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Institutional Programs

CALIFORNIA LEGISLATURE'S STUDY OF CORRECTIONAL NEEDS 1978

Approach Associates 5207 College Avenue Oakland CA

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ABBREVIATIONS

The following abbreviations for institutions have been used throughout this report:

CCC	California Correctional Center, Susanville
CIM	California Institution for Men, Chino
CIW	California Institution for Women, Frontera
CMF	California Medical Facility, Vacaville
CRC	California Rehabilitation Center, Corona
CMC	California Men's Colony, San Luis Obispo
Folsom	Folsom State Prison, Represa
San Quentin	San Quentin State Prison, San Quentin
CTF	Correctional Training Facility, Soledad
DVI	Deuel Vocational Institution, Tracy
SCC	Sierra Conservation Center, Jamestown
CCI	California Correctional Institution, Tehachapi

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INTRODUCTION

On the subject of institutional programs, an inmate at Folsom State Prison recently wrote:

> "Prisons have turned out excellent legal scholars who have found jobs as researchers for some very prestigious law firms. Some jailhouse lawyers have even gone on to law school. A judge in Northern California was once a federal prisoner.
>
> College professors who teach within the walls have commented that the students are more motivated, get higher grades, and show more interest in learning than students on the streets.
>
> Don't let the time work on you, make it work for you."*

The above statement formulates an excellent starting point for a discussion of institutional programs. These programs should be viewed not as merely a way for prisoners to "pass time," or to "stay clean," but as a means to their successful reintegration into the community.

The goals of all institutional programs are well stated by the California Department of Corrections (CDC):

> "A basic goal of all programs is to improve an inmate's ability to adjust to the world outside, more than the world inside the prison. Programs and institutional routines should provide opportunities to make choices and decisions related to future life in the community."**

The concept of "choice" is crucial. It enables prisoners to freely decide what programs to be involved in. No prisoner should be required to participate in programs of rehabilitation or treatment, nor should the failure

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*Bob Collins, "The Editor's Desk," The Folsom Observer, Vol. 35, No. 2 (Folsom State Prison: Represa, California, February, 1978), p. 2.

**The California Department of Corrections, Program Planning Report for 1978-79 Fiscal Year, Vol. II: Program Analysis and Recommendations (April 1, 1978), p. 8.

or refusal to participate be used to penalize an inmate in any way in the institution.* Prisoners should attend programs because they offer something of value; this is one way to ensure program quality.

The CDC goals statement also emphasizes the need for prisoners to learn to adjust to the world outside rather than the world inside the prison. This shift in focus constitutes a radical departure from past objectives. To enable prisoners to accomplish this adjustment successfully, a prison should be organized in such a way as to increase the probability that, starting from the day of a prisoner's admission, his or her efforts would focus on what to do when paroled or released, rather than on how to adjust to prison life.

The need for role modeling provides one major reason why prison communities must become more systematically linked with the outside. The probability that an individual will make realistic selections for self-construction increases as the variety and range of resources increase. This is as true for the prisoner as it is for any person.

The institution, by its very nature, interrupts the relationships between the prisoner and his or her family, friends, and community at large. If these relationships are stifled, the prisoner is forced to develop strong substitute relationships with other prisoners. In light of this problem, the correctional institution should become an integral part of the community rather than a place of banishment. Institutional programs are the vehicle around which this interaction can take place.

The programs discussed in this report are the same as those covered in the CDC report, which (in the language of the Legislature) was expected to address the ". . . treatment programs which will be utilized within any proposed new institution, including: academic purposes; medical services; counseling services; leisure time activities; religion, and inmate employment."**

Most of the material presented here by Consultants has been gleaned from published information and reports, from interviews with CDC staff at institutions and in the central office, and from interviews with outside individuals with extensive backgrounds and expertise in each particular area.

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*National Advisory Commission on Criminal Justice Standards and Goals, Corrections, Standard 2.9 (January 23, 1973), pp. 43-44.

**Item 410.1 of the 1977-78 Fiscal Year Governor's Budget for the Department of Corrections.

While each program area is examined separately, programs are also analyzed by Consultants as interdependent components, since it is unrealistic to view each program area as an isolated unit. For example, the employment area cannot be effectively dealt with unless one simultaneously considers vocational training (providing the necessary skills to be employable) and community resources (providing the jobs). Thus, Consultants have combined the area of employment with vocational training. (See Volume IV of Consultants' Final Report.)

Adequate vocational training or employment while in prison -- or even upon release -- does not guarantee prisoners' successful reintegration. He or she may have a negative attitude toward training or employment which may stem from emotional problems or lifestyle choices. Thus, psychiatric and counseling services should be made available in a comprehensive program geared toward the prisoner as a whole person.

Although this section covers institutional programs, other areas (e.g., security classification) have a major effect on programming. As emphasized in the CDC report, security has been the major influence on all other prison activities, because of the need to ensure that prisoners harm neither the public nor persons within the prison.* The classification process plays an important role in both security needs and program operations.

> "In some instances, an inmate's training and programming needs are not the determinant of institutional placement. Instead, gang affiliation or geographic origin may dictate this placement."**

Prisoners in specialized housing areas (adjustment centers, management-control, and protective custody) are unable to participate in work, education, and other programs.

Related to security and in issue throughout the various program areas discussed in this report is the extent to which outside resource persons are involved with inside programs; e.g., in the health service area, Consultants recommend the use of community hospitals instead of prison hospitals.

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*CDC Program Planning Report for 1978-79 Fiscal Year, Vol. II, p. 31.

**Ibid., p. 33.

Some other issues discussed herein are:

- scope and quality of service;
- prisoner access to service;
- staff training;
- availability and use of community resources; and the
- prisoner/staff relationship.

A. HEALTH CARE SERVICES

Health care includes medical-surgical care, psychiatric and psychological care, and dental care. The psychiatric/psychological program is discussed separately from the medical/dental program (as in the CDC report). The Department of Health report concerning the health services provided by the Department of Corrections is summarized and reviewed in each area.*

MEDICAL/DENTAL

Six of the CDC institutions provide inpatient hospitalization and are designated by the CDC as hospitals;** six provide infirmary-level care only. Table 1 summarizes medical/dental programs at the six CDC hospitals.

Staffing at the other six institutions*** includes a Chief Medical Officer (CMO), one or more physicians and surgeons, a Chief Dental Officer (CDO), and one or more other dentists, nurses, medical technical assistants (MTA), x-ray technicians, and other support staff.

In general, minor medical problems are handled at all 12 institutions. Medical problems of a fairly serious nature are referred to a nearby departmental hospital for screening and care, or for referral to a community hospital. Emergency hospital cases are referred directly to nearby community hospitals.

The objectives of dental care in the department are (1) restorative dentistry and (2) preventive dentistry.

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*Ibid., Appendix D.

**California Institution for Women, California Institution for Men, California Men's Colony, California Medical Facility, San Quentin State Prison, Folsom State Prison.

***California Correctional Institute, California Correctional Center, California Training Facility, Deuel Vocational Institution, Sierra Conservation Center, California Rehabilitation Center.

TABLE 1

SUMMARY OF MEDICAL/DENTAL PROGRAMS AT SIX CDC HOSPITALS

FACILITIES	Number of Beds	Major Surgeries Performed in 1976-77 Fiscal Year	MEDICAL STAFF				DENTAL STAFF	
			Chief Med. Officer	Other Physicians	Nurses	Med. Tech. Asst.	Chief Dental Officer	Other Dentists
California Institution for Women	36	123	1	2	14	1	1	1
California Institution for Men	100	126	1	5	12	29	1	9
California Men's Colony	56*	180	1	4	6	11	1	4
California Medical Facility	78**	486	1	6***	7	48	1	5
California State Prison at San Quentin	85	127	1	4	10	27	1	4
Caifornia State Prison at Folsom	30	115	1	2	2	15	1	2

*Also a two-bed post-surgical recovery unit.

**Medical/surgical beds only; there is also a four-bed Intensive Care Unit, and a Renal Hemodialysis Center.

***About 20 additional consulting specialists in virtually all specialties. Proximity to U.C. Davis Medical School and Sacramento Medical Center enables their facilites to be used for difficult cases.

Table 2 illustrates the per capita cost of medical/dental services at each institution, based on the 1976-77 CDC operating budget. While the average cost per inmate is $712.98, the cost ranges from a low of $383.39 at Sierra Conservation Center to a high of $1,221.81 at California Medical Facility.*

Department of Health Report

The Department of Health report, which addressed health services provided by the CDC and responded to Item 410.1 of the 1977-78 Fiscal Year Governor's Budget for the Department of Corrections, made recommendations based upon two major findings:

1. That the CDC health system is currently fragmented among 12 institutions, and could reap signficant benefits in both quality and cost savings by adopting a centralized health system approach; and

2. That licensing is required for CDC hospitals.

Specific recommendations include:

1. A proposed model for a centralized health system approach;

2. A reduction in the number of inpatient hospitals;

3. A reduction in the number of physicians and dentists; and

4. A methodology for CDC to offset the cost of licensure requirements.

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*Reasons for differences in per capita cost of service at the different institutions are not clearly delineated in the CDC literature. For example, the more expensive facilities may have better or more extensive programs; or the less expensive institutions may reflect differences in economies of scale realized through population size; or the costs may demonstrate priorities of institutional administrators; or costs may be influenced by the location of the institution.

TABLE 2

PER CAPITA COST OF MEDICAL/DENTAL SERVICES AT EACH INSTITUTION

BASED ON 1976-77 OPERATING EXPENSES

FACILITIES	COST OF MEDICAL-DENTAL SERVICES	AVERAGE DAILY POPULATION	PER CAPITA COST
California State Prison at San Quentin	$2,175,820	$2,013	$1,080.88
California State Prison at Folsom	962,888	1,750	550.22
California Institution for Women	804,067	775	1,037.51
California Institution for Men	1,972,725	2,450	805.19
California Training Facility	1,183,616	2,552	463.80
California Medical Facility	2,333,663	1,910	1,221.81
Deuel Vocational Institution	744,431	1,280	581.59
California Correctional Institution	691,853	1,070	646.60
California Men's Colony	1,296,439	2,455	528.08
California Rehabilitation Center	1,480,034	2,325	636.57
California Correctional Center	613,924	990	620.13
Sierra Conservation Center	623,001	1,625	383.39

CDC Program Concept

In their Program Planning Report,* CDC makes comments and recommendations relative to present prison medical services. They are summarized here as follows:

Scope and Quality of Services. Prison medical services have not kept pace with the improvements in the quality, quantity, and range of community medical services which have developed in recent years. While the actual level of medical care in California institutions has not diminished, it appears to have lost ground when compared with outside levels of medical care and with the increasingly stringent standards by which community health programs are regulated.

Licensing. None of the Department's hospitals are accredited at this time. Bringing institutional structures, equipment, and staffing up to community standards for licensing of health care facilities would require a tremendous capital outlay and a significant increase in the annual operating budget.** A study of departmental health care facilities by the Department of Health Licensing staff is currently underway to update their cost estimates necessary to meet licensing standards. The Department favors the concept that State institutional medical services should generally meet community licensing standards for hospitals offering equivalent services, but with some exceptions for the unique problem of prisons.

Medical Technical Assistant (MTA). The MTA is one of the exceptions that should be made to the licensing standards. MTA staffing used in correctional institutions is a highly valuable and versatile paramedical position. The classification should be recognized by state licensing authorities by development of certification standards, and should then be part of the staffing standards for correctional institutions, offsetting some of the nursing staff requirements of current community facility standards. This would be similar to the professionalization of the Psychiatric Technician class in the state mental hospitals a number of years ago.

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*CDC Program Planning Report, Vol. II, pp. 148-149.

**Relevant discussions pertaining to this issue are addressed in the CDC Program Planning Report, section on the Department of Health Report, Health Services in Correctional Institutions, Vol. II, Appendix D; and in the Department of Finance Program Evaluation, CDC/CYA Medical Surgical Study (October, 1977).

Recruitment. Recruitment continues to be a problem in the Department, especially for physicians and surgeons, psychiatrists, dentists, and nurses. Recruitment problems are qualitative, as well as quantitative.

Standards for CDC's medical staff should meet or exceed standards in the free community. Additionally, various stresses in a prison setting require that staff be alert, stable, and slow to anger; that they have skills of diplomacy and personal relations as well, and that they possess the necessary professional skills. To recruit doctors of this caliber, the Department offers pay and fringe benefits which are equal or superior to those offered in other departments of State service.

Especially heavy emphasis is placed on continuing post-graduate medical education, and a physician or dentist can get five days of State-paid post-graduate education per year, including travel, per diem, and tuition costs. In spite of this, it is still difficult to recruit physicians and dentists, especially in the more remote locations. A special ongoing recruitment program is in operation in coordination with the State Personnel Board.

Recruitment is made difficult by problems with: fears of the prison setting, pay levels compared to private or group practice, operational restrictions related to security needs, opportunities for advancement, liability protection, and relations with medical and nursing schools. Many qualified doctors, especially those who are continuing their educations toward higher professional qualifications, decline work in non-accredited institutions.

Preventive Care and Health Education. Paralleling community trends, the Department intends to develop a holistic approach to inmate health care, with emphasis upon preventive care and health education. Through understanding of the body and its functions and learning the symptoms of disease and illness, inmates will be able to develop better personal health habits and seek treatment in the early stages of medical or dental problems. It is probable that any significant program of preventive health care will require additional staffing. The Department is not prepared to make a specific proposal at this time.

The Department states that the environmental quality of the proposed new institutions is vital to health maintenance of prisoners. Requirements for a healthful environment include: some personal privacy; reasonable noise limits; a variety of visual textures and colors; and adequate exercise space. Such surroundings will reduce tensions which can lead to serious illness in both inmates and staff.

Response to CDC and Department of Health Reports*

The reports from CDC and the Department of Health raise a number of significant issues:

Scope and Quality of Service. Investigations conducted by the Legislature (Karabian Committee), grand juries, California Medical Association, Soledad Task Force, and internally by the CDC-commissioned Lawry study, all attest to the problems with the level, quality, and appropriateness of health care in corrections, and give substance to CDC's assertion that their services have not kept pace with the free community. The correctional hospitals have lost their Joint Commission Accreditation, and attempts to increase the health budget within the Department have been frustrated. All agencies, including the CDC, want the level of health services to be equivalent to the prevailing standards in the free community, recognizing that some custody issues have impinged on this goal in the past.

Licensing. The existing documents contain contradictory opinions on the question of whether CDC hospitals must be licensed by the State. CDC is on record for favoring licensing to eliminate unfavorable comparisons with community health services. Since malpractice and other litigations will undoubtedly use the institutions' lack of licensing in court proceedings, the argument for licensure of hospital facilities is fiscal as well as ethical and moral. (Physicians employed by the State are covered for litigation by the State; however, both the State and physician can be sued individually at this time, and the State's liability has yet to be fully tested in court.)

Medical Technical Assistant (MTA). Medical Technical Assistant is a classification of paramedical health worker used primarily in state prisons. They are the counterpart of military "corpsmen," and were introduced into correctional health systems to provide a male substitute for registered nurses (RNs), who are traditionally women. Their promotional lines are custodial, and they often are members of the Correctional Officers Association. Most consultants contacted, and Dr. Edward South, the new Director of Medical Services for CDC, would prefer to replace MTAs with RNs for inpatient positions. CDC prefers to keep MTAs working in psychiatric hospitals, infirmaries, and outpatient activities (such as sick call). CDC is currently exploring the licensing and regulation of

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*Consultants also reviewed the Department of Finance report referred to in the Department of Health report.

