniles only (N=16)	Adults only (N=74)	All (N=99)
Work/education release only	0.0%	50.0%	11.1%	13.6%	0.0%	12.5%	2.1%	3.3%	0.0%	0.0%	12.5%	6.3%	0.0%	12.5%	5.4%	6.1%
Partial release only	0.0	0.0	0.0	0.0	0.0	12.5	2.1	3.3	0.0	0.0	0.0	0.0	0.0	6.3	1.4	2.0
Conditional release only	0.0	0.0	33.3	27.3	20.0	12.5	25.0	23.0	50.0	16.7	12.5	18.8	22.2	12.5	25.7	23.2
Other special release only	50.0	0.0	0.0	4.5	20.0	0.0	8.3	8.2	0.0	0.0	0.0	0.0	22.2	0.0	5.4	6.1
Two or three programs	50.0	0.0	27.8	27.3	60.0	25.0	43.7	42.6	0.0	83.3	50.0	56.3	44.4	43.8	40.5	41.3
All programs	0.0	0.0	11.1	9.1	0.0	12.5	6.3	6.6	0.0	0.0	0.0	0.0	0.0	6.3	6.8	6.1
No transitional release programs	0.0	50.0	16.7	18.2	0.0	25.0	12.5	13.1	50.0	0.0	25.0	18.8	11.1	18.8	14.9	15.2
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0

* Includes only facilities that release to the community.

Table A–9. Staff–to–resident ratios,* by auspices and age jurisdiction of referring court

Staff category	Median number of staff per hundred residents															
	Corrections				Mental health				Social services/Other				Total			
	Adults and juveniles (N=2)	Juveniles only (N=2)	Adults only (N=22)	All (N=26)	Adults and juveniles (N=6)	Juveniles only (N=7)	Adults only (N=57)	All (N=70)	Adults and juveniles (N=2)	Juveniles only (N=5)	Adults only (N=9)	All (N=16)	Adults and juveniles (N=10)	Juveniles only (N=14)	Adults only (N=88)	All (N=112)
Senior administrators	6.5	4.0	1.4	1.8	1.8	7.0	2.5	2.6	4.0	5.0	4.0	4.5	2.2	5.2	2.2	2.5
Other administrators/ clerical	6.5	7.5	4.0	5.0	17.0	17.0	7.3	8.7	21.0	9.0	8.3	9.5	13.0	9.5	7.0	8.0
Treatment staff																
Psychiatrists	1.5	2.0	1.1	1.1	2.0	6.0	2.7	2.8	3.0	1.0	3.3	3.0	2.2	3.5	2.2	2.3
Other graduate-level therapists	9.5	8.5	5.0	5.2	9.0	17.0	7.3	8.5	12.5	4.0	10.8	8.0	8.5	13.2	6.9	7.3
Sr. medical staff	9.0	4.0	5.5	6.5	22.0	25.0	17.2	19.5	23.0	5.0	12.8	11.5	20.5	11.5	12.7	12.8
Technicians/aides	23.0	53.0	4.5	5.5	63.0	110.2	65.0	72.8	90.5	37.0	24.0	25.5	53.5	89.5	42.5	50.0
Ancillary therapists	0.0	2.0	0.2	0.3	0.2	8.2	1.9	2.1	2.0	3.0	4.0	3.5	0.2	3.5	0.9	1.4
Educators	7.5	12.5	0.4	0.4	0.5	22.8	0.6	0.8	14.5	8.0	0.4	1.5	1.5	15.5	0.4	0.8
Security staff																
Armed	0.0	0.0	0.2	0.1	0.0	0.0	0.0	0.0	0.0	0.0	1.3	0.6	0.0	0.0	0.1	0.0
Unarmed	24.0	5.5	18.0	10.5	25.5	0.0	10.2	9.5	6.0	1.0	44.0	3.5	17.5	0.3	12.5	9.0
Maintenance staff	1.5	0.5	2.5	0.5	26.0	14.0	8.0	10.5	41.5	4.0	7.8	8.0	21.0	4.5	5.8	6.5
Total staff	88.5	98.0	63.5	65.5	216.0	262.0	161.0	175.5	217.5	100.0	170.0	147.5	121.5	219.0	133.0	136.5

* Staffing data reflect full-time equivalents actually on staff, rather than authorized levels.