MTA activity with the appropriate division of the Health Department. Several studies (CMA Report of 1975 and Soledad Task Force Report) amplify the serious problems of a health system dependent on MTAs. These center around controlling access to physicians, personal privileges like excuses from work details and, in many institutions, control of medications. In general, Consultants think that the category of persons providing service should be adequately trained, certified by an appropriate regulatory agency, and have documented continuing education skills maintenance. RNs should be hired to replace MTAs in inpatient settings, and licensed Psychiatric Technicians should be used instead of MTAs in psychiatric hospital settings. The original need for male health workers has diminished with the introduction of women into all aspects of CDC. MTAs should continue to be used in ambulatory settings throughout the Department, and licensing and certification should continue to be developed by the Health Department.

Recruitment. While the number of applicants to vacant positions in correctional health services is not a major problem, every investigating report has mentioned lack of "quality applicants," chiefly physicians. As detailed in a number of reports, there are no incentives or promotional opportunities within the system as currently structured. Consultants suggest that more vigorous recruiting from neighborhood medical centers, where possible, could upgrade the quality of physicians hired by the CDC. This could also help establish promotional lines within State Civil Service.

Preventive Care and Health Education. There have been no systematic studies of the effect of preventive health care and health education on the health system in corrections. Both CDC and the Health Department acknowledge the need for an analysis of preventive possibilities. The large amount of data collected by the Northern and Southern Reception Guidance Centers (RGCs), the intake points for the state penal system, has never been formally analyzed to quantify the types of problems, both physical and psychiatric, that are encountered. The level of follow-up from RGC examinations is minimal, and there is little attempt to secure relevant information from the county institution where the prisoner resided prior to entering the state system. Data analysis and medical follow-up would generate a "needs assessment" for preventive programs (e.g., drug and alcohol abuse) for the entering population, and could help make placement in facilities more rational. Consultants' experience suggests that the individual prisoners are very "body conscious," and programs that emphasize self-care and "wellness" would be eagerly received. Neighboring community colleges or interested volunteer health agencies could augment a preventive medicine program. High yield preventive measures should be implemented system-wide: these could include screening kitchen workers for hepatitis and infectious skin lesions; venereal

disease screening for prisoners returning from furloughs where a high incidence of V.D. has been reported; and influenza and pneumonic vaccination for appropriate subpopulations within CDC.

Centralized Administration. Both the CDC and the Health Department recognize the serious deficiencies in health administration and planning within the current system. The Health Department's Health Maintenance Organization (HMO) plan creates a central medical authority with minimal responsibilities to wardens of individual institutions. CDC requests three additional positions (Program Analyst, Senior Administrative MTA, and Clerk) to bolster its central staff, but has not addressed the issue of the responsibilities and authority of the Medical Director.

Historically, the Medical Director was part of the CDC Director's staff, but the job was downgraded in the 1960's and placed under the Deputy Director of Institutions. At that point, the authority to hire and fire physicians was taken from the Medical Director, and subsequently given to individual wardens and superintendents. They were naturally hesitant to terminate an incompetent physician or Chief Medical Officer (CMO), since they were not licensed medical professionals. The Medical Director no longer had the power to discipline CMOs directly, since they reported to the wardens, and consequently individual empires arose (well-documented in the Soledad Task Force Report).

The Medical Director of CDC should, therefore, either be part of the Director of CDC's staff, or part of a separate medical correctional agency responsible to the Health Department or HMO agency. Standards of care, procedural protocols, hiring priorities, and overall budgets must be coordinated centrally with sufficient staff to serve as the administrative and planning central body. The HMO concept of the Health Department does not adequately address local institutional needs. For example, in most correctional medical systems there is a direct relationship between the warden and the local CMO and a professional supervisory relationship to a medical director. The State Health Departments HMO plan should be reorganized, taking these working relationships into account. The physician's responsibilities to the central medical unit and to the local superintendent should be organized in a way that meets the needs of the local institution.

None of the reports suggest a viable mechanism for quality control. Currently, there is no formal system of medical audit, peer review, or continuing educational requirements above what is required for individual physician licensure. There is no formal in-house medical review of deaths and complications, much less professional outside monitoring. Most institutions have no formal and effective medical appeal or grievance system, despite numerous studies showing that effective grievance and appeal processes decrease the level of tension and anxiety experienced in prisons and improves the quality of prison care.

- Consultants recommend that some medical review process and ombudsman position should be incorporated into the central administration to guarantee quality of care. An outside health review agency should also be developed to advise the peer review organization of the Department.

Options for Restructuring the CDC Health Care System

1. Contract out all emergency and inpatient care to accredited community hospitals, and maintain office level outpatient care and infirmary beds in each institution.

Advantages:

a. Guarantees a level of care equal to that of community hospitals for prison patients;

b. Does not require any of the existing facilities to meet state licensing requirements for hospitals;

c. May permit reduction in health care positions currently used in correctional hospitals; and

d. Removes the probability of patients in CDC hospitals suing the Department. (This issue is minimized in the Finance Committee report, but in most states, including California, malpractice suits are filed with increasing frequency.)

Disadvantages:

a. Cost to the CDC. Outside care is certainly more expensive, but this also reflects the disparity between the level of care provided in the community compared with correctional hospitals. There are numerous cost containment models in existence: for example, prior authorization reviews for non-emergency cases, second opinion panels for major non-emergency surgery, and general audits;

b. Triage and transportation will be a problem area. Major deficiencies exist currently in the ability of individual CDC institutions to provide rapid emergency medical transportation to the community hospital. Increased transportation needs due to community hospital contracting will require a viable and sophisticated plan for transportation;

c. Will need increased number of guards for patients in community hospitals. This disadvantage can be minimized by clustering patients in one area of the community hospital, by using hospital security wards which currently exist in several counties, and by possibly developing a secure ward in a community hospital where the need would justify this expense;

d. Community hospital reluctance to accept prisoner patients. Since the existing institutions contract some hospital services to community facilities, the relationships already exist. There is a growing acceptance of prisoner patients in community and county facilities, as evidenced by the increased number of security wards in community hospitals; and

e. May affect ability of CDC to recruit physicians: This has been a recurring problem at CDC institutions which do have hospitals. Arrangements can be made with the local community hospital for an inpatient experience; physicians who could not qualify for staff privileges at the local community hospital should not be hired by CDC. There is not sufficient financial data in the reports of CDC, Health Department and Finance Committee to predict what the actual costs of contracting out will be compared with other alternatives discussed below.

2. Regionalize two inpatient services or three or four licensed CDC hospitals, and improve the existing correctional health care system.

Advantages:

a. Removes the custody issue in community hospital settings. Use of outside community health services would sharply decline and guards would be needed only for the emergency cases too sick to go to regional centers;

b. May be cheaper than contracting out. The Finance Committee Report indicates that this option would cost less, but the fiscal data is very incomplete (as will be discussed later); and

c. Does not require major administrative changes.

Disadvantages:

a. Does not seriously address the six issues discussed earlier, chiefly, the danger of substandard medical care;

b. Creates transportation problems. Moving patients to regional hospitals and emergencies to local community hospitals will require a transportation plan equivalent to that needed for contracting services out; and

c. Perpetuates the conflicting roles in correctional medicine. CDC's major emphasis is security and custody; health services have always had a lower priority, and CDC's plan does not guarantee reversal of past failures to correct the health care problems.

3. Create a Health Maintenance Organization with two regional hospitals, as advocated by the Health Department Report.

Advantages:

a. Addresses some of the major six issues including quality of care;

b. Existing models will make implementation studies easier; and

c. May be cheaper than contracting out all inpatient services.

Disadvantages:

a. Requires major administrative changes in relationships between CDC and the new Health Maintenance Organization;

b. Creates transportation problems; and

c. Perpetuates the conflicting roles in correctional medicine (as listed in Option #2).

Conclusions

1. The majority of medical consultants favor contracting out all inpatient health services to accredited community hospitals if a fiscal feasibility study* would show it can be done without incurring excessive costs. Such a study would take into account the following variables:

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*Consultants project that a feasibility study could be completed in four months, and would require the combined recommendations of planners, accountants, and medical consultants.

a. Experience of other states (like New York) which currently contract all inpatient services. Senior level program analysts and budget officers should analyze this data and consult with the appropriate agencies of the Health Department;

b. Costs and volume by procedure of "come and go" surgery cases currently being performed as "major surgeries" in correctional hospitals requiring inpatient beds inappropriately;

c. Analysis of use of community hospital critical care beds by prisoners, which can cost $1,000 per day as compared to regular non-critical inpatient costs of $354 per day;

d. Cost of the CDC running a security ward in a community hospital to decrease custody expenses of guarding individual prisoners;

e. Possibilities of requiring county custody personnel to guard state prisoners in hospitals which have existing security wards, thereby cutting the costs of guards from CDC;

f. Analysis of transportation systems including the air ambulance system currently in use by the CDC. This would be necessary for regional centers as well as for contracting out;

g. Feasibility of using physicians from the National Health Service Corps or State Health Service Corps if the current bill is passed by the Legislature to decrease CDC expenditures for physician services;

h. Health costs under National Health Insurance bills, which include coverage for prisoners (e.g., the Dellums bill which provides financing for prisoners' health care, both pre-trial and sentenced).*

i. Design pilot study to show effect of implementing system of prior authorization for non-emergency surgery; and

j. Analyze health data from intake facilities like RGC (Reception Guidance Center) to project financial and health impact of preventive programs.

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*All such bills are not yet law; they are under advisement only.

2. Maintain skilled nursing home level of infirmary care in each institution, using trained personnel who are certified by the appropriate regulatory agency and recertified as needed to maintain skills as required by the regulatory agency.

3. Centralize health administration under the office of the Medical Director, who then reports to the Director of CDC; establish an outside advisory medical board to review policy and advise the Medical Director. There should be a central staff to:

a. Prepare budgets for the entire health system;

b. Recruit staff according to specific needs of the entire systems;

c. Establish and maintain system-wide standards and protocols; including emergency procedures, use of paraprofessionals, and peer review activity;

d. Conduct on-site inspections;

e. Collect and review data to provide sufficient management information regarding health system needs;

f. Use, authorize, and review outside services;

g. Develop and update a master plan for correctional health services.

4. Replace all prisoners who handle medical records with civilian personnel.

PSYCHIATRIC SERVICES

Most male prisoners requiring psychiatric care are located in the hospital of the California Medical Center at Vacaville. The hospital facility at CMC handles CMF's overflow. San Quentin has a small psychiatric unit, and other institutions have a small number of designated psychiatric "holding beds." In all cases, acute psychotic cases are sent to CMF (via air ambulance). Female prisoners are treated at CIW's Psychiatric Treatment Unit (PTU). However, the PTU cannot be considered a "psychiatric clinic" in

the true sense, since its facilities are regularly used to provide secure and segregated housing for management and protective custody cases.

Treatment of patients at CIW consists primarily of drug therapy. Table 3 summarizes the psychiatric programs at each of these four institutions.

Table 4 illustrates the per capita cost of psychiatric services at each institution, based on the 1976-77 CDC operating budget. While the average cost per inmate is $223.87, the cost ranges from a low of $1.09 at the Sierra Conservation Center to a high of $836.33 at the California Medical Facility.

Department of Health Report

The Department of Health report concerning health services provided by the CDC presented the following findings in regard to psychiatric/psychological services:

1. CMF operates continually at capacity, and patients must be referred frequently to CMC.

2. CMF's ability to serve as a general medical hospital for the CDC system is impaired because of the psychotic patient load it carries.

3. Many psychotic patients can be helped by treatment routines which bring normalizing influences into their environment, especially contact with their families. Centralizing all services in the northern part of the state makes it difficult, if not impossible, to involve families who live in the southern part of the state in treatment routines.

4. No true psychiatric programs are offered at any of the other institutions, although in some institutions limited psychological counseling is available.

5. Although drug abuse is a serious problem in the prison system, and occurs at all institutions, there are minimal attempts at drug abuse therapy and counseling (except at CMF and San Quentin).

6. It is widely recognized by psychologists and prison officials that the prison institutional environment itself can cause psychological disturbances. In spite of this, there is little training of prison guards or counselors in the early recognition of the onset of such disturbances.

TABLE 3

SUMMARY OF PSYCHIATRIC PROGRAMS AT FOUR INSTITUTIONS

FACILITIES	NUMBER OF BEDS	PSYCHIA-TRISTS	PSYCHO-LOGISTS	NURSES	MTAs
CIW	61	1	1	5	0
CMF	1,068	12*	11	2	38
San Quentin	14	5	2	0	0
CMC	22	8	6	2	23

*The superintendent is a psychiatrist, as are the assistant superintendent of psychiatric services, the chief psychiatrists and treating physicians.

TABLE 4

PER CAPITA COST OF PSYCHIATRIC SERVICES

AT EACH INSTITUTION BASED ON 1976-77 OPERATING EXPENSES

FACILITIES	COST OF PSYCHIATRIC SERVICES	AVERAGE DAILY POPULATION	PER CAPITA COST
San Quentin	$ 480,744	2,013	$238.82
Folsom	191,757	1,750	109.58
CIW	375,109	775	484.01
CIM	33,241	2,450	13.57
CTF	58,315	2,552	22.85
CMF	1,597,397	1,910	836.33
DVI	82,567	1,280	64.50
CCI	24,770	1,070	23.15
CMC	1,800,844	2,455	733.54
CRC	176,951	2,325	76.11
CCC	82,003	990	82.83
SCC	1,765	1,625	1.09

7. Current duties of counselors are largely clerical. The reasons for the shift from counseling duties are multiple: for example, a lack of clerical support and a lack of training in counseling roles and techniques. Counselors for the most part are ex-guards, and tend to retain the custodial attitude of a guard which inhibits their effectiveness as counselors. Inmates also tend to avoid counseling services from the counselors, apparently because they perceive counselors as custodial personnel rather than as neutral sources of assistance.*

CDC Program Concept

In their Program Planning Report,** CDC states:

> "In view of our current population needing psychiatric services and the anticipated increase directly related to overall population increases, we are recommending that one of the proposed new institutions be a specialized psychiatric facility."***

The Department then makes the following comments concerning this new facility:

1. This new facility should be designed, constructed and staffed in accordance with community standards for such treatment units, to provide the quality of care required and to avoid the controversy which has surrounded the California Medical Facility in recent years.

2. In keeping with the need for flexibility and planning to avoid obsolescence, the psychiatric institution should be designed with essentially the same size and modular configuration as discussed in the architectural evaluation.**** The major differences will be the inmate quarters: 110 square feet per patient vs. 80 square feet per inmate room in a regular institution, and 3 foot wide doors to accommodate gurneys.

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*CDC Program Planning Report, Vol. II (Appendix D), pp. 22-24.

**Ibid., pp. 149-150.

***Ibid., p. 149.

****Ibid.

3. While the cost will be somewhat higher than for a nonspecialized facility, both construction and operation costs will be significantly lowered if the psychiatric facility can be located adjacent to an existing departmental hospital which can provide the necessary medical support.

4. With the range of controls available in modular institutions, one or more of the living/program units can be used for care of women prisoners requiring inpatient psychiatric attention as a more satisfactory alternative to the psychiatric treatment unit at the Institution for Women.

5. As the Department's health care programs are becoming more standardized and specialized, appropriate reorganization will be required to ensure consistency and efficient use of resources. A model is proposed by the Department of Health in their report. This need will be one element of the organizational study the Department will launch following legislative action on the policy proposals.

Response to CDC and Department of Health Reports

While the Department of Health raises a number of significant issues regarding psychiatric/psychological services in the CDC institutions, CDC's only response in its report is to recommend building a new psychiatric facility. Before commenting on the CDC recommendation, Consultants will address some of the issues raised by the Department of Health and will additionally review other issues vital to this subject.