Table A–10. Staff–to–resident ratios,* by facility population

Staff category	Median ratio of staff per hundred residents for category							
	Population 10 or less (N=3)	Population 11–25 (N=17)	Population 26–50 (N=24)	Population 51–100 (N=20)	Population 101–250 (N=29)	Population 251–500 (N=11)	Population 501 or more (N=8)	All (N=112)
Senior administrators	17.0	9.0	5.5	2.4	1.6	1.1	0.5	2.5
Other administrators/ clerical	17.0	7.7	9.5	9.5	8.0	5.3	4.5	8.0
Treatment staff								
Psychiatrists	10.0	6.3	3.4	1.4	1.7	2.3	0.5	2.3
Other graduate-level therapists	10.0	15.0	12.5	5.5	6.9	4.0	2.5	7.3
Sr. medical staff	18.8	27.0	23.0	14.5	9.0	8.2	3.5	12.8
Technicians/aides	20.0	120.0	65.5	42.5	23.2	6.0	2.5	50.0
Ancillary therapists	4.2	0.4	3.0	1.5	1.6	0.8	0.3	1.4
Educators	0.0	0.2	2.5	0.5	1.4	1.1	0.5	0.8
Security staff								
Armed	0.0	0.0	0.1	0.8	0.1	0.1	0.2	0.0
Unarmed	25.0	2.1	5.5	9.5	26.0	25.0	2.5	9.0
Maintenance staff	0.0	7.6	3.5	10.5	5.8	7.2	6.0	6.5
Total staff	300.0	229.0	201.0	147.0	118.0	106.0	71.5	136.5

* Staffing data reflect full-time equivalents actually on staff, rather than authorized levels.

Table A–11. Availability of treatment modalities, by auspices and staff–resident ratio quartiles*

Treatment	Percent of facilities offering treatment*																			
	Corrections					Mental health					Social services/Other					All				
	Quartile 1 (N=6)	Quartile 2 (N=7)	Quartile 3 (N=5)	Quartile 4 (N=8)	All (N=26)	Quartile 1 (N=16)	Quartile 2 (N=19)	Quartile 3 (N=17)	Quartile 4 (N=18)	All (N=70)	Quartile 1 (N=4)	Quartile 2 (N=4)	Quartile 3 (N=4)	Quartile 4 (N=4)	All (N=16)	Quartile 1 (N=26)	Quartile 2 (N=30)	Quartile 3 (N=26)	Quartile 4 (N=30)	All (N=112)
Psychoanalysis	16.7%	14.3%	20.0%	0.0%	11.5%	0.0%	0.0%	23.5%	33.3%	14.3%	0.0%	0.0%	25.0%	0.0%	6.3%	3.8%	3.3%	23.1%	20.0%	12.5%
Weekly individual psychotherapy	83.3	100.0	80.0	100.0	92.3	81.3	94.7	88.2	83.3	87.1	75.0	100.0	75.0	75.0	81.3	80.8	96.6	84.6	86.6	87.5
Less frequent individual psychotherapy	50.0	71.4	40.0	100.0	69.2	68.8	63.2	52.9	66.7	62.9	100.0	50.0	50.0	25.0	56.3	69.3	63.4	50.0	70.0	63.4
Weekly group psychotherapy	66.7	100.0	100.0	100.0	92.3	93.8	100.0	82.4	88.9	91.4	100.0	75.0	100.0	50.0	81.3	88.5	96.7	88.5	86.7	90.2
Less frequent group psychotherapy	16.7	28.6	40.0	37.5	30.8	50.0	42.1	47.1	33.3	42.9	50.0	0.0	25.0	25.0	25.0	42.3	33.3	42.3	33.3	37.5
Psychotropic medication	100.0	85.7	100.0	100.0	96.2	100.0	94.7	100.0	100.0	98.6	100.0	100.0	100.0	100.0	100.0	100.0	93.3	100.0	100.0	98.2
Electro-convulsive therapy	0.0	42.9	0.0	12.5	15.4	25.0	31.6	23.5	16.7	24.3	0.0	0.0	25.0	0.0	6.3	15.4	30.0	19.2	13.3	19.7
Behavior modification	16.7	57.1	80.0	62.5	53.8	50.0	63.2	76.5	72.2	65.7	100.0	50.0	75.0	75.0	75.0	50.0	60.0	76.9	70.0	64.3
Occupational therapy	16.7	71.4	40.0	75.0	57.8	93.8	78.9	76.5	77.8	81.4	50.0	75.0	0.0	75.0	50.0	69.3	76.6	57.7	76.7	70.5
Art therapy	33.3	71.4	80.0	50.0	57.7	68.8	78.9	52.9	55.6	64.3	75.0	75.0	50.0	75.0	68.8	61.6	76.6	57.7	56.7	63.4
Psychodrama	0.0	28.6	20.0	37.5	23.1	37.5	15.8	17.6	38.9	27.1	0.0	25.0	25.0	0.0	12.5	23.1	20.0	19.2	33.3	24.1
Movement/dance therapy	0.0	28.6	0.0	12.5	11.5	37.5	47.4	29.4	22.2	34.3	0.0	25.0	25.0	25.0	18.8	23.1	40.0	23.1	20.0	26.8
Range of staff per hundred residents	37 or less	38–65	66–97	98 or more	All	107 or less	108–175	176–233	234 or more	All	79 or less	80–147	148–228	229 or more	All	89 or less	90–136	137–225	226 or more	All