Scope and Quality of Service. The right of prisoners to medical care is usually seen as including the right to psychiatric/psychological services:

> "Prisoners should be entitled to proper medical service, including but not limited to, dental, physical, psychological, psychiatric, physical therapy, and other accepted medical care."*

As noted in the Department of Health report, serious problems exist as to the quality and scope of these services. Among the problems observed by Consultants:

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*The American Bar Association (Section on Criminal Justice), Tentative Draft of Standards Relating to the Legal Status of Prisoners, Vol. 1, No. 3 (Winter 1977). See also National Advisory Commission on Criminal Justice Standards and Goals, Corrections, Standard 2.6, pp. 36-37.

- Extensive professional time of psychiatrists and psychologists is used in diagnostic evaluations, particularly diagnosis of "inmate violence potential." It was the consistent opinion of interviewed CDC psychiatrists performing this evaluation that it is a complete waste of time. In the opinion of these professionals, no one is capable of accurately predicting violence, as it is almost always situationally rather than pathologically related.

  Violence potential evalutions should be eliminated to free up valuable psychiatric/psychological time for treatment.

- The Department of Health report states that no true psychiatric programs are offered at any of the institutions (other than CMF and CMC), although in some institutions limited psychological counseling is available. Available counseling is usually referred to as "group counseling"; CDC staff at these institutions, however, described the counseling as ranging from simple "transfers of information" to "anti-therapeutic" processes.

- Security classifications present a special problem to diagnosis and treatment. It seems clear from discussions with CDC staff that some prisoners referred to CMF as "psychiatric" patients are actually seen as needing protective custody or discipline rather than psychiatric care. The reason for this misclassification is that CMF has more segregation beds than any other facility.

- While CMF is designated as the primary psychiatric hospital, there are serious questions regarding the quality of psychiatric/psychological service provided there. The only treatment modality other than psychopharmacology (drug therapy) used at CMF to any significant extent is group counseling. Group counseling is not always a useful treatment approach, particularly for people unwilling or unable to share intimate thoughts with others. Also, prisoners' personal information can be used by other prisoners in the counseling group for blackmail or other non-therapeutic purposes. Some psychiatric staff at CMF state that group counseling provides a protective barrier against therapists' mistakes (the peer group is present, and therefore there is a smaller potential for therapeutic abuse). While this reasoning is valid to some degree, it suggests real concerns regarding staff quality more than it does an appropriate treatment model.

- Psychiatric staff at CMF said most referrals came from certain correctional counselors and not others. This uneven receptiveness points out a real need for training at the correctional counselor level. Since correctional counselors handle initial screenings at the reception centers -- at which time the determination as to need for psychiatric/psychological services is made -- intensive training in diagnostic skills is essential. It appears to Consultants that whether a particular inmate needing service is seen by a correctional counselor, psychologist or psychiatrist depends more on who is available than upon the prisoner's particular need.

- As noted in the Department of Health report, although drug abuse is a serious problem in the prison system, there are only minimal attempts made at drug abuse therapy and counseling. Even at CRC, which deals almost exclusively with addicts, very little occurs in the way of "treatment."

Inmate Access to Care. Due to the preoccupation with diagnostic evaluations, psychiatrists and psychologists are rarely available for therapeutic intervention. Counselors are preoccupied with clerical duties or are either untrained or unhelpful. (See Section C on Counseling Services.) The only service likely to be made available to prisoners is psychopharmacology or group counseling. Moreover, to obtain any kind of counseling service an inmate must do something extraordinary, which in all likelihood has a direct bearing on the number of inmates labeled "psychotic."

Type of Treatment. The limited variety of available treatment should be remedied. The use of individual psychotherapy, family therapy, and drug and alcohol abuse therapy should be explored.*

Family therapy in particular should be used as much as possible. As set forth in the Department of Health recommendations, "many psychotic patients can be helped by treatment routines which bring normalizing influences into their environment, especially contact with their families." Family problems are often the source of prisoners' offenses, and are believed to be most responsible for parole failures. The family visiting program offered by CDC has greatly improved the stability of inmate/family relationships.

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*For a discussion of drug and alcohol treatment see Commission on Accreditation for Corrections, Manual of Standards for Adult Correctional Institutions, Standard 4444 (August, 1977), p. 84.

Consultants recommend that a voluntary program of family counseling be offered to prisoners and their families in conjunction with the family visiting program. (See Section E on Visiting.) If conducted properly, this program could both increase the number and quality of family visits and improve the likelihood of inmates' successful reintegration into family and community life.

Training. All of the above suggestions regarding treatment modalities require an extensive and intensive training program for all staff providing psychiatric/psychological services. Some might have expertise in one treatment modality and not another. Expertise requires not only initial training (to provide a basic framework) but also follow-up training. The most useful and practical application in a prison setting would be on-the-job training, where skilled therapists would work with the trainee as co-therapists (e.g., trainee observes session with the individual prisoner, prisoner group, or family).

As noted in the Department of Health report, correctional officers and guards need this training in order to recognize the onset of physchological disturbances caused by the institutional environment. Courses in general psychology and therapeutic techniques should be offered in the academic education program and should be made available to both the CDC staff and prisoners. (See Section B on Academic Education.)

Recruitment Procedures. There is a general lack of flexibility in job specifications relating to the psychiatric/psychological service area. There is no recognized position for a psychiatric social worker even though such social workers are well recognized in the mental health profession. In expanding recruitment procedures, the CDC should examine the use of MSWs and other "professional" categories, such as the psychiatric nurse and psychiatric technicians (See Medical/Dental section for a discussion of the use of the Psychiatric Technician in place of MTAs in the psychiatric inpatient setting). There should be some means of hiring interns and volunteers who have served a year or more in that capacity and who have demonstrated their usefulness in the program even though they perhaps lack other qualifications.

Role of State and County Mental Health Systems. While state and county mental health systems may offer adequate treatment resources, they are not equipped to handle custody problems posed by some prisoners. While the CDC offers custody solutions, it lacks adequate treatment resources. It is certainly both feasible and desirable for certain prisoners to receive mental health services in the community; however, it is also incumbent on the CDC to upgrade their treatment resources.

Other issues regarding psychiatric/psychological services are preventive care and health education, licensing, and centralized administration. For a discussion of these topics, see the Medical/Dental section.

The CDC Proposal for Building a New Psychiatric Facility.

As noted earlier, CDC recommends that a new institution be built to serve as a specialized psychiatric facility.

- Consultants argue strongly against that recommendation. At this time, CDC has not demonstrated the need for such a facility. It is uncertain how many prisoners actually require psychiatric services; some prisoners are misclassified, other prisoners requiring psychiatric services should be maintained in the general population, where programs should be developed to meet their needs. Additionally, an anticipated increase in overall prisoner population (as projected by CDC) and thus in persons requiring psychiatric services is highly speculative at this time.

Current Population Needing Psychiatric Services. As suggested in Consultants' comments above, the size of the current CDC population needing psychiatric services is subject to significant speculation. Several factors, however, are clear. According to the CDC report:

> "In general, roughly half of the mentally ill inmates in the Department of Corrections were mentally ill when committed (by retrospective analysis) and about half became mentally ill after incarceration."*

By improving conditions in the prisons, it should be possible to reduce the number that become mentally ill after incarceration.

- Consultants think the less disturbed inmates should be retained in general inmate population of the various institutions (other than CMF or CMC) if competent treatment programs are provided at these institutions. The policy of the various institutions in referring protective custody and discipline cases to CMF as "psychiatric" cases to take advantage of the segregation beds should be discontinued.

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*CDC Program Planning Report, Vol. II, p. 42.

- If the State should decide to contract out all inpatient medical services to accredited community hospitals, based on results of a feasibility study (See Section on Medical/Dental Services), there will be a number of additional inpatient beds in CDC hospitals available for psychiatric care.

Anticipated Increase Directly Related to Overall Population Increases. All of the comments discussed above are also appropriate here. For additional information regarding the accuracy of CDC projections in general and other problems projecting future population trends, see Volume II of Consultants' Final Report (Section on Population Projections).

Conclusion

There is no basis at this time for building a new psychiatric facility in northern California, based on either the number of current prisoners needing psychiatric services or increases directly related to CDC's projected population increases. Unless the other issues discussed here are addressed and the situation remedied, building a new facility will just increase the problems specified, not diminish them. CDC should continue to use CMF as its primary psychiatric hospital, with the CMC hospital facility as a back-up to handle any overflow of prisoners needing inpatient psychiatric care.

- In regards to females, Consultants recommend that all management and protective custody prisoners be removed from the Psychiatric Treatment Unit (PTU) at CIW, and that the PTU be used strictly for psychiatric patients. The Reception Center, which is close custody, should fulfill the disciplinary and protective custody function now served by the PTU. Any overflow from the Reception Center could be handled by the closed 17 cell wing of the hospital, which is also close custody.

- Additional use should be made of community resources for both inpatient and outpatient care, whenever possible. While severely psychotic patients should be held at CMF, CMC, CIW or referred to State or community hospitals, less disturbed inmates should

be retained in the general inmate population of the various institutions,* and provided supervised treatment programs staffed by competent mental health professionals.

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*Commission on Accreditation for Corrections, Manual of Standards for Adult Correctional Institutions, Standard 4725 (August, 1977), p. 52.

B. ACADEMIC EDUCATION

The academic programs in each institution consist of adult basic education (grades 1-5); adult school (grades 6-12); and college level education (grades 13-16). Formal classes are taught by credentialed teachers and supervised by credentialed administrators. Some resources are provided by State employed teachers and some through contracts with school districts.

Programs at each of the institutions vary considerably, but in general they are undergoing a gradual transition from traditional elementary and high school programs to a total adult-level school. Some institutions have evening high school and college classes: others do not. A few provide cell study and correspondence courses. While many have programs leading to an AA degree, Folsom State Prison has just started classes geared to a BA degree.

An average of 6,800 inmates are enrolled system-wide. Diplomas earned last year approximated 800 elementary school, 350 high school, and 50 Associate of Arts. Some 500 GED high school equivalency certificates were issued, and approximately 3,300 college courses were completed.

Table 5 is a summary of the program costs, number of prisoners participating, and per capita cost depicted by activity level. The highest proportion of prisoners (14 percent of the total population) are enrolled in Adult Level III (grades 9-12.9, see Table 5) with the per capita cost of $570.52. Approximately 33 percent of the total prisoner population participates in academic education.

Table 6 illustrates the per capita cost of academic education for each institution, based on the 1976-77 CDC operating budget. While the average cost per prisoner is $221.73, the cost ranges from a low of $76.40 at California Institution for Men to a high of $383.36 at Deuel Vocational Institution.

Department of Education Report

The Department of Education report concerning the education program provided by the CDC, prepared in response to Item 410.1 of the 1977-78 Fiscal Year Governor's Budget for the Department of Corrections, made the following nine recommendations for modification and improvement of the academic education programs:

TABLE 5

PROGRAM COSTS, NUMBER OF INMATES PARTICIPATING AND PER CAPITA COST DEPICTED BY ACTIVITY LEVEL*

ACTIVITY LEVEL	NUMBER OF INMATES PARTICIPATING	% OF TOTAL POPULATION**	TOTAL COST***	PER CAPITA COST
Adult Level I (0-5.9)	1,240	6	$ 742,119	$598.48
Adult Level II (6-8.9)	1,105	5	910,775	824.23
Adult Level III (9-12.9)	3,028	14	1,727,524	570.52
Post-secondary	1,725	8	317,233	183.90

*Table derived from Health and Welfare Agency Synopsis of Zero Base Budget Change Proposals - 1978-79 Fiscal Year.

**Departmental Inmate Population, 20,904 on October 27, 1976.

***There was an additional management/ancillary cost of $38,966 and a total of 116.9 full-time positions.

TABLE 6

PER CAPITA COST OF ACADEMIC EDUCATION

AT EACH INSTITUTION BASED ON 1976-77 OPERATING EXPENSES

FACILITIES	COST OF ACADEMIC EDUCATION	AVERAGE DAILY POPULATION	PER CAPITA COST
San Quentin	$481,182	2,013	$239.04
Folsom	268,177	1,750	153.24
CIW	207,539	775	267.79
CIM	187,169	2,450	76.40
CTF	690,925	2,552	270.74
CMF	219,810	1,910	115.08
DVI	489,423	1,280	382.36
CCI	302,822	1,070	283.01
CMC	525,309	2,455	213.98
CRC	445,398	2,325	191.57
CCC	342,232	990	345.69
SCC	198,020	1,625	121.86

1. The Department needs to explore ways to ensure an improved level of comparability among the various institutions with regard to student access to programs, scope of curriculum, student services, materials of instruction, and classroom facilities.

2. Additional educational counseling and guidance services should be provided and should be available to inmates.

3. Consideration should be given to the provision of an educational scholarship stipend for all inmates who participate in the educational program, based on attendance and educational achievement, and commensurate with funds provided for participation in prison industries programs.

4. A competency-based approach to the curriculum and instructional program should be incorporated to better provide the inmate with necessary social survival skills.

5. Funding levels should be established commensurate with those in public school adult education programs.

6. Provisions should be made to assure that substitute teachers are available when needed.

7. There should be more effective articulation between academic and the vocational programs which will allow the student to participate in both programs at the same time.

8. The student-faculty advisory committee should be used at each institution.

9. Provisions should be made to ensure that each educational employee has the opportunity to participate in staff development activities.*

CDC Program Concept

In their Program Planning Report,** CDC proposed to integrate academic education with work and training in a skill-center concept. The academic education would be based on the adult education model in the community, voluntary but with heavy encouragement for participation by educationally-handicapped prisoners. The CDC proposed the following:

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*CDC Program Planning Report, Vol. II (Appendix C), pp. 2-3.

**CDC Program Planning Report, Vol. II, p. 146.

1. The Department will develop an increased range of available educational experience, including traditional classrooms, media learning centers, mobile education units, and individual and group instruction, with emphasis on assistance toward functional literacy and high school equivalency certification.

2. There will be increased emphasis upon survival-coping-social skills training. Most inmates are typical of the disadvantaged strata of society who lack basic skills in managing their personal lives and coping with the complexities of modern living. Many of the same consumer and domestic training resources developed for community needs can be brought into the institutions for inmate education. In some instances inmates and their wives can attend the training together, which may have a strengthening effect upon their post-release relationship.

3. Inmates in need of education are drawn away from the program by pay numbers and other institutional incentives. The proposed solution is to provide pay to inmates such as functional illiterates and others with especially critical needs, subject to the inmate meeting standards for participation and achievement.

4. There are inflating costs of contractual education community school adminstration due to increased fringe benefits and retirements for teachers. Classroom instruction available under the statutory formula for inmate education funding is diminishing as the proportion required for overhead increases. This can be remedied by legislative revision to recognize inflationary factors.

5. There is a lack of continuity in academic programming during summer months and when teachers are on vacation, sick leave or on educational sabbaticals. This may require additional funding and should be considered in planning to integrate education with work/training.

6. Dependency on classroom instruction is being reduced by the establishment of open schools, external schools, and by stationing teachers in industrial areas and in special housing units so that the program is more available to inmates. Open schools will allow individual entry into and exit from the program at any time. External schools will allow the inmate to participate at his own pace, working alone in a housing unit instead of a classroom. Learning centers have been established so that inmates can go to the center featuring the skill they want to learn and work at their own speed. The Department plans the expansion and refinement of these innovative approaches to adult education to the extent that resources permit. To accomplish these educational objectives in the proposed new facilities, CDC plans space in the living units useable as classrooms for in-group instruction including closed-circuit TV capacity. This will permit educational programs to be offered even to inmates in closed housing units, something very difficult to achieve in present institutions.