* To construct quartiles by auspices, facilities were ordered by staff-to-resident ratio and divided into groups of equal size (plus ties). The range of staff-to-resident ratios within each quartile appears in the bottom line of this table.

Table A–12. Availability of treatment modalities, by auspices and treatment staff–resident ratio quartiles*

Treatment	Percent of facilities offering treatment*																			
	Corrections					Mental health					Social services/Other					All				
	Quartile 1 (N=6)	Quartile 2 (N=7)	Quartile 3 (N=6)	Quartile 4 (N=7)	All (N=26)	Quartile 1 (N=17)	Quartile 2 (N=16)	Quartile 3 (N=19)	Quartile 4 (N=18)	All (N=70)	Quartile 1 (N=4)	Quartile 2 (N=4)	Quartile 3 (N=4)	Quartile 4 (N=4)	All (N=16)	Quartile 1 (N=27)	Quartile 2 (N=27)	Quartile 3 (N=29)	Quartile 4 (N=29)	All (N=112)
Psychoanalysis	16.7%	28.6%	0.0%	0.0%	11.5%	5.9%	0.0%	10.5%	38.9%	14.3%	0.0%	25.0%	0.0%	0.0%	6.3%	7.4%	11.1%	6.9%	24.1%	12.5%
Weekly individual psychotherapy	83.3	100.0	100.0	85.7	92.3	70.6	100.0	89.5	88.9	87.1	75.0	75.0	100.0	75.0	81.3	74.1	96.3	93.1	86.2	87.5
Less frequent individual psychotherapy	50.0	71.4	66.7	85.7	69.2	64.7	62.5	63.2	61.1	62.9	100.0	50.0	50.0	25.0	56.3	66.7	63.0	62.1	62.1	63.4
Weekly group psychotherapy	83.3	85.7	100.0	100.0	92.3	88.2	100.0	100.0	77.8	91.4	100.0	100.0	75.0	50.0	81.3	88.9	96.3	96.6	79.3	90.2
Less frequent group psychotherapy	16.7	14.3	50.0	42.9	30.8	47.1	50.0	42.1	33.3	42.9	25.0	25.0	25.0	25.0	25.0	37.1	37.0	41.4	34.5	37.5
Psychotropic medication	100.0	100.0	83.3	100.0	96.2	100.0	100.0	94.7	100.0	98.6	100.0	100.0	100.0	100.0	100.0	100.0	100.0	93.1	100.0	98.2
Electro-convulsive therapy	0.0	28.6	33.3	0.0	15.4	23.5	31.3	26.3	16.7	24.3	25.0	0.0	0.0	0.0	6.3	18.5	26.0	24.1	10.3	18.8
Behavior modification	16.7	71.4	50.0	71.4	53.8	47.1	62.5	73.7	77.8	65.7	75.0	75.0	75.0	75.0	75.0	44.5	66.7	69.0	75.9	64.3
Occupational therapy	16.7	57.1	66.7	71.4	53.8	82.4	87.5	73.7	83.3	81.4	50.0	25.0	50.0	75.0	50.0	63.0	70.4	69.0	79.3	70.5
Art therapy	33.3	100.0	50.0	42.9	57.7	70.6	75.0	57.9	55.6	64.3	50.0	50.0	100.0	75.0	68.8	59.3	77.8	62.1	55.2	63.4
Psychodrama	0.0	14.3	50.0	28.6	23.1	17.6	31.3	15.8	44.4	27.1	0.0	25.0	25.0	0.0	12.5	11.1	26.0	24.1	34.5	24.1
Movement/dance therapy	0.0	0.0	33.3	14.3	11.5	35.3	43.8	21.1	38.9	34.3	0.0	0.0	50.0	25.0	18.8	22.2	26.0	27.6	31.0	26.8
Range of treatment staff per hundred residents	8 or less	9–25	26–46	47 or more	All	60 or less	61–102	103–161	162 or more	All	27 or less	28–61	62–140	141 or more	All	27 or less	28–81	81–140	141 or more	All

* To construct quartiles by auspices, facilities were ordered by staff-to-resident ratio and divided into groups of equal size (plus ties). The range of staff-to-resident ratios within each quartile appears in the bottom line of this table.