Response to the CDC and the Department of Education Reports

CDC recommendations include five of the nine made by the Department of Education in the academic education area. CDC does not address the following:

1. Ways to ensure an improved level of comparability among the various institutions with regard to student access to programs, scope of curriculum, student services, materials of instruction, and classroom facilities.

2. Additional educational counseling and guidance services to prisoners.

3. Use of the student-faculty advisory committee at each institution.

4. Ways to ensure that each educational employee has the opportunity to participate in staff development activities.

In general, there appear to be some consistent underlying themes operating around the four unaddressed areas, as well as some entirely different themes operating around the five that were addressed. For example, all four of the areas not addressed by CDC involve some type of outside involvement. The first involves standardization among the various institutions in regard to student access to programs, scope of curriculum, etc. It implies some "outsider" coming in and making a determination of how a program should operate and questioning practices unique to that institution. The second would involve hiring a new staff person as an educational or guidance counselor to look into problems students may be having, and to determine whether they relate to emotional or learning difficulties or to the quality of the program itself. The third recommendation relates to using the student-faculty advisory committee at each institution, suggesting that this is not currently done. It would mean an additional student or outsider observing prison programming, which could again lead to program evaluation. The fourth recommendation suggests that each educational employee has the opportunity to participate in staff development activities, which can also be assumed to involve both some outside consultation and some outside input into program content and policy.

By contrast, the five areas covered by the CDC proposal relate either entirely to administrative matters or to the inmate and the individual program. Two CDC recommendations are administrative matters -- one having to do with inflation and costs of contractual education requiring legislative revision; the other relating to lack of continuity in academic programming due to vacations, sick leave, etc. and the possibility

of needing additional funding. Two have to do with an increased range of available educational experiences to inmates, such as media learning centers, mobile education units, open schools, and closed circuit TV. While these provide prisoners greater access to programs, they actually limit outside involvement or input into program content. The fifth recommendation involves an increased emphasis upon survival-coping-skills training.

This discussion is not meant to detract from any recommendations made by either the Department of Education or the CDC; they are all excellent suggestions well worth implementing. The real issue is: what can be changed in the CDC educational system given the framework within which prison administrators operate. The primary tasks in the administration of a prison are custody and security. Without considering these tasks, all manner of recommendations can appear constructive on paper. Realistically, though, security concerns greatly effect programs. As noted in Consultants' earlier inventory report ("Institutional Programs"),

> "The constant tension in every area of programming caused by security classification concerns cannot be over-emphasized. It limits contact with the outside world that is necessary for the inmate to make a successful adjustment to society upon leaving prison."*

Even more to the point is information gathered from CDC officials that underscores the tendency to approach any matter relating to prisoners conservatively:

> "In preliminary interviews with CDC officials, most indicated a preference for handling the issue of 'risk' by erring on the side of caution - that is, security."**

In view of this, it may be assumed that the CDC would prefer those recommendations not involving some type of outside interference or involvement.

In order to implement all of the recommendations offered by the Department of Education, as well as those offered by CDC (to be later discussed by Consultants), it may be necessary to create a whole new type of academic education system for the CDC and its prisoners.

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*See Approach Associates' Inventory Report, Institutional Programs, (March, 1978), p. 46.

**See Approach Associates' Inventory Report, Alternatives to Incarceration, (March, 1978), p. 5.

Option I - CDC Liaison with an Independent System of Education

CDC may not need to maintain an education department of its own. The present operation could be closed down and personnel reassigned. A single member of the CDC staff could direct and supervise the work of one or two prisoner clerks in the minimal clerical operations necessary to update prisoners' educational records. All other duties presently associated with an on-site Department of Education in corrections could be turned over, along with the design and implementation of the teacher-learning process itself, to a system of educational institutions independent of the Department of Corrections. Both public and private educational systems are capable of delivering on-site expert educational services, Kindergarten through Graduate School, to correctional facilities: not piecemeal, but as an integrated educational program which could ensure consistent educational standards throughout the CDC. In the private sector, Stanford University would be one example of a university capable of providing this service, and the California State Universities and Colleges would be another example in the public sector.

One of the recommendations of the Department of Rehabilitation was that:

> "All academic, remedial, and trade training programs should be operated independently by local education agencies, Community Colleges and/or State Colleges and Universities."*

Advantages:

a. Ensures educational standards. CDC would have a way to ensure a level of comparability among the various institutions in regard to program access, scope of curriculum, student services, and materials of instruction as recommended by the Department of Education. This does not appear possible under the present system, where some institutions contract with local school districts or community college systems and others hire civil service employees. Some institutions contract for education services on a course-by-course basis.

b. Provides a comprehensive system. At the present time the range of educational attainment levels varies from institution to institution. For example, not all institutions offer an AA and only one offers a BA. Not all institutions have night courses.

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*CDC Program Planning Report, Vol. II (Appendix E), p. 8.

Under this option, courses can be provided from Basic Education (grades 1-5) through Graduate School at all institutions, and courses can be designed for evening hours throughout the system.

c. Provides a greater level of expertise at the design level. Rather than piecemeal planning by local communities and institutions, people skilled in developing comprehensive educational systems on a statewide basis can be involved in designing the appropriate system for the CDC.

d. Provides greater variety and flexibility. Outsiders who are experts in designing educational systems and who have experience in a multitude of settings are more likely to come up with innovative and novel ideas and be more flexible in their thinking about special populations. They are more likely to emphasize survival-coping, social skills, open school, and external school programming.

e. Provides a clear-cut philosophy at the state level. At present the attitude toward education varies from site to site, depending on the particular attitudes of the Supervisor of Education. It also depends on current public opinion about crime and criminals.

An independent system of education can more easily maintain a consistent philosophical approach toward education.

f. Provides more flexibility in dealing with staff problems. An independent system of education can more easily resolve current problems of substitute teachers, teacher absences, vacations, and sick leaves. Such a system is more likely to provide fully developed plans and resources to ensure that educational employees participate in staff-developed activities as suggested by the Department of Education.

g. Provides more flexibility in dealing with prisoners. An independent system of education would most likely be better equipped to treat prisoners as students rather than as criminals, and would be freer in inviting their participation in program design and evaluation, a concept stressed by many of the standards* and alluded to by the Department of Education.

h. Eliminates conflicting requirements and standards between contracting resources and CDC education staff. The CDC sometimes has special standards for prisoners who wish to participate in courses taught by outside contractors. For example, the CDC sometimes requires a H.S. Diploma or GED to take a college course where the community college district has no such requirement.

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*See National Advisory Commission on Criminal Justice Standards and Goals, Section 11.4, p. 368; and Commission on Accreditation for Corrections, Manual of Standards for Adult Correctional Institutions, Standard 4394, p. 46.

i. Provides access to special learning equipment and resources. An independent system of education is more likely to have such resources as mobile education units, closed-circuit TV, and equipment for media learning centers. Such a system would also have special resource persons (e.g., education or guidance counselors.)

j. Provides additional incentives for prisoner participation in educational programs. A comprehensive, well-planned program providing flexibility and variety, a clear-cut philosophy, greater prisoner input, and an independent system of education is likely to attract more students than is the present system, with or without pay incentives.

Disadvantages:

a. Custody Problems. Lack of familiarity of educational staff with prisoner security considerations may cause some problems for custody staff.

b. Inappropriate Course Design. Lack of familiarity with the prisoner population may initially lead to the development of curricula that, while successful for other general populations, will not succeed with this special population.

c. Remoteness. The fact that there will be no education supervisors or staff permanently on site means that prisoners will have more limited access to educational programs. It is more likely that there will be slower response to prisoners' changing needs.

Consultants recognize the advantages and disadvantages of Option I; and at the same time, perceive certain unknowns which must be considered:

a. Feasibility. While Consultants have knowledge of both public and private education systems capable of designing and implementing the type of education system discussed above, Consultants have no knowledge as to whether such public or private education systems would be interested in taking over CDC's education system.

b. Cost. Consultants cannot now determine the short-term and long-term costs of such an independent system and how it compares to present system costs.

- Consultants recommend that the State contract with a public or private education system capable of and interested in administering and delivering the entire academic educational service

to CDC. System contractor should determine the feasibility and cost of developing such service, and should provide an initial plan detailing methods of implementation and proposed educational content.

Once the State receives this information, it will be better able to determine whether to implement the plan. In any case, some of the information may be of use to the CDC in improving its educational services.

Option II - An Improved CDC Academic Education System

The second option is to retain the present CDC academic education system without considering the possibility of a liaison with an independent system of education. It seems obvious, however, that certain improvements are necessary; proof of this is well-documented by the CDC and the Department of Education. Rather than reiterating their suggestions, Consultants make the following comments on improving the CDC system:

1. Educational Incentives. As suggested above, there are additional incentives to academic education beyond a pay number. While Consultants agree with the basic concept of an educational stipend, several issues should be taken into consideration before any decision is made:

a. CDC is currently experimenting with an educational stipend in several institutions, but the study and its evaluation are not yet complete. (It should be noted that the stipend is less than that provided to most inmates with pay numbers.)

b. Consultants' recommendation as to prisoner wages (see Volume IV of Consultants' Final Report) may have some effect on this concept if implemented.

c. There are many other incentives that may be equally as effective in inducing prisoners into educational programs. Among these are home furlough, family visiting, and extra canteen privileges. Prisoners can also be paid to tutor other prisoners.

d. In general, the more desirable the overall program is, the less problem there will be in attracting students to it.

2. Inmate-Staff Relationship. The academic program provides an excellent opportunity for improving inmate-staff relationships, a matter of immediate concern to CDC and Consultants. Courses can be designed of

interest to both inmates and staff, which both can be encouraged to attend. The classroom should provide a relatively neutral setting in which the distinctions between inmate and staff can be minimized.

3. Inmate-Staff Input into Program. There exists in each CDC institution an untapped resource of inmates and staff with a particular expertise that each would be willing to share. This resource should be used.

4. Extended Day School. Each institution should develop an extended day school to include evening classes, cell study, and correspondence courses. This would allow inmates to both work and go to school. Consultants propose that the Director of Corrections shall, to the extent possible, assume that academic programs are scheduled so as not to restrict a program participant's opportunity for employment.* This would have an obvious effect on the need for an educational stipend.

5. Inmate Participation in Program Planning and Evaluation. It is essential that prisoners have a greater say in both determining what courses they receive and in evaluating them once they are completed. This is standard practice in any educational setting, and is one of the only ways of assuring that meaningful material is presented. It has even greater significance in a prison setting, where prisoners are rarely given an opportunity to present their opinions, or to seek alternatives.

6. Presentation of Academic Program. A prisoner's first impressions of a program often shapes his or her subsequent receptivity to and involvement in the program. Not all CDC institutions have written material available on their academic program. The materials available are often difficult to comprehend by the educationally handicapped, the ones most needful of the service, and they are usually in English only. Whether the program is presented verbally to inmates varies from institution to institution. Consultants think it essential to focus in on this initial stage in order to successfully "recruit" students. Aside from well-written, attractive, and easy-to-comprehend booklets on the academic program (presented in both Spanish and English), there should be a separate orientation around the academic program in which prisoners and staff should be encouraged to exchange ideas on educational techniques.

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*National Conference of Commissioners on Uniform State Laws, Uniform Corrections Act, Section 4-407 (September, 1977), p. 386.

C. COUNSELING SERVICES

Counseling services are treated as separate from the category of Psychiatric/Psychological Services by the CDC, and for this reason are addressed separately by Consultants (even though there is some overlap). Correctional counselors and program supervisors carry out a wide range of activities which effect the classification and treatment process of all prisoners. Typically, counselors spend approximately 50 percent of their time preparing reports; 20 percent of their time is devoted to classification activities and prisoner program development; 25 percent to individual interviews on matters of prisoner concern; and approximately 5 percent to clerking board hearings. Exceptions to these time estimates are those counselors assigned to specialized units (e.g., security and protective housing units), and to pre-release units.

There are approximately 300 authorized correctional counselor positions in the Department, and 350 correctional program supervisor positions. Caseload may vary from 16 to 20 for the program supervisors, to 35 to 150 for the counselors (except in specialized units where the caseloads may be smaller).*

Table 7 shows the correctional counselor (CC) and correctional program supervisor (CPS) positions available in the Governor's Approved Budget for 1977-78.

Table 8 illustrates the per capita cost of counseling services at each institution, based on the 1976-77 CDC operating budget. While the average cost per prisoner is $422.27, the cost ranges from a low of $149.73 at CMF to a high of $911.49 at CRC.

Department of Health Report

The Department of Health report presented two findings specifically related to the correctional counselor in its section on psychiatric/psychological services**:

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*CDC Program Planning Report, Vol. II, p. 45.

**Ibid., Vol. II, Appendix D, pp. 22-24.

TABLE 7

EXISTING POSITIONS

FACILITY	CC I	CC II	CC III	CPS I	CPS II	CPS III
CCC	0	4	1	66	27	15
SCC	2	4	1	64	25	15
SCC CAMPS	3	2	0	14	3	6
CCI	12	2	2	40	8	4
CTF, Central	10	4	1	36	7	5*
CTF, North	6	2	1	36	7	5
CTF, South	3	0	0	0	0	0
DVI	12	6	1	0	0	0
FOLSOM	14	3	1	0	0	0
CIM	9	3	3	32	13	8
CMF	1	12	2	38	4	0
CMC	8	11	2	30	4	2
SQ	19	7	1	0	0	0
CIW	9	2	1	18	1	0
CRC Men's	30	7	6	0	0	0
CRC Women's	6	4	1	3	0	0

*Since budget, unit has been moved to different facility.

TABLE 8

PER CAPITA COST OF COUNSELING SERVICES AT EACH INSTITUTION

BASED ON 1976-77 OPERATING EXPENSES

FACILITIES	COST OF COUNSELING SERVICES	AVERAGE DAILY POPULATION	PER CAPITA COST
San Quentin	$ 1,082,386	2,013	$ 537.70
Folsom	789,894	1,750	451.37
CIW	282,459	775	364.46
CIM	804,314	2,450	328.29
CTF	1,087,758	2,552	426.24
CMF	285,977	1,910	149.73
DVI	701,634	1,280	548.15
CCI	591,471	1,070	552.78
CMC	724,221	2,455	295.00
CRC	2,119,214	2,325	911.49
CCC	312,797	990	315.96
SCC	497,355	1,625	306.06

1. There is little training of prison guards or counselors in the early recognition of psychological disturbances.

2. Current duties of counselors are largely clerical; also, counselors for the most part are ex-guards, and tend to retain a custodial attitude. Inmates tend to avoid counselors, since they perceive them as custodial personnel.

CDC Program Concept

In their Program Planning Report,* CDC makes several comments concerning counseling services:

> 1. "Individual and group counseling should be available to inmates on a voluntary, not required, basis, and must be integrated into the total institutional program rather than conducted in a vacuum. We need a team approach to program planning, progress evaluation, and crisis prevention/intervention. Several years ago we introduced the Correctional Program Supervisor personnel structure to some of our institutions in an effort to combine the responsibility for custody and casework in one person with the objective of providing closer staff/inmate relationships. While this class has not fully achieved the objectives, nevertheless, we continue to believe the concept has merit. Such generalists require access to highly-skilled counseling specialists for team training, consultation, and casework quality control.
>
> 2. "One point on which line staff and inmates are in complete agreement is that we need to break down the barriers, physical and otherwise, which now separate staff and inmates in most of our institutions. We believe the correctional team approach offers the best potential of achieving this objective. Essential to success, though, will be smaller institutions permitting closer acquaintance between staff and inmates, and a much stronger role on the part of the line case manager in the decision-making process. The concept that the living unit supervisor who is also the inmate's caseworker will have a more meaningful relationship with the inmate, is still a valid one which deserves a proper opportunity for demonstration.