Table A–13. Level of highest academic degrees of senior administrators, by auspices

Degree level	Percent of facilities												
	Corrections			Mental health			Social services/other			All			
	Superintendent (N=23)	Administrative Director (N=18)	Clinical Director (N=16)	Superintendent (N=30)	Administrative Director (N=65)	Clinical Director (N=59)	Superintendent (N=10)	Administrative Director (N=13)	Clinical Director (N=16)	Superintendent (N=98)	Administrative Director (N=90)	Clinical Director (N=97)	Program Director (1972)*
M.D.	0.0%	0.0%	50.0%	46.2%	8.4%	86.2%	20.0%	15.4%	62.6%	32.7%	7.8%	76.3%	70%
Ph.D., Ed.D.	13.0	22.2	25.0	13.9	17.0	9.2	20.0	15.4	18.8	14.3	17.8	13.4	10
D.S.W.	0.0	0.0	0.0	1.6	1.7	0.0	0.0	0.0	0.0	1.0	1.1	0.0	—
M.S.W.	4.3	5.6	0.0	3.0	3.3	3.0	0.0	7.8	6.3	3.1	4.4	3.1	16
Other Master's level	43.4	44.4	18.8	27.7	49.1	1.6	60.0	53.9	12.5	34.7	48.8	6.2	
Bachelor's level	26.1	22.2	6.2	6.2	20.4	0.0	0.0	7.8	0.0	10.2	18.9	1.0	3
Less than Bachelor's level	13.0	5.6	0.0	0.0	0.0	0.0	0.0	0.0	0.0	3.1	1.1	0.0	0
J.D./L.L.D.	0.0	0.0	0.0	1.6	0.0	0.0	0.0	0.0	0.0	1.0	0.0	0.0	0
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100

* Source: Eckerman (1972), p.16.

Table A–14. Academic field of senior administrators highest degrees, by auspices

Discipline	Percent of facilities												
	Corrections			Mental health			Social services/other			All			
	Superintendent (N=17)	Administrative Director (N=15)	Clinical Director (N=19)	Superintendent (N=65)	Administrative Director (N=59)	Clinical Director (N=65)	Superintendent (N=11)	Administrative Director (N=13)	Clinical Director (N=16)	Superintendent (N=93)	Administrative Director (N=87)	Clinical Director (N=100)	Program Director (1972)*
Medicine	0.0%	0.0%	10.5%	9.2%	0.0%	7.7%	0.0%	0.0%	12.5%	29.0%	0.0%	9.0%	38%
Psychiatry	0.0	0.0	15.8	36.9	6.8	73.8	27.3	23.1	50.0	29.0	8.0	59.0	33
Psychology	23.5	40.0	26.3	12.3	20.3	6.2	27.3	15.4	25.0	16.1	23.0	13.0	16
Social work	5.9	0.0	0.0	7.7	5.1	3.1	0.0	7.7	6.2	6.5	4.6	3.0	6
Public administration	11.8	13.3	0.0	21.5	32.2	1.5	36.4	23.1	0.0	21.5	27.6	1.0	
Nursing	5.9	0.0	0.0	6.2	3.4	1.5	0.0	7.7	0.0	5.4	3.4	1.0	
Other social science/business	52.9	46.7	47.4	4.6	32.2	4.6	9.1	23.1	6.2	14.0	33.3	13.0	1
Law	0.0	0.0	0.0	1.5	0.0	1.5	0.0	0.0	0.0	1.1	0.0	1.0	
Counseling/ Guidance	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	5
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100

* Source: Eckerman (1972), p.17.

Table A–15. Concentration of female staff, by occupational category and concentration of female population