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*Ibid., pp. 147-148.

3. "Original architectural planning for existing institutions placed counselors in offices in the administration buildings, and not readily accessible to inmates. Subsequent realization that counselors should be located within the institution where inmates can easily contact them, especially as the number of segregated housing units increased, has led to some remodeling to provide offices in the living units. This important need must be accommodated in planning for new facilities and remodeling of existing ones.

4. "Departmental planning emphasizes the team concept for new facilities, with program supervisors doing the routine casework counseling, and Correctional Counselors doing training, auditing, and specialized counseling."

Response to CDC and Department of Health Reports

There are several important issues raised by the CDC and Department of Health reports which need to be addressed. They are as follows:

Scope and Quality of Services. The Department of Health report clearly describes the problems of correctional counselors -- their clerical duties, lack of training in counseling roles and techniques and their custodial attitude which stems from their background and past experience as guards. The problem with Correctional Program Supervisors (CPS) is even greater; they are supervised by the correctional counselor and they play an even more specific custody role, often while in uniform. Many administrative staff in the CDC system think the CPS designation should be abandoned. Others think correctional counselors are generally unqualified, often afraid of inmates, and have resisted training.

That CDC in their report can continue to think that the system "is still a valid one which deserves a proper opportunity for demonstration,"* that this correctional team approach offers the best potential of breaking down the barriers ("physical and otherwise") separating inmate and staff,** and that the essential ingredient to accomplishing this is "smaller institutions permitting closer acquaintance between staff and inmates, and a much stronger role on the part of the line case manager

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*The CDC Program Planning Report, Vol. II, p. 147.

**Ibid.

in the decision-making process,"* is again to assume that all problems disappear if new institutions are built. As long as the "counselors for the most part are ex-guards and tend to retain the custodial attitude which is seen as necessary for guards,"** their attitude and role will remain the same.

- Consultants agree with CDC's statement in their Program Planning report, and recommend that the decision to participate in the counseling program be made by the prisoners.

- Consultants recommend a careful review and subsequent modification of the job specifications for the Correctional Counselor (CC)*** to reflect the need for backgrounds in counseling or counseling-related activities and/or an aptitude for counseling. Consultants further recommend that a task analysis be accomplished for the CC position and training be developed based on this analysis. (One of the reasons CCs may resist training is that current training is not job-related.)**** If, for example, the task analysis identifies therapeutic counseling as a responsibility of the CC, training should be developed in various therapeutic approaches (such as family counseling). Such training should be provided by outside consultants skilled in those areas with some knowledge of the prison population. The CC's job should also be clarified in its relationship to prisoners, psychologists, and psychiatrists. Treatment for more serious mental illness should not be attempted by the CC unless accompanied by a psychologist or psychiatrist (or other mental health professionals such as an MSW). All programs for treatment of prisoners should be coordinated through a senior psychologist or psychiatrist, who should also provide intensive on-going supervision of correctional counselors.

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*Ibid.

**The CDC Program Planning Report, Vol. II; Appendix D, p. 24.

***The term "counseling" is used here in its clinical sense as differentiated from routine advice. See Manual of Standards for Adult Correctional Institutions, Standard 4439, pp. 83-94, for a discussion of "counseling" and a definition of the term. Also, see Corrections, Standard 11.9, p. 385.

****This type of analysis and training development is occurring in the law enforcement field. See for example, Project Star; and, Peace Officers Standards and Training for behavioral objectives training curricula.

- Consultants recommend that the position of CPS be re-examined. If the position is found warranted, it is important to clarify the role of the CPS vis-a-vis the CC. Specific job-related training should also be developed and implemented for this positions.

It is also suggested that ex-convicts not be excluded for consideration for the position of correctional counselor and that college students and paraprofessionals be used as "counselor-aids" (as in the model of probation and parole aids) to accomplish some of the many administrative tasks (e.g., letters from welfare and other governmental agencies, outstanding warrants on tickets, and notices to review file) which take the CCs energies away from actual counseling.*

Architectural Planning. Consultants agree with CDC's recommendation to place correctional counselors within the institution, where prisoners can have easy access to them. These spaces should be large enough to accommodate small groups and should have the necessary degree of privacy from other prisoners and staff. Consultants' renovation alternatives for housing units have included provisions for counselors' offices (See Volume V of Consultants' Final Report).

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*Manual of Standards for Adult Correctional Institutions, Standard 4441, p. 84.

D. SELF-HELP GROUPS

Self-help groups are operated primarily by the prisoners, and are frequently centered around ethnic and cultural interests. The groups meet in the evening or on weekends. Each proposed group is required to state its purposes, to establish by-laws and procedures for self-government, and to have an outside volunteer staff sponsor as a prerequisite to administration approval for operation. The sponsor acts as a liaison between the group members and the institutional staff in meeting the group's needs.*

Consultants conducted a survey at each of the CDC institutions to determine the various groups currently active, the average number of members, how often they meet, and their purposes. The results of this survey are contained in Consultants' Inventory Report on Institutional Programs, pages 23-37.

CDC Report

While CDC does not discuss self-help groups in its Program Concepts Section**, CDC does raise the following problems in regard to this activity in its Institutional Program Description section:***

> "Among program problems are the practical limits on the number and size of groups, preventing establishment of additional groups which might be beneficial to inmates and the institutional program. Groups require meeting places, space for records and paraphernalia, volunteer sponsors, and administrative resources for monitoring, all of which are limited. It is sometimes difficult to find volunteer staff sponsors for new groups or to replace retiring sponsors."

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*CDC Program Planning Report, Vol. II, p. 46.

**See CDC Program Planning Report, Vol. II, pp. 136-157. This is probably due to its omission from Item 410.1 of the 1977-78 Fiscal Year Governor's Budget for the Department of Corrections.

***Ibid., p. 46.

Response to CDC Report

Consultants address some of the problems raised by CDC, along with other problems observed in this program area:

1. Prisoner Access to Self-Help Groups. Attitudes and approaches to self-help groups vary considerably from one institution to another. This in part explains the wide range in groups currently available at each institution, as well as the number of inmates involved and how often the meetings take place.* While the variance in part relates to security concerns, it also has to do with the perceived value of the program. For example, although a common problem expressed is the difficulty in finding a volunteer sponsor, some sponsors are paid while others are not, and the pay per hour varies per institution. In almost all cases, the pay per hour is considerably less than that currently being earned by the sponsor on his regular institutional job. While most sponsors are at the correctional counselor level, CRC assigns a program administrator as the chief sponsor for certain self-help groups to demonstrate administrative support. While some sponsors must work overtime, others are assigned to a shift that allows them to participate within regular working hours. There should be a systematic approach to determining the personnel and financial requirements needed to support these inmate activities.** Consultants view self-help groups as important to both the morale of prisoners and to the improvement of prisoner/staff relationships.

Prisoners should be allowed to form organizations for any lawful purpose; such organizations should be entitled to reasonable use of institutional facilities and should have access (without charge) to available resources and materials. A refusal to permit such access, on the basis that the group's purpose is unlawful, should be subject to consideration by the Grievance Committee.***

2. Facilities. As mentioned in the CDC report, space for meetings is limited. For example, there is no group room in CCI's medium security facility. However, Consultants think the issue, more often than not, relates to priority and security concerns and is not strictly a facility issue.

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*See Consultants Inventory Report on Institutional Programs, pp. 23-37.

**Commission on Accreditation for Corrections, Manual of Standards for Adult Correctional Institutions, Standard 4428, p. 82.

***American Bar Association (Section on Criminal Justice, Tentative Draft of Standards Relating to the Legal Status of Criminal Justice; Vol. 14, No. 3, Standard 6.4, p. 514.

Community Involvement. As in the area of recreation (see Section E), there are many outside individuals or groups anxious to volunteer their services in connection with some useful group activity. Written policies and procedures must be developed that encourage rather than discourage their involvement. Such policies and procedures should permit prisoners to participate in activities in the community, provided the prisoners' custodial status allows them to leave the institution.*

*Manual of Standards for Adult Correctional Institutions, Standard 4429, p. 82.

E. LEISURE TIME ACTIVITIES

The following section treats recreation and visiting. Table 9 illustrates the per capita cost of leisure time activities at each institution, based on the 1976-77 CDC operating budget. While the average cost per prisoner is $44.06, costs range from a low of $20.94 at Folsom to a high of $65.96 at DVI.

RECREATION

Responsibility for the indoor and outdoor athletic program, including participatory and spectator experiences, rests with the instructor in physical education at each CDC facility. The recreation program varies according to the types of prisoners and the security classification of the institution. Sports common to most institutions are baseball, softball, boxing, track, basketball, weight lifting, table tennis, handball, tennis, volleyball, horseshoes, and football. There are also social games such as checkers, dominoes, and certain card games.

Library facilities are available at all institutions. General entertainment activities are scheduled for all institutions.*

CDC Program Concept

In their Program Planning Report,** CDC outlines certain needs pertaining to recreation:

1. The need to continue to provide a variety of options for constructive use of leisure time, including games, sports, physical recreation, and wholesome entertainment and cultural activities.

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*CDC Program Planning Report, Vol. II, p. 47.

**Ibid., p. 150.

TABLE 9

PER CAPITA COST OF LEISURE TIME ACTIVITIES AT EACH INSTITUTION

BASED ON 1976-77 OPERATING EXPENSES

FACILITIES	COST OF LEISURE TIME ACTIVITIES	AVERAGE DAILY POPULATION	PER CAPITA COST
San Quentin	$ 71,165	2,013	$ 35.35
Folsom	36,638	1,750	20.94
CIW	30,223	775	39.00
CIM	138,063	2,450	56.35
CTF	76,925	2,552	30.14
CMF	115,482	1,910	60.46
DVI	84,428	1,280	65.96
CCI	39,305	1,070	36.73
CMC	83,870	2,455	34.16
CRC	77,388	2,325	33.29
CCC	63,724	990	64.37
SCC	84,378	1,625	51.92

2. The need to anticipate more active community involvement.

3. A proposed physical plant which would provide centralized indoor and outdoor recreation and visiting; also, facilities in and adjacent to the living units so that prisoners who are in closed units or do not wish to participate in the centralized activities will have access to adequate facilities.

Response to CDC Report

Several recreation issues that need to be addressed are as follows:

Quality and Scope of Recreational Programs and Facilities

- There were serious problems observed by Consultants as to the condition of recreation facilities at different institutions, particularly outside facilities. For example, at Vacaville, tennis courts needed repaving, and handball courts needed resurfacing. Outdoor tracks need paving to be useful during the rainy season. While gymnasiums on the whole appeared adequate, there is the obvious problem of Folsom Prison having no gym. Facilities and equipment must be maintained in good condition suitable for planned recreational activities.

- As suggested by CDC, more active community involvement needs to be encouraged. Such interaction should include bringing in volunteers to provide instruction, inviting local teams to compete with institutional teams, and where possible, taking inmates into the community for recreational activities. While there is some interaction now, it is quite limited. Institutional restrictions in policy and practice which bar use of community recreation resources should be relaxed to the maximum extent possible.*

- There should be more prisoner involvement in planning and organizing recreation programs. Selected prisoners should

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*National Advisory Commission on Criminal Justice Standards and Goals, Corrections, Standard 11.8, p. 383.

be used as assistant coaches, administrative clerks, equipment clerks, and as officials in games and contests held on institutional grounds.* Inmates should also be involved in an ongoing assessment process.**

- While some institutions provide a diversity of recreational programs, others are quite limited. Along with athletics, programs should include music, painting, writing, drama and handicrafts. Programs such as music, hobbies, and art, which appear quite popular to prisoners, need not be developed in great depth, but should be made available to everyone.

Inmate Access to Recreational Programming

- Consultants observed that even where adequate facilities existed, there was limited access of prisoners to those facilities, due largely to administrative problems. Some obvious problems of access stem from security classification and segregated housing, but the most wide-spread access problems pertain directly to the mainstream population. For example, San Quentin has no night gym, and has had none since late 1973 (due to shortage of supervisory staff). Tennis courts at San Quentin were only available for use on weekends and holidays, again due to staffing problems. At CMF, the gymnasium is closed during the summer because the only officer assigned to recreation is working outdoors. There needs to be a systematic approach to determine the personnel requirements for recreation programs to ensure prisoners access to staff and services.***

- Staff shifts should be determined not by the normal nine-to-five criteria of the free community, but by the ability of prisoners to participate in programs. For example, prisoners assigned to jobs during the normal work day should have access to these programs during their free time. This necessitates a creative approach in planning staff shifts.

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*Manual of Standards for Adult Correctional Institutions, Standard 4422, p. 81.

**Ibid., Standard 4426, p. 81.

***Ibid., Standard 4425, p. 81.

Criteria for Use of Outside Entertainment Groups

- Discussions with recreation staff at CDC institutions and with Inmate Activity Coordinators demonstrated that there are an unlimited number of excellent outside entertainment groups available and interested in providing free entertainment to CDC institutions. They are not being used because of a shortage of supervisory staff (volunteer sponsors) to handle the security precautions seen as necessary by the administration. Some steps should be taken (see page 55) to either loosen these restrictions or to provide the necessary staff to allow prisoners access to this free and valuable resource.

VISITING

A 1972 CDC publication on prisoner/family relationships concluded:

> "The central finding of this research is the strong and consistent positive relationship that exists between parole success and maintaining strong family ties while in prison."* (Emphasis added.)

Observers in corrections and related fields throughout the country have long noted the positive relationship between strong family and community ties and a prisoner's successful re-entry into the community. Institutional visiting programs are a key element to sustaining these ties, while simultaneously enabling prisoners to strengthen their skills in relating to others and to community norms. Visiting programs provide normalizing experiences, which serve to diminish the negative effects of institutionalization.

A variety of visiting programs and opportunities, aimed at increasing the frequency and quality of visits and contacts for prisoners, are therefore vital elements of any state prison system because such programs link the prisoner to the community.

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*Norm Holt and Donald Miller, Explorations in Inmate-Family Relationships (Research Division: California Department of Corrections, January, 1972), p. v.

For years, California prisons have been innovative in the area of inmate visiting. In the CDC plan, it was proposed that new facilities include a physical plant for centralized indoor and outdoor visiting areas to be located adjacent to housing units; also, integral to the institutional design would be family visiting units.

However, nothing was stated regarding the need to develop new or expanded visiting programs within existing institutions. Given the benefits and relatively low operational costs of visiting programs, it is important to consider expanding and diversifying them.

The following section develops recommendations for implementing innovations in the visiting program. These recommendations are intended to be implemented system-wide. The programs should be made available to both male and female prisoners, regardless of sentence or offense (except in the case of furloughs, where offense and past behavior would be considered).

An obvious correlation exists between location of facilities and ease of visiting. Although Consultants are recommending a comprehensive array of visiting programs, including transportation services, such recommendations are not intended to diminish the CDC's commitment to housing prisoners as near to their family and community as possible. Any visiting program will increase in value (due to frequency and ease of visiting) and diminish in costs (e.g., transportation) as prisoners are located nearer family and friends.

Recommendations

The following five recommendations are listed in order of priority, according to Consultants' estimation of the most outstanding system-wide needs. Note, however, that while the first recommendation requires funding for implementation, the second recommendation is essentially a policy issue, and would require little funding.

1. Escort Service for Children. Currently, children under 18 years of age wishing to visit their parents must be accompanied to the facility by a responsible adult. This requirement often presents hardships for those children living with foster parents or relatives who do not want to accompany the child, for whatever reason.

- Consultants recommend establishing an escort service to transport children to the facilities.* Volunteers should be reimbursed for travel expenses and meals; if the distance is far and necessitates an overnight stay, they should also be reimbursed for motel or hotel expenses.

There are a number of volunteer community agencies with established "track records" in assisting prisoners, most notably Friends Outside, and M-2 Sponsors. The CDC should contract with such an agency to provide staff members who would be responsible for recruiting and coordinating volunteers for the escort service, in response to prisoner requests. (One staff member should be attached to each institution unless the institutions are geographically close; for example, CIM and CIW, in which case one staff member could cover all the institutions.) The contracted agency should be allocated funds for reimbursing expenses incurred through the escort service.

In order to accommodate the visiting of children who live great distances from the facility, the staff member should establish contact points with various agencies and service organizations around the state (e.g., family services agencies, churches, and staff members at other institutions) to recruit volunteers in the child's community to transport them to the point of transit (e.g., airport, bus station). Another volunteer located near the facility could then pick up and transport the child to the facility. Parents (not the volunteers or the institution) would assume complete responsibility for the child visiting under the escort service.

2. Furlough Program. Furloughs, or temporary releases, serve a number of purposes, including:

a. maintenance of family and community ties;

b. preparation towards "reintegration" into the community; and

c. normalization experience providing a break in the possible "institutionalization" of prisoners' behavior.

Massachusetts administers a furlough program, in which all prisoners have the right to apply for regular furloughs (e.g., to visit family or friends,

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*The total estimated annual cost of this service is $101,750. See Appendix A for cost analysis.

or to look for a job). Attention is paid, however, to the nature of prisoners' crime and length of his or her sentence, but the granting of furloughs is not tied to time of release or to custody classification. All furlough requests go through an approval process. Prisoners are allowed up to fourteen 24-hour period passes per year. They must arrange their own transportation; however, there is a furlough fund from which prisoners can borrow for travel. This money must be paid back, and credit cannot exceed a certain amount.

- Consultants recommend establishing a furlough program in the California corrections system.

The following features, drawn in part from the Massachusetts program, should serve as guidelines for such a program:

a. Each prisoner should undergo a specified waiting period before being granted the first furlough. This allows the prisoner an initial adjustment period, and provides staff with a working knowledge of the individual.

b. After passing the waiting period, any prisoner should be able to apply for a furlough. A furlough committee should screen applications according to certain specified considerations, such as nature of offense and past behavior (e.g., has the person been convicted of a heinous crime that would arouse public anxieties?) and potential benefits of the furlough (will the furlough fulfill a useful purpose, such as family visiting or applying for a job?). Upon the committee's recommendation, the request should be forwarded to the Superintendent for final approval. In consideration of furlough applications, the committee should specify in writing the reasons for any denial.

c. Inmates should be eligible for up to a specified number of furloughs per year.

d. Institutions should have the option of placing specific requirements on furloughs (e.g., urinanalysis and phone checks).

e. Prisoners should be able to borrow from a furlough/visiting fund, if necessary, for transportation expenses; the amount borrowed should be paid back within a specified time period.*

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*Prisoners' ability to finance transportation would be enhanced if Consultants' recommendation to increase wages was adopted. (See Volume IV of Consultants' Final Report.)

3. Expanded Institutional Visiting Programs.

- Visiting hours and days vary among institutions. Contact visiting should be extended system-wide to seven days a week, and should include weekday evening hours. Evening hours are particularly conducive for non-family visitors such as M-2 sponsors.

Currently, the Department sets no limitation on the number of visitors which may be approved for visiting, or the frequency of visits allowed. However, each institution has the option of placing certain restrictions on visiting due to space considerations. At least one institution restricts the number of visits per approved visitor to twice monthly (except for children under 18, who may visit as frequently as space permits). Consultants are aware that it is necessary for prison administrators to place a ceiling on the number of persons visiting an institution daily; however, specific restrictions on the number of visits a prisoner can receive per person do not appear necessary. Instead, prisoners should set priorities for visitors matched against the number of visits allowed per month. This would allow prisoners to visit with close family members or friends more frequently.

Certain institutions have ample indoor and outdoor visiting space, while others clearly do not. Suffucient indoor and outdoor space should be available at all institutions, with appropriate space and activities for children. (See Volume IV of Consultants' Final Report.)

If no other means is available for a potential visitor to travel to an institution, the prisoner should be allowed to borrow from the furlough/visiting fund to pay for transportation expenses. Prisoners should be required to repay the amount borrowed with a specified period of time. (See footnote on page 59.)

4. Family/Friend Days. Certain institutions sponsor a variety of special events, such as family days, kid days, and "sweetheart" days, whereby visitors and prisoners are permitted to mingle on the grounds of the facility, in the auditorium, and day rooms; others do not, presumably for security concerns. Consultants recommend, however, that all institutions host these special events. If these events are jointly planned by staff and prisoners, they will possibly lead to better overall morale within the institutions, with parallel benefits in the security area. The underlying assumption behind the potential success of such events is that prisoners will police those activities which are most highly valued.

5. Expanded Family Visiting Program. Presently, all institutions have one or more trailers for family visiting, but there are not enough units to accommodate one family visit per year for the approximate eligible prisoner population. This finding is based on a useage estimate of two visits per week per unit (104 per year), multiplied by the combined number of family visiting units available or under construction at this time. (Table 10 is a summary of family visiting procedures at each institution, including total visits available, and availability by security classification; hours per visit; average wait for visit; capacity per unit; and, facility population eligible.)

In order to accommodate at least one family visit per eligible prisoner per year, approximately 67 additional trailers would be required.

- Consultants recommend that each institution be provided the additional units to accomplish this objective, so that the benefits of family visiting will be extended to all eligible prisoners.*

Consultants also suggest that the scope and purpose of family visiting be expanded. No person should be denied family visiting based on custody classification or escape hazard, since family visiting usually occurs within an armed perimeter.

The definition of family should be broadened to include common law partners and close personal friends. Prisoners who do not have a family, or who are out of contact with family members for whatever reason, should be able to receive private visits from close friends.

Additionally, a prisoner should be able to spend time alone in the unit if he or she desires. In other words, the purpose of the family visiting program should be to provide privacy and a break from institutional routine, whether the break is with family, friends, or by oneself.

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*Based on a cost of $7,000 for a new one-bedroom trailer, the total cost for trailers would be $469,000. This is based on current population figures. Note, also, that since trailers' life-expectancy is twenty years, the annual cost for this program would only be $23,450 (for the current population) not including finance costs. Consultants have approximated the cost of expanding this program based on the cost of a one-bedroom trailer (larger trailers or visiting apartments may be needed).

TABLE 10

FAMILY VISITING

FACILITY	Total Units Available	Maximum Security	Close Security	Medium Security	Minimum Security	Protective Custody
CCC	4			2	2	
CIM*	5			1	4	
CMF	7			6	1	
CMC**	11			7	4	
DVI	6			4	1	1
SCC***	4			3	1	
CRC****	1				1	
CIW	4		3 (shared)	3 (shared)	1	
CTF	13			8	4	1
CCI	7			4	3	
Folsom	3		1 (shared)	1 (shared)	1 (shared)	2
San Quentin *****	8				7	1

*CIM: Inmates in processing centers and in protective custody are not eligible for family visits (1,900 inmates).

**CMC: Two new trailers awaiting hook-up (for medium and minimum custody classifications).

***SCC: Two additional minimum custody units were available May 1, 1978.

****CRC: Civil commitments are not eligible for family visits.

*****San Quentin: Two additional maximum custody units are now under construction.

(continued)

TABLE 10
FAMILY VISITING

FACILITY	Hours Per Visit	Average Wait for Visit	Capacity Per Unit	Approximate Eligible Population	Total Facility Population
CCC	72	30 - 45 days	6	700	1,224
CIM*	44	85 days	4	1,120	2,681
CMF	43	50 - 70 days	4	1,100	1,959
CMC**	44	90 days	9: 4 2: 10-12	2,400	2,694
DVI	48	120 days	5	general: 900 protective: 150	1,523
SCC***	67	45 - 60 days	6	1,200	2,084
CRC****	Week/72 W-end/48	21 - 45 days	6	60	2,163
CIW	69	90 days	4-5	930	930
CTF	44 Prot. Cust./6	35 - 90 days	2-6	2,000	3,041
CCI	Med/44 Min/48	54 - 70 days 83 days	2-7	650 500	1,177
Folsom	48	75 - 150 days	4	1,400	1,535
San Quentin *****	42	21 - 90 days	4	1,694	2,193

Consultants believe that every prisoner can benefit from at least one of the above-recommended visiting programs. With the additional effect such programs will have on family relationships (e.g., with spouse, children, or common law partner), Consultants suggest that counseling opportunities to explore developments in these relationships and provide "carry-overs" from visiting experiences be developed.

The services of a family therapist or counselor should also be used in special settings, whereby the prisoner and family member(s) participate together in a therapy session. This would be particularly useful to the prisoner who is nearing release.

F. RELIGION

Presently, Catholic and Protestant chaplains are employed full-time and Jewish chaplains are employed part-time as staff at CDC institutions to provide religious services for prisoners.* In addition, ministers and lay persons representing numerous denominations from local communities conduct religious classes, discussions, and worship services for prisoners. Representatives from a wide range of religions, faiths, and groups are active within the institutions (e.g., Black Muslim, Mormon, Yoga, Spanish Evangelist, American Friends Visiting Services, Hindu, Pentecostal, Christian Science, Metro Church group, Salvation Army, Scientology, Jehovah's Witnesses, Meditation groups, Yoke Fellows, Holy Name Society, and Beth Takua). The Protestant chaplain in most instances coordinates the activities of the aforementioned faiths and groups in the institutions.

The per capita cost of religious programming at each institution (based on the 1976-77 CDC operating budget) ranges from a low of $39.62 at CRC to a high of $63.93 at CIW. (See Table 11.) The total budget allocation for religion is $784,775, and is the lowest of all programs in the treatment area. (See Table 12.)

Statistical data gathered from CDC and interviews with chaplains indicate that chaplains:

1. Interview and counsel at least 70 prisoners per week;
2. Supervise 5 to 15 visiting chaplains per week;

*CDC Program Planning Report, Vol. II, p. 50.

TABLE 11

PER CAPITA COST OF RELIGIOUS PROGRAMMING

AT EACH INSTITUTION BASED ON 1976-77 OPERATING EXPENSES

FACILITIES	COST OF RELIGIOUS PROGRAMMING	AVERAGE DAILY POPULATION	PER CAPITA COST
San Quentin	$ 78,972	2,013	$39.23
Folsom	52,760	1,750	30.15
CIW	49,542	775	63.93
CIM	124,804	2,450	50.94
CTF	98,192	2,552	38.48
CMF	53,088	1,910	27.79
DVI	56,372	1,280	44.04
CCI	48,192	1,070	45.04
CMC	57,111	2,455	23.26
CRC	49,109	2,325	21.12
CCC	49,852	990	50.36
SCC	66,781	1,625	41.10

TABLE 12

OPERATING EXPENSES, TREATMENT 1976-77

FACILITIES	PSYCH. SERVICES	COUNSELING SERVICES	ACADEMIC EDUCATION	VOCATIONAL EDUCATION	LEISURE TIME ACTIVITIES	RELIGION	TOTAL
San Quentin	$ 480,744	$ 1,082,386	$ 481,182	$ 489,452	$ 71,165	$ 78,972	$ 2,663,901
Folsom	191,757	789,894	268,177	266,594	36,638	52,760	1,605,820
CIW	375,109	282,459	207,537	219,585	30,223	49,542	1,164,457
CIM	33,241	804,314	187,169	455,387	138,063	124,804	1,742,978
CTF	58,315	1,087,758	690,925	528,693	76,925	98,192	2,540,808
CMF	1,597,397	285,977	219,810	114,005	115,482	53,088	2,385,759
DVI	82,567	701,634	459,423	610,605	84,428	56,372,	2,025,029

TABLE 12
OPERATING EXPENSES, TREATMENT 1976-77
(cont'd)

FACILITIES	PSYCH. SERVICES	COUNSELING SERVICES	ACADEMIC EDUCATION	VOCATIONAL EDUCATION	LEISURE TIME ACTIVITIES	RELIGION	TOTAL
CCI	24,770	541,471	302,822	529,379	39,305	48,192	1,535,939
CMC	1,800,844	724,221	525,309	466,475	83,870	57,111	3,657,830
CDC	176,951	2,119,214	445,398	374,960	77,388	49,109	3,243,020
CCC	82,003	312,797	342,232	773,528	63,724	49,852	1,624,136
SCC	1,765	497,355	198,020	261,376	84,378	66,781	1,109,675

3. Supervise and teach 10 to 25 religious groups per week, averaging 5 to 20 prisoners;

4. Perform 2 to 5 religious services per week, averaging 55 to 60 prisoners;

5. Perform about 40 sacramental acts per week;

6. Coordinate religious activities;

7. Visit hospitals, locked wings, and visiting areas (not included in the 70 interviews);

8. Do family counseling;

9. Attend staff meetings; and

10. Run prisoner volunteer programs helping other prisoners.

The above data indicates that religious programs reach 1,000 prisoners each month per institution. They indirectly reach many more prisoners. When compared to the other programs (in terms of cost of service and service provided), the religious program is an outstanding investment.

CDC Program Concept

In their Program Planning Report,* CDC proposes to continue encouraging prisoner participation in religious activities, but states that the growing number of recognized denominations and the subsequent demands for equal shares of budgeted resources and space necessitates a new two-fold program approach, including:

1. The provision of a multipurpose space for religious services and activities rather than multiple single-purpose, single-faith chapels.

2. The establishment of a coordinator of religious activities to be provided in lieu of permanent civil service chaplains serving only specific faiths. The coordinator will assist inmates in meeting their religious needs by providing community resources on either a volunteer or contractual basis.

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*Ibid., p. 150.

CDC concludes its proposal with the statement that "this approach does not represent a lower level of religious programming. Instead, it will enable flexibility and equality in meeting the various spiritual needs of inmates."*

Response to CDC Concepts

Single Purpose Structure. Using a single, all-purpose building to provide separate services areas for religious groups (e.g., library space, meeting rooms, and chapel areas) is now an accepted practice. It has worked well in the military, colleges, and in hospitals. The days of rigid chapels with bolted down pews and altar are part of a luxurious past. Flexible units, with movable walls for use in religious programming, are most practical. Such a facility allows enough space for Sunday services and offices, but can also be adjusted for week-time and evening use, allowing several different religious groups to meet at the same time.

- However, it must be noted at this point in the discussion that Consultants argue strongly against the building of any additional CDC facilities now. If, however, facilities are required in the future, a single all-purpose building should be designated for religious purposes only.

The unit should be adequate for both worship and small group meetings. Its flexibility should reflect a needed variety in religious programming, while the unit's designation for religious activities would symbolize the necessary degree of dignity and permanence. The religious community using this building should be given primary consideration in its design.

The issue of whether to designate such a facility for religious use only is not addressed in the CDC Report. The two full-time chaplains at CIW, for instance, have had to program activities without chapels (which are part of the physical plants in other CDC institutions).

At CIW, where the main campus houses 600 residents, the facility designated for religious use is tentative depending on the other needs of the institution. For instance, in January of 1973 when the women from

*Ibid.