Prevalence of Female Staff by Occupational Category	Percent of facilities			
	No Female Residents (N=75)	Low Proportion Female Residents (N=20)	High Proportion Female Residents (N=28)	All (N=123)
Treatment/Professional				
No Females	2.7%	0.0%	0.0%	1.6%
Low Female Concentration	53.3	50.0	10.7	43.1
High Female Concentration	44.0	50.0	89.3	55.3
Not Ascertained	0.0	0.0	0.0	0.0
Total	100.0%	100.0%	100.0%	100.0%
Security				
No Females	24.0%	0.0%	28.6%	21.1%
Low Female Concentration	33.3	40.0	14.3	30.1
High Female Concentration	29.3	45.0	25.0	30.9
Not Ascertained	13.3	15.0	32.1	17.9
Total	100.0%	100.0%	100.0%	100.0%
Maintenance				
No Females	36.0%	10.0%	35.7%	31.7%
Low Female Concentration	2.7	10.0	7.1	4.9
High Female Concentration	22.7	55.0	39.3	31.7
Not Ascertained	38.7	25.0	17.9	31.7
Total	100.0%	100.0%	100.0%	100.0%
Administrative/Clerical				
No Females	25.3%	15.0%	10.7%	20.3%
Low Female Concentration	18.7	10.0	17.9	17.1
High Female Concentration	48.0	60.0	64.3	53.7
Not Ascertained	8.0	15.0	7.1	8.9
Total	100.0%	100.0%	100.0%	100.0%
Volunteers/Interns				
No Females	6.7%	0.0%	7.1%	5.7%
Low Female Concentration	48.0	60.0	53.6	51.2
High Female Concentration	14.7	25.0	32.1	20.3
Not Ascertained	30.7	15.0	7.1	22.8
Total	100.0%	100.0%	100.0%	100.0%

Table A–16. Status of female staff on male wards, by auspices and age jurisdiction of referring court

Status of female staff/male wards	Percent reporting status															
	Corrections				Mental health				Social services/Other				Total			
	Adults and juveniles (N=2)	Juveniles only (N=2)	Adults only (N=23)	All (N=27)	Adults and juveniles (N=8)	Juveniles only (N=9)	Adults only (N=60)	All (N=77)	Adults and juveniles (N=2)	Juveniles only (N=6)	Adults only (N=10)	All (N=18)	Adults and juveniles (N=12)	Juveniles only (N=17)	Adults only (N=93)	All (N=122)
Do not assign	0.0%	0.0%	17.4%	14.8%	0.0%	0.0%	6.7%	5.2%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	8.6%	6.6%
Assign with no special precautions	0.0	0.0	21.7	18.5	25.0	22.2	36.7	33.8	0.0	83.3	10.0	33.3	16.7	41.1	30.1	30.3
Assign in pairs or with male escorts	100.0	50.0	47.8	51.8	87.5	77.8	56.6	62.3	100.0	50.0	60.0	61.1	91.7	64.7	54.8	59.8
Assign but restrict areas/ procedures	0.0	50.0	0.0	3.7	0.0	11.1	5.0	5.2	0.0	0.0	0.0	0.0	0.0	11.8	3.2	4.1
Assign but use security devices	50.0	50.0	8.7	14.8	25.0	0.0	1.7	3.9	0.0	0.0	20.0	11.1	25.0	5.9	9.7	10.7
Assign with security training	50.0	0.0	17.4	18.5	0.0	33.3	11.7	13.0	0.0	0.0	40.0	22.2	8.3	17.6	20.4	18.8

Table A–17. Use of security measures, by auspices

Security Measures	Percent of facilities employing measures			
	Corrections (N=30)	Mental Health (N=79)	Social Services/ Other (N=18)	All (N=127)
Perimeter				
Security Towers	63.3%	5.1%	11.1%	19.7%
Security Fence/ Wall	93.3	59.5	27.8	63.0
Armed Guards	56.7	6.3	11.1	18.9
Unarmed Guards	70.0	44.3	38.9	49.6
Surveillance Devices	23.3	24.1	27.8	24.4
Other	0.0	12.7	5.6	8.7
Grounds				
Security Gates	83.3	43.0	33.3	51.2
Armed Guards	30.0	5.1	0.0	10.2
Unarmed Guards	63.3	51.9	50.0	54.3
Surveillance Devices	10.0	16.5	16.7	15.0
Other	0.0	6.3	0.0	3.9
Building				
Locked Wards	90.0	93.7	72.2	89.8
Telephone Alarm System	73.3	44.3	55.6	52.8
Security Windows/ Doors	83.3	87.3	83.3	85.8
Metal Detectors	53.3	46.8	33.3	46.5
Armed Guards	13.3	[illegible].8	5.6	6.3
Unarmed Guards	83.3	53.2	44.4	59.1
Surveillance Devices	13.3	30.4	22.2	25.2
Sallyport	46.7	44.3	11.1	40.2
Other Alarm System	26.7	39.2	22.2	33.9
Other	3.3	21.5	11.1	15.7