CRC were moved to CIW, the chaplains and religious programming were removed from the designated building to accommodate CRC. The chaplain's offices and services were relocated in the Education Building. Months later, when the CRC residents were transferred to Norco, the chaplains were moved back to the building where they were previously located. This building, called CORAL (Center of Religion and Life), is designated for religious activities; it adequately meets the needs for office space and small gatherings. Mass is held in the Auditorium/Gymnasium. During any given week, there are religious activities meeting in several other areas of the institution, because of the limitations of the CORAL. Sunday services have been moved to five different locations during the past 13 years.

The chaplains at CIW consider the inadequate and tentative nature of the CORAL detrimental to religious programming. The chaplains told Consultants that residents interpret these inadequate facilities to mean that their religious needs are not important enough to CDC to merit a unit which will allow dignity, comfort, and a degree of permanence. Residents interviewed at CIW agree with this assessment. An adequate facility, designed solely for religious purposes, would solve most of their problems.

Consultants agree that if such a building is not permanently designated as a religious structure, it will probably be used at some point for utilitarian purposes, which inevitably will in some way demean religious atmosphere, symbols and worship.

Religious Coordinator. CDC recommends that a "religious coordinator" be used in place of a chaplain to assist inmates in meeting their religious needs through community resources. The religious needs of the inmate population are diverse, and the chaplains have recognized that they cannot adequately meet the variety of religious needs without the assistance of outside resources. The role of the prison chaplain has evolved over the years from someone who cares for an isolated population in an institution, to someone who coordinates community resources to be brought into the institution.

The chaplains' role has not been limited to serving only specific faiths, but has encompassed all faiths described thus far. Therefore, the issue seems not so much one of a lack of coordination or use of community resources, but a question of whether this task is best handled by a chaplain or non-chaplain "religious coordinator."

- Consultants recommend continued use of the chaplain for the following reasons:

a. The concept of "religious coordinator" appears managerial. It does not reflect theological, pastoral, or sacramental concepts; neither does it take into account the identity of religious vocation. It does not reflect the specialized nature of ministry called for by the specific needs of the population housed in the institutions. It implies that any administrator understands the religious needs of prisoners, and that any religious person in the community is capable of meeting these needs.

b. There are inmates who do not identify with any religious group, but do identify with the chaplain and general religious program. They come to the chaplain because they relate more strongly to his pastoral identity than to his faith group or administrative identity.

c. The more untrained the coordinator is, the more danger there will be that he or she will act out of ignorance or prejudice in a manner to comply with institutional expedience, neglecting the prisoners' religious needs. A lay person would have less expertise in distinguishing between religious groups, their legitimate requests, their prejudicial requests, and their infringement on other religious groups. Such a coordinator would have difficulty determining when a group is serving the inmates or using the inmates, and the institution, for their own ends.

d. There is a need for a person to whom the prisoner population can look as their "chaplain." Persons from the outside community fulfill an important aspect of religious programming, but they are not involved with the whole milieu unique in each institution.

e. A lay person is more likely to be looked upon with suspicion by the free community, the religious community, and the prisoners.

f. The concept of religious coordinator does not ensure religious rights. Each person has beliefs and prejudices about religion which affect how they handle religious groups and their needs. However, a person grounded in religious ethics is more likely to have this awareness.

While recommending the continued use of the chaplain as coordinator of religious programs, Consultants also think there are problems in the present system that need to be addressed:

a. The most difficult issue arising in protecting religious freedom is the definition of what a religion is. Courts have struggled with this definition without satisfactory resolution. Often the burden of dealing with this issue initially has been placed on the shoulders of the chaplain, with no clear guidelines from CDC, which puts the chaplain in the difficult position of either appearing prejudicial or showing favoritism. While the ultimate determination in any given situation must be made by the courts, the National Advisory Commission on Criminal Justice Standards and Goals* has made an attempt to separate sham from "true" religious groups. The standard attempts to list some indicators of religious base and others that should not be considered relevant. The standard also recommends that, where difficult questions arise, correctional agencies should authorize the prisoner involved to present evidence regarding the religious instruction of the practice asserted. However, Standard 2.15** recognizes that prisoners have a right to express themselves and to retain their identity as individuals. This indicates that CDC should grant broad leeway toward practices involving merely the expression of individuality, whether or not based on religious belief. (See Self-help Groups, Section D.)

- It also seems desirable that CDC, in accordance with NAC Standards and in consultation with chaplains, and prisoner and community representatives, develop and implement policies and procedures that will fulfill the right of prisoners to exercise their own religious beliefs.

b. There can be better use of existing chapels or religious facilities. Part-time use in some CDC institutions is not caused by lack of need but by a lack of enough chaplains or free persons to supervise activities. This is the same problem discussed in Section D: that of locating a sponsor. To encourage and facilitate inmate participation in religious activities, and to recognize the growing number of denominations and demands for equal shares of budgeted resources, it is recommended that:

- CDC provide paid employees to supervise religious activities in the chapels and religious facilities during hours when chaplains are not available and a legitimate need exists.

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*National Advisory Commission on Criminal Justice Standards and Goals, Standard 2.16, p. 63.

**Ibid., p. 58.

c. There needs to be some re-examination of the chaplains' specifications. For example, two years of parish experience may be inadequate preparation for becoming a prison chaplain. It is recommended that:

- CDC, in consultation with the chaplains, and prisoner and community representatives, develop chaplains' specifications that ensure a high quality of professional care and ministry to the inmates' religious needs.

Since the chaplainship is presently without minority representation, it is recommended that:

- CDC take immediate, affirmative action to recruit and employ minority group individuals (e.g., Black, Chicano, Native American) for the position of chaplain.

In summary, as to CDC's concept of "religious coordinator," Consultants favor a "Chaplain Coordinator" or "Chaplain Supervisor and Coordinator of Religious Programs." The coordinator should be an ordained clergyperson, trained and certified in the art of supervision. Such a chaplain would have the theological background to understand and work not only with the prison population, but also with various outside religious groups. He or she would be a competent and sensitive supervisor of outside clergy and religious leaders, and would promote harmony and good working relationships. This chaplain supervisor should likewise be qualified to offer accredited training programs for students and clergy working with prisoners.

SUMMARY OF PROGRAMS

The Department of Corrections has included psychiatric services, counseling services, academic education, vocational education, leisure time activities, and religion under a budget category called "Treatment."

Table 12 (see Section F) summarizes the operating expenses at each institution for treatment as defined and set out in the 1976-77 CDC operating budget. While the total expenses average $2,108,279, they range from a low of $1,109,675 at SCC to a high of $3,657,380 at CMC.

Allocating a per capita cost for each of the treatment services at each institution, one can derive a total treatment per capita cost for each institution. The summary of this data is presented in Table 13.

Last, the per capita cost of treatment programs for each institution can be compared with the per capita cost of the total operating expenses at each institution to determine the percent of the per capita cost of operating expenses expended on treatment (see Table 14). It is most interesting to note that the treatment per capita cost averages approximately 14.3 percent of the total per capita cost and ranges from a low of 8.0 percent at CIM and 8.6 percent at SCC to a high of 21.7 percent at CMC. As can be expected, security is the largest operating expense in the budget.

The constant tension in every area of programming caused by security classification concerns is one that cannot be over-emphasized. It limits contact with the outside world that is necessary for the inmate to make a successful adjustment to society upon leaving prison. On the one hand, it prevents the inmate from leaving the institution to work, attend school, or to receive counseling services in the community. On the other hand, it restricts outsiders from coming in, thus limiting family and other visits, and minimizing outside sponsors for self-help groups and entertainment.

It is interesting to note that the CDC, setting forth the specific principles central to charting future direction, states that:

> "Use of community resources, both paid and volunteer, provides more flexible and adaptive institutional programs."*

*CDC Program Planning Report, Vol. II, p. 122.

TABLE 13

SUMMARY OF PER CAPITA COSTS OF ALL "TREATMENT" SERVICES AT EACH INSTITUTION

BASED ON 1976-77 OPERATING EXPENSES

FACILITIES	PSYCH. SERVICES	COUNSELING SERVICES	ACADEMIC EDUC.	VOCATIONAL EDUC.	LEISURE TIME ACTIVITIES	RELIGION	TOTAL PER CAPITA
San Quentin	$238.82	$537.70	$239.04	$233.21	$35.35	$39.23	$1,323.35
Folsom	109.58	451.37	153.24	152.34	20.94	30.15	917.62
CIW	484.01	364.46	267.79	283.33	39.00	63.93	1,502.52
CIM	13.57	328.29	76.40	185.87	56.35	50.94	711.42
CTF	22.85	426.24	270.74	207.17	30.14	38.48	995.62
CMF	836.33	149.73	115.08	59.59	60.46	27.79	1,249.08
DVI	64.50	548.15	382.36	477.04	65.96	44.04	1,582.05
CCI	23.15	552.78	283.01	494.76	36.73	45.04	1,435.47
CMC	733.54	295.00	213.98	190.01	34.16	23.26	1,489.95

CONTINUED

1 OF 2

TABLE 13
SUMMARY OF PER CAPITA COSTS OF ALL "TREATMENT" SERVICES AT EACH INSTITUTION
BASED ON 1976-77 OPERATING EXPENSES
(cont'd)

FACILITIES	PSYCH. SERVICES	COUNSELING SERVICES	ACADEMIC EDUCATION	VOCATIONAL EDUCATION	LEISURE TIME ACTIVITIES	RELIGION	TOTAL PER CAPITA
CRC	$76.11	$911.49	$191.57	$161.27	$33.29	$21.12	$1,394.85
CCC	82.83	315.96	345.69	781.34	64.37	50.36	1,640.55
SCC	1.09	306.06	121.86	160.85	51.92	41.10	682.88

TABLE 14

PER CAPITA COST OF TREATMENT PROGRAMS AS COMPARED TO PER CAPITA COST OF TOTAL OPERATING EXPENSES AT EACH INSTITUTION BASED ON 1976-77 OPERATING BUDGET

FACILITIES	COST OF TREATMENT PROGRAMS	AVERAGE DAILY POPULATION	PER CAPITA COST TREATMENT PROGRAMS	TOTAL COST OPERATING EXPENSES*	PER CAPITA COST OPERATING EXPENSES	PERCENT PER CAPITA COST OPERATING EXPENSES SPENT ON TREATMENT
San Quentin	$ 2,663,901	2,013	$ 1,323.35	$ 19,989,384	$ 9,930.15	13.3
Folsom	1,605,820	1,750	917.61	13,374,062	7,642.32	12.0
CIW	1,164,457	775	1,502.53	8,472,839	10,932.69	13.7
CIM	1,742,978	2,450	711.42	21,920,045	8,946.96	8.0
CTF	2,540,808	2,552	995.61	20,577,743	8,063.38	12.3
CMF	2,385,759	1,910	1,249.08	17,152,835	8,980.54	13.9
CVI	2,025,029	1,280	1,582.05	12,771,206	9,977.50	15.9
CCI	1,535,939	1,070	1,435.46	9,995,318	9,341.42	15.4
CMC	3,657,830	2,455	1,489.95	16,817,665	6,850.37	21.7
CRC	3,243,020	2,325	1,394.85	16,918,284	7,276.68	19.2
CCC	1,624,136	990	1,640.54	9,565,207	9,661.83	17.0
SCC	1,109,675	1,625	682.88	12,896,624	7,936.38	8.6

*Operating expenses include cost of security, inmate support (feeding, clothing, medical-dental services, housekeeping and facilities operations), treatment, administration, and inmate employment less reimbursements.

However, on the other hand, CDC recognizes that:

> "Some inmates may be unable to function effectively in nontraditional prison environments and will require the level of controls now available in existing institutions."*

Consultants argue for a drastic shift away from "the level of controls now available in existing institutions" and toward the use of community resources to provide more flexible and adaptive institutional programs.

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*Ibid.

G. PRISONERS WITH DISABILITIES

INTRODUCTION

Consultants have explored the needs of prisoners with serious physical disabilities* and specific learning disabilities (e.g., dyslexia, aphasia) because they constitute a definable pocket of California prisoners who have a minimal chance of successfully adjusting to their eventual release unless they develop basic survival skills.** These individuals, because of their handicapping conditions, require extra attention to prevent their further deterioration and to adequately prepare them for independent living. Without access to special activity or program opportunities while in prison, they may either revert to criminal activity or become institutionalized in state hospitals upon release. Both outcomes are costly to the State.

Presently, physically disabled prisoners are, for the most part, congregated at CMF and CIM and sequestered from mainline operations. They are confronted with a dearth of specialized or adapted programs and activities. Prisoners with specific learning disabilities are located throughout the various institutions and are integrated into the mainline population; they do not have access to specialized programs.

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*In the California prisons, there are prisoners with a number of serious physically disabling conditions, including absence or amputation of limbs, chronic kidney failure, multiple sclerosis, spinal cord injuries, and visual and hearing impairments.

**There is also a small number of mentally retarded prisoners throughout the prison system who receive no special treatment or attention. (One prison official estimated that there were approximately 130 mentally retarded prisoners.) Consultants have placed priority on the other two disabilities, which include more prisoners. However, Consultants suggest it may be possible to transport some of the mentally retarded prisoners to a sheltered employment workshop in the community, which would prepare them for successful independent or semi-independent living upon release. The full cost per client at the present time totals $300 per month in a community workshop, with an average participation rate of five to six hours per day. CDC per capita budget allocations for vocational training (1977-78) averages $216 per student.

It is of interest to note that the California Legislature has recently expressed explicit concern for the rights of physically and mentally disabled persons in general through the enactment of AB 803, which states that:

> "No person in the State of California shall, on the basis of . . . physical or mental disability, be unlawfully denied the benefits of, or be unlawfully subjected to discrimination under, any program or activity that is funded by the State or receives any financial assistance from the State."

ESTIMATING THE TARGET POPULATION

Consultants have attempted to determine the approximate number of prisoners with physical and learning disabilities in the California prison system. Based on interviews with prison officials, it appears that there is an estimated 160 seriously physically disabled male prisoners in the total population, including approximately 120 geriatric cases who suffer from a range of physical and mental disabilities. Consultants were unable to obtain a comparable estimate of the number of physically disabled women.

Another five to six percent of the prison population (or 1,000-1,200 prisoners) is estimated to have specific learning disabilities.

- Consultants recommend that a comprehensive disability survey be undertaken in order to locate and determine the number and status of disabled prisoners within the State prison system.

The survey should focus on physical and learning disabilities as well as developmental disabilities and mental illness. Such a survey would provide quantifiable data to guide the development of programs and services for disabled prisoners. (In 1976, the California Youth Authority (CYA) and the Department of Rehabilitation conducted a similar survey on the numbers and locations of physically and mentally disabled CYA wards and parolees in order to gather data which would point out the kinds and extent of programs needed.)*

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*"Department of Rehabilitation - California Youth Authority Disability Survey," Judy Oster, Research Analyst (Research Section, California State Department of Rehabilitation, June, 1977).

In Consultants' estimation, the program recommendations which follow constitute the core of services necessary to meet the most pressing needs of these special populations. Without programs geared to impart basic survival skills, disabled prisoners will continue to be a financial burden to the State; costs, then, should be viewed from this perspective.

PHYSICALLY DISABLED PRISONERS

Independent Living Skills Training

The physically disabled prisoners' greatest need is a comprehensive independent living skills program. Currently, there are no independent living skills programs in California prisons which teach the incremental skills a disabled person needs in order to learn how to care for him or herself (e.g., dress, bathe, cook, and increase mobility). This need was pointed out in the report, "Recommendations for Rehabilitation Programs in the California Department of Corrections," January 9, 1978, prepared by the Department of Rehabilitation in response to Item 410.1 of the 1977-78 Final Fiscal Year Governor's Budget for the Department of Corrections.