Table A-18. Security measures during family/friend visits, by auspices

Security Measures for Family/Friend Visits*	Percent of facilities using measures			
	Corrections (N=30)	Mental Health (N=79)	Social Services/ Other (N=18)	All (N=127)
TOTAL PHYSICAL SEPARATION				
Screen	6.7%	10.1%	5.6%	8.7%
Glass	16.7	7.6	11.1	10.2
Laser	0.0	0.0	0.0	0.0
Strip Search Resident	70.0	35.4	33.3	43.3
Prohibit Contact Visits	10.0	10.1	22.2	11.8
Metal Detectors	66.7	48.1	38.9	51.2
Security Guard Present	83.3	50.6	44.4	57.5
Television Monitoring	6.7	7.6	11.1	7.9
Other (Locked Room, Vistor Search)	6.9	31.6	22.2	24.4

*Excludes conjugal visits, which are permitted by 6.7% of corrections facilities, 7.6% of mental health facilities, 0.0% of social services facilities, and 6.3% of all facilities.

Table A–19. Occurrences of critical incidents, by facility population category

Facility Population Category	Percent of population (N=18452)		Percent of suicides (N=38)		Percent of other deaths (N=170)		Percent of escapes* (N=1088)	
	In Category	Cumulative	In Category	Cumulative	In Category	Cumulative	In Category	Cumulative
10 or less (N=4)	0.1%	0.1%	0.0%	0.0%	0.0%	0.0%	0.5%	0.5%
11-25 (N=11)	1.0	1.1	10.5	10.5	0.0	0.0	5.4	5.9
26-50 (N=21)	4.3	5.4	5.3	15.8	4.1	4.1	17.2	23.1
51-100 (N=22)	8.6	14.0	7.9	23.7	1.2	5.3	8.2	31.3
101-250 (N=30)	25.8	39.8	31.6	55.3	8.8	14.1	12.4	43.7
251-500 (N=10)	17.7	57.5	18.4	73.7	7.6	21.7	28.3	72.0
501-More (N=8)	42.6	100.0	26.3	100.0	78.2	100.0	28.0	100.0

*Includes escapes/elopements with and without return.

Table A–20. Separation of minors from adults in service delivery

Type of Service	Percent separating minors* from adults for service delivery			
	All Serving Minors and Adults (N=41)	Minors Exceed 10 Percent of Population (N=12)	10 Percent or Less of Population (N=16)	Not Ascertained (N=13)
Housing	22.0%	41.7%	12.5%	15.4%
Treatment	24.4	25.0	18.8	30.8
Recreation	19.5	25.0	12.5	23.1
Education	37.5	25.0	37.5	38.5

*"Minors" refers to persons 17 years old or younger, regardless of jurisdiction of referring court.

Table A–21. Frequency of management problems presented by ethnic mix, by auspices

Problems Presented By Ethnic Mix	Percent of facilities citing problem			
	Corrections (N=30)	Mental Health (N=79)	Social Services/ Other (N=18)	All (N=127)
Management Problems Presented	13.3%	17.7%	5.6%	15.0%
Among Residents	10.0	12.7	0.0	10.2
Between Residents and Staff	6.7	16.5	0.0	11.8

Table A–22. Distribution of ethnicity–related problem types among residents, by auspices

Type of Problem Due to Resident Ethnic Mix	Percent of facilities* reporting problem		
	Corrections (N=3)	Mental Health (N=10)	All (N=13)
Fights	33.3%	20.0%	23.1%
Acting Out	33.3	20.0	23.1
Discrimination Charges	33.3	30.0	30.8
Language Barrier	0.0	20.0	15.4
Cliques	0.0	20.0	15.4
Unspecified	33.3	40.0	38.5

*Table based on only those facilities reporting existence of a problem among residents due to ethnic mix. No Social Services/other facilities reported such problems. Total of percentages may exceed 100, because respondents cited up to three problem types in a single facility.

Table A–23. Distribution of ethnicity–related resident/staff problem types, by auspices

Type of Problem Due to Resident/ Staff Ethnic Mix	Percent of facilities* reporting problem		
	Corrections (N=2)	Mental Health (N=13)	All (N=15)
Need for Bilingual Staff	0.0%	46.2%	40.0%
Used for Additional Staff	50.0	30.8	33.3
Discrimination Charges	50.0	7.7	13.3
Communication Problems	0.0	7.7	6.7
Unspecified	0.0	15.4	13.3

*Table based on only those facilities reporting existence of a problem between residents and staff due to ethnic mix. No Social Services/Other facilities reported such problems. Total of percentages may exceed 100, because respondents cited up to two problem types in a single facility.

Table A–24. Court order status of facilities, by auspices

Court order status	Percent of facilities reporting status			
	Corrections (N=30)	Mental Health (N=79)	Social Services/ Other (N=18)	All (N=127)
No court orders	93.4%	89.8%	83.3%	89.7%
Court Order: Standards	0.0	1.3	0.0	0.8
Court Order: Treatment	3.3	2.6	5.6	3.1
Court Order: Overcrowding	0.0	1.3	5.6	1.6
Court Order: Other issue	0.0	3.8	0.0	2.4
Not ascertained	3.3	1.3	5.6	2.4
Total	100.0	100.0	100.0	100.0

Table A–25. Prevalence and substance of legislative controversies, by auspices

Nature of controversy	Percent of facilities reporting legislative controversy			
	Corrections (N=30)	Mental Health (N=79)	Social Services/ Other (N=18)	All (N=127)
None reported	93.3%	77.2%	88.9%	82.7%
Insanity defense repeal	0.0	2.5	0.0	1.6
Other statute repeal	0.0	3.8	0.0	2.4
Upgrading security/ treatment	6.7	6.3	5.6	6.3
Funding	3.3	12.7	5.6	9.4
Decrease sex offender treatment	0.0	1.3	0.0	0.8
Revision of civil commitment procedures	0.0	2.5	0.0	1.6

Table A–26. Legal–status distribution, by auspices and nature of commitment statute

Legal category	Percent of population in category, by type of commitment statute and facility auspices																			
	1. Mandatory for NGI* and IST				2. Mandatory for NGI, discretionary for IST				3. Discretionary for NGI, mandatory for IST				4. Discretionary for NGI and IST				All			
	Corrections (N=15)	Mental health (N=937)	Social serv./ other (N=386)	All (N=1338)	Corrections (N=359)	Mental health (N=1035)	Social serv./ other (N=0)	All (N=1392)	Corrections (N=2020)	Mental health (N=5930)	Social serv./ other (N=505)	All (N=8455)	Corrections (N=1062)	Mental health (N=3019)	Social serv./ other (N=270)	All (N=4351)	Corrections (N=3456)	Mental health (N=10921)	Social serv./ other (N=1161)	All** (N=15538)
Adults																				
Being evaluated for competency	0.0%	21.4%	1.6%	15.4%	0.0%	1.7%	--	1.3%	0.1%	4.6%	2.8%	3.4%	0.0%	13.4%	8.5%	9.8%	0.1%	8.2%	3.7%	6.1%
Being evaluated for responsibility	0.0	1.3	1.0	1.2	0.0	0.8	--	0.6	0.0	7.1	2.4	5.1	0.0	1.9	0.0	1.3	0.0	4.6	1.4	3.3
Guilty but mentally ill	0.0	4.7	0.3	3.4	0.0	0.0	--	0.0	1.1	0.3	0.0	0.5	2.4	0.1	1.1	0.7	1.4	0.6	0.3	0.8
Incompetent to stand trial	0.0	10.2	4.2	8.4	0.0	5.0	--	3.7	0.0	22.7	5.4	16.1	0.0	5.0	8.5	4.0	0.0	15.1	5.7	11.0
Not guilty by reason of insanity	0.0	45.4	16.8	36.6	0.0	37.6	--	28.0	0.0	18.5	5.7	13.3	0.0	6.4	0.0	4.4	0.0	19.3	8.1	14.2
Penal transfers	0.0	5.3	2.6	4.5	40.1	6.4	--	15.0	58.0	14.4	17.6	25.0	61.1	12.4	5.6	23.9	56.9	12.3	9.8	22.0
Sex offenders	0.0	3.1	14.8	6.4	59.0	7.4	--	20.6	13.4	17.4	4.0	15.6	1.9	1.9	73.7	6.4	14.6	11.0	23.8	12.8
Civilly admitted	0.0	4.9	50.0	18.0	0.0	28.8	--	21.4	0.0	10.3	12.7	8.0	0.0	44.6	0.0	30.9	0.0	21.1	22.3	16.5
Other	100.0	3.6	0.5	3.8	0.8	12.3	--	9.1	17.5	2.6	3.4	6.2	34.6	9.7	0.4	15.2	21.4	5.6	1.7	8.8
Juveniles																				
Being evaluated for competency	0.0	0.0	0.0	0.0	0.0	0.0	--	0.0	0.0	0.0	0.0	0.0	0.0	0.3	0.0	0.2	0.0	0.1	0.0	0.1
Incompetent to stand trial	0.0	0.0	0.0	0.0	0.0	0.0	--	0.0	0.0	0.0*	0.2	0.0*	0.0	0.1	0.0	0.1	0.0	0.0*	0.1	0.0*
Not guilty by reason of insanity	0.0	0.0	0.0	0.0	0.0	0.0	--	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Sentenced to treatment	0.0	0.0	6.7	1.9	0.0	0.0	--	0.0	9.8	0.0*	42.0	4.8	0.0	1.8	2.2	1.4	5.8	0.5	21.0	3.2
Civilly admitted*	0.0	0.0	0.8	0.2	0.0	0.0	--	0.0	0.0	2.0	0.2	1.4	0.0	1.9	0.0	1.3	0.0	1.6	0.3	1.1
Other	0.0	0.0	0.3	0.1	0.0	0.0	--	0.0	0.0	0.0*	3.8	0.2	0.0	0.5	0.0	0.3	0.0	0.2	1.7	0.3
Total	100.0	100.0	100.0	100.0	100.0	100.0	--	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0

* Percentage non-zero but less than 0.05% of total.
**Total differs from overall population of 19,543 due to item nonresponse and exclusion of Federal facilities from analysis.

Table A–27. Legal–status distribution, by presence of GBMI provision and facility auspices

Legal category	Percent of population in category, by presence of GBMI statute and facility auspices											
	GBMI provision				No provision				All			
	Corrections (N=960)	Mental health (N=2129)	Social serv./ other (N=559)	All (N=3648)	Corrections (N=2496)	Mental health (N=8792)	Social serv./ other (N=602)	All (N=11890)	Corrections (N=3456)	Mental health (N=10921)	Social serv./ other (N=1161)	All** (N=15538)
Adults												
Being evaluated for competency	0.0%	14.4%	4.6%	9.1%	0.0%	6.7%	2.8%	5.1%	0.1%	8.2%	3.7%	6.1%
Being evaluated for responsibility	0.0	2.1	0.2	1 3	0.0	5.1	2.5	3.9	0.0	4.6	1.4	3.3
Guilty but mentally ill	4.9	2.8	0.5	3.0	0.0	0.1	0.2	0.1	1.4	0.6	0.3	0.8
Incompetent to stand trial	0.0	16.1	4.8	10.1	0.0	14.8	6.5	11.3	0.0	15.1	5.7	11.0
Not guilty by reason of insanity	0.0	11.0	0.4	6.5	0.0	21.3	15.3	16.5	0.0	19.3	8.1	14.2
Penal transfers	74.9	14.5	2.9	28.6	49.9	11.8	16.3	20.0	56.9	12.3	9.8	22.0
Sex offenders	6.1	0.5	39.2	7.9	17.8	13.5	9.5	14.2	14.6	11.0	23.8	12.8
Civilly admitted*	0.0	30.5	9.1	19.2	0.0	18.8	34.6	15.7	0.0	21.1	22.3	16.5
Other	13.9	4.1	0.4	6.1	24.3	5.9	3.0	9.6	21.4	5.6	1.7	8.8
Juveniles												
Being evaluated for competency	0.0	0.1	0.0	0.1	0.0	0.1	0.0	0.1	0.0	0.1	0.0	0.1
Incompetent to stand trial	0.0	0.1	0.0	0.1	0.0	0.0*	0.2	0.1	0.0	0.0*	0.1	0.0*
Not guilty by reason of insanity	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Sentenced to treatment	0.0	1.5	37.9	6.7	8.0	0.3	5.3	2.2	5.8	0.5	21.0	3.2
Civilly admitted*	0.0	1.4	0.0	0.8	0.0	1.6	0.7	1.2	0.0	1.6	0.3	1.1
Other	0.0	0.7	0.0	0.7	0.0	0.0*	3.3	0.2	0.0	0.2	1.7	0.3
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0

* In some states, includes persons who are involuntarily civilly committed after a finding that they are unlikely to regain competency to stand trial.

**Total differs from overall total of 19,543 due to item nonresponse and exclusion of Federal facilities from analysis.

Table A–28. Prevalence of statistics/research activity, by auspices

Data Analysis Activity	Percent of facilities reporting activity			
	Corrections (N=30)	Mental Health (N=79)	Social Services/ Other (N=18)	All (N=127)
Outcome evaluation	43.3%	44.3%	61.1%	46.5%
Management information system	23.3	32.9	38.9	31.5
Significant research/ documentation activities	30.0	17.7	33.3	22.8
Routine data collection/ publication	86.7	97.5	94.4	94.5

*U. S. GOVERNMENT PRINTING OFFICE 1987: 181-350/73901