Independent living skills training, designed to break tasks down into simple components, is required if disabled prisoners are to develop and maintain any measure of independence either in prison or upon release. The living skills program would include the services of a therapist (physical and speech), as needed.

- It is recommended that the Department of Corrections contract with community agencies to provide comprehensive independent living skills training programs in those institutions where there are a sufficient number of seriously disabled prisoners to merit such a program. Based on what is known regarding the current population, Consultants recommend implementing such a program at CMF and CIM.*

*For cost analysis, see Appendix B of this report.

Recreation

Physically disabled prisoners additionally need recreational opportunities (as noted in the Department of Rehabilitation's recommendations). CMF is in the process of constructing a special yard for wheelchair sports, which will also be equipped with protective roofing for activities during inclement weather.*

Work

Except for the two specialized programs recommended by Consultants for physically disabled prisoners (e.g., independent living skills program and recreation), these prisoners would be integrated into mainline activities as much as possible. In particular, opportunities for work and vocational training should be expanded to include more physically disabled prisoners. As prisoners learn new skills through the independent living skills training program, they will be more able to accomplish work tasks in industrial settings or plant maintenance operations.

The CDC has stated that one of its primary objectives is to provide suitable and, if possible, personally rewarding occupations for prisoners, "including those presently considered unassignable by reason of . . . age and physical or psychiatric condition."** In order to accomplish this objective, extra attention and assistance will be required. Such assistance may include comprehensive skills evaluation services, in addition to modified work stations and equipment where necessary to accommodate disabled workers, as well as assistive devices to enhance workers' capacity. Additionally, minor architectural modifications may be required to give non-mobile and semi-mobile prisoners physical access to existing vocational, educational and work areas. The American National Standards Institutes, Inc. has developed "Standard Specifications for Making Buildings and Facilities Accessible to, and Usable by, the Physically Handicapped," which should be used as guidelines for such modifications.

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*Cost for constructing this type of yard, which Consultants also recommend for CIM, is approximately $12,000 at current prices.

**California Department of Corrections, "Inmate Work Program: Preliminary Issue Paper" (February 15, 1978), p. 2.

PRISONERS WITH SPECIFIC LEARNING DISABILITIES

Prisoners with specific learning disabilities have normal intelligence, but are handicapped by a history of academic failure and resulting low self-esteem. Therefore, a remedial treatment program, designed specifically to upgrade learning skills, is needed in addition to a psychotherapy component to deal with improving the prisoners' self-image if these prisoners are to succeed in prison programs and make a successful transition upon release. The Department of Rehabilitation also noted the need for "screening, diagnosis, and remedial treatment programs for inmates with specific learning disabilities."*

Presently, there is a very limited program for diagnosis and remediation of prisoners with learning disabilities at CMF. Consultants have discussed a proposal with a staff psychologist at CMF which would provide a complete treatment program for eighty prisoners with specific learning disabilities; including diagnosis, special classes in reading and math, individualized education programs, and psychotherapy.** Offshoots of this proposed program, which would include all four components (diagnosis, group remediation work, individualized education, and psychotherapy), and which are tailored wherever possible to existing resources, should be implemented at those institutions which have a sufficient number of prisoners with learning disabilities to warrant a special program. The CDC should explore the possibility of implementing these programs with community college districts, which receive a fixed State allocation for handicapped adult students (definition includes physical, communication and learning disabilities).

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*California Department of Rehabilitation, Recommendations for Rehabilitation Programs in California Department of Corrections (January 9, 1978), p. 4.

**The cost of the program package totals over $400,000; $300,000 is allocated for staff. Several non-recurring items are included, such as construction and equipment.

H. CO-CORRECTIONS

INTRODUCTION

Recent experimentation with co-corrections in this country, practitioners generally agree, constitutes a productive and innovative trend in the administration of prisons.* Indeed, the CDC has considered co-corrections as a possible future direction for California corrections: ". . . it will even be possible in the future if desired to operate (these) proposed new facilities with both male and female inmates . . ."**

- After exploring co-corrections from a number of perspectives, Consultants conclude that a co-corrections program is a viable and merited option to pursue at this time, and recommend that the CDC begin immediately to implement such a program on an experimental basis.***

In conducting this analysis of co-corrections, Consultants interviewed administrators of federal, state, and county coed facilities and programs. In addition, co-corrections literature was reviewed. However, because little has yet been written on co-corrections, Consultants have relied primarily on the observations of practitioners. The remainder of this section is devoted to a discussion of findings regarding the advantages and disadvantages of co-corrections, and the operational features of co-corrections.

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*A co-correctional institution is defined as "an adult institution; the major purpose of which is the custody of sentenced felons; under a single administration; having one or more programs or areas in which male and female inmates from the institution are both present and in interaction." (See Summary Report: Phase 1 Assessment of Coeducational Corrections, Koba Associates, Inc. (LEAA, September, 1977), p. 2.

**CDC Program Planning Report for 1978-79, Vol. II, p. 158.

***Pending legislation (AB 2634, McVittie) would add Section 5070 to the Penal Code to allow prisoners to be assigned to academic or vocational training programs located in institutions "established for the incarceration of offenders of the opposite sex."

Advantages

The overriding benefit of co-corrections, which manifests itself in a number of specific ways, is normalization of the prison environment. Because men and women participate in programs and activities together, and interact personally and socially in co-correctional institutions, the atmosphere more closely parallels the outside community. Practitioners in co-corrections comment that normalization of environment leads to improved social behavior (e.g., physical appearance, language, and manners) of prisoners.* A sexually integrated environment also tends to better prepare prisoners for release, and reduces adjustment problems after release by providing everyday opportunities for interacting with the opposite sex.

Normalization of the prison environment presents the following specific advantages:

a. Reduction of Institutional Violence. All persons interviewed agree that assaultive behavior and predatory and violent homosexual activity is greatly reduced in co-correctional institutions, although consensual homosexuality still exists. The interaction of males and females positively molds the institutional environment, thus becoming a useful management tool. Prisoners' interests and activities become diverted from "prison games" to what has been described as "cultural games" (e.g., showing off to the opposite sex, cultivating heterosexual relationships).**

b. Increased Program Opportunities for Women. It is often difficult to provide equal programming opportunities for women due to the small female population in most prison systems. Co-correctional institutions remedy this situation by providing equal program access for both men and women. One researcher noted that "a case study of Kennedy

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*Superintendent, Massachusetts Correctional Institute: Framingham, Massachusetts; Director, Napa County Department of Corrections: Napa, California; former Superintendent, Federal Correctional Institution: Pleasanton, California.

**John Symka, "A Phenomenological Analysis of the Social Environment in a Coed Prison" (LEAA), p. 87.

Youth Center* states that co-corrections provides better programs for women than a women's institution."**

c. Improved Staff/Prisoner Relationships. Staff/prisoner interaction occurs frequently in co-correctional institutions, leading to better overall morale. Staff is sexually integrated, and therefore more effective in dealing with a variety of emotional and interpersonal problems which may arise in a co-correctional setting. There appears to be more open communication and even friendships between prisoners and staff: a situation atypical of at least one aspect of the "total institution" as typified by sociologist Erving Goffman. In discussing the binary nature of a "total institution" (e.g., staff and prisoners), Goffman notes that social interaction between the groups is severely restricted and usually formally dictated; such restricted and rigid contact reinforces the negative and fixed images each group holds for the other.***

d. Prisoner Sexual Adjustment. Consultants have observed (through interviews with both prisoners and staff) that establishing positive relationships with the opposite sex is a major difficulty confronted by prisoners before incarceration. Co-corrections can provide an opportunity for developing what has been labeled "heterosexual coping skills,"**** by establishing a setting which facilitates exploration of sexual identity and roles with members of the opposite sex (both prisoners and staff).

e. Cost Effectiveness. Co-correctional facilities provide equal access to programming for both sexes in a cost effective manner. Additionally, duplication of certain specialized services (e.g., for the elderly and infirm inmate) can be avoided.

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*Kennedy Youth Center is located in Morgantown, West Virginia; it is no longer co-correctional.

**Joellen Lambiotte, "Sex-Role Differentiation in a Co-Correctional Setting," unpublished Master's thesis, University of California at Santa Barbara (January, 1977), p. 5.

***Erving Goffman, "On the Characteristics of Total Institutions: Staff-Inmate Relations," The Prison, Studies in Institutional Organization and Change, ed. Donald R. Cressey (New York: Holt, Rinehard and Winston, 1961).

****Koba Associates, op. cit., p. 43.

f. Safety for "Target" Prisoners. A researcher for the Federal Bureau of Prisons observed that prisoners victimized in single sex institutions (e.g., effeminate homosexuals and non-predatory homosexuals) do well in co-correctional facilities because predatory behavior diminishes in such setting? Conceivably, this could reduce the need for protective housing.

Disadvantages

a. Increased Staff Supervision. The need for staff supervision increases in co-corrections, particularly for leisure time activities. Very simply stated, it is harder to run a co-correctional institution from one management perspective because it requires more staff energy to interact with prisoners and to deal with the day-to-day problems that arise. This problem exists, even though extra energy exerted results in better staff/prisoner relationships and a better quality of life within the prison.

b. Physical Contact Violations. Although policies regarding physical contact sanctions vary among co-correctional institutions, sexual intercourse is prohibited. It appears that some, particularly younger prisoners, violate physical contact policies more frequently than others. However, it also appears that where behavior expectations are clearly communicated by staff, and where the population is mature, physical contact violations are less likely to occur.

c. Strain on Married Prisoners. For some prisoners who are married, co-corrections can present a strain on their marital relationship: spouses may exhibit jealousy, or the married prisoner may not want to be "bothered" by the opposite sex. For this reason, wherever possible, prisoners should have the option of choosing not to be housed in a co-correctional facility. Additionally, opportunities for married prisoners to participate in community programs and visit their families on furloughs would enhance family relationships (see Section E on Visiting).

d. Diminished Program Participation of Women. Observers of co-corrections have commented that "coeding" often takes the place of programming for women. One researcher found that the coed environment detracts from women being involved in programs and activities, because they focused "their energies on men, their coed relationships, and being responsible for the maintenance and personal or expressive dynamics of these relationships."* This passive program observer role has also been

*Lambioette, op. cit.

noted in single sex institutions, albeit perhaps less frequently. As women in this society become more assertive in general, and as distinct and sustained efforts are made to increase the awareness of female prisoners regarding their abilities and potential, this passivity may well diminish.

e. Cost. Because the staff/prisoner ratio is often higher in co-correctional institutions, such facilities may be somewhat more expensive to operate. On the other hand, the potential benefits realized through co-corrections (e.g., equal access to programs for both sexes and non-duplication of specialized services) may offset some or all of these additional staff costs.

FEATURES OF CO-CORRECTIONS

Through the review of literature and interviews with experts and practitioners in the field, a number of operating features have emerged which should be considered in the implementation of an effective co-correctional program.

1. Sex Ratio of Prisoners. A two-to-three or one-to-one ratio (male to female or vice versa) is ideal. If the ratio becomes much higher, problems with "turf" and the needs of the majority outweighing the minority arise. Regardless of the ratio, past experience dictates that when the opposite sex is transferred to an already established single-sex institution, an adjustment period for "outsiders" ensues. However, officials at such institutions state that with staff leadership, transitional tension is minimized.

2. Staff/Prisoner Ratio. A ratio of approximately two prisoners to one staff member works well in co-corrections for purposes of supervision and productive staff/prisoner interaction. (The CDC prisoner/employee ratio for 1977-78 ranges from 2.3:1 at CIW to 4.1:1 at CMC.)*

3. Staff Characteristics. Staff should be sexually integrated. Mature attitudes regarding sex roles, heterosexual and homosexual behavior, and interracial relationships are required. In-service training for staff should be instituted before co-corrections is implemented in order to begin the program on a sound footing.

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*Governor's Budget for California, 1978-79, Health and Welfare, Department of Corrections, p. 715.

4. Selection Criteria. Several selection criteria should be considered, and screening should apply equally to both sexes.

a. Prisoner Choice. Prisoners should, wherever possible, have the choice of being in a single sex or co-sex institution.

b. Age. Some practitioners think it more difficult to operate co-correctional programs and facilities with very young prisoners (late teens and early twenties), although it is agreed that co-corrections is psychologically beneficial for juvenile and young prisoners in terms of establishing a positive sexual identity.

c. Violence. Some observers would exclude persons with a history of assaultive or predatory behavior. However, the Massachusetts Correctional Institution (MCI) has accepted sex offenders, and no negative consequences have occurred. In this case, sex offenders are transferred to MCI as preparation for release (approximately 24 months to probation).

d. Time to Release. Time to release should be considered on an individual basis. The Massachusetts experience would suggest that some individuals can serve long periods of time in a co-correctional setting, while others profit from it on a pre-release basis only.

5. Design Features. Housing units must be separate (e.g., separate cottages or wings of buildings). A compact facility and grounds, with easy access to program areas from the housing units, is practical because such features facilitate surveillance and reduce supervision problems. For the most part, program areas (e.g., recreation and other leisure time activities) should be housed in a central facility adjacent to housing units.

6. Community Relations and Involvement. Community involvement adds to the success of co-corrections. Public relations activities should precede the development of co-corrections in order to elicit community cooperation, support, and involvement, and to counter any negative rumors or reactions.

7. Full Sexual Integration of Programs. Programs (e.g., work and education) should be fully integrated, as should activities such as dining, recreation, and religious events. The more integration in institutional programs, the more benefits can be accrued from co-corrections. Of course, special activities may be limited to one sex.

8. Articulated Physical Contact Policy. Although the physical contact policy must be articulated, it should not be too stringent, nor should

it be overstated lest prisoners overreact to unnecessary control. Generally, discreet and reasonable behavior which is suitable in public (e.g., social activities such as dances) is an appropriate rule of thumb.

9. Attention to the Needs of Both Sexes. Health needs of men and women differ, as do other needs. Differences should not be overlooked in the process of establishing co-correctional programs and services.

10. Capacity. Co-correctional facilities have operated at varying capacities, from slightly over 100 to over 1,000. It appears the number of prisoners does not positively or negatively influence the success of co-corrections.

- Consultants recommend that the Department of Corrections establish a co-correctional program at this time by transferring 200 selected female felons from the California Institution for Women to the California Institution for Men to occupy two single-story dormitories at that facility.

Issues and problems that arise in the implementation process should be studied and addressed with an eye to determining what does and does not work in California. Further development of co-corrections programs, based on knowledge gained during the implementation phase, should occur by transferring men to the California Institution for Women at a later date.

- Consultants further recommend that the CDC enter into co-corrections with a firm commitment to the philosophy and programmatic value of co-corrections.

Experiences in other states have revealed that if the determination to experiment with co-corrections is made on the basis of population (e.g., overcrowding or lack of use), staff will in all likelihood not be committed to the co-corrections approach; therefore, the value of such a program will be at least partially lost to security and surveillance concerns.

I. WOMEN PRISONERS AND THEIR CHILDREN

INTRODUCTION

Consultants have explored the issue of women prisoners and their children for several reasons. To begin with, existing California law provides for the retention of children who are under two years of age at CIW, although the CDC has never acted on this legislative authorization. Responding to litigation by a female prisoner, denied the right to keep her baby with her at CIW, the CDC established a working policy not to keep babies or young children at the facility. The CDC took the position that prison is not a safe or proper environment for children.

Although there is strong sentiment against housing female prisoners and their children together, there is also compelling evidence to suggest that live-in arrangements that allow the mother and child to be together from birth are instrumental to healthy development of the child and growth of parenting skills and responsibility in the mother. If the child is separated, the mother's incentive to assume responsibility for the child upon release diminishes. However, if the mother has the opportunity from the beginning to be the primary caretaker of the child and to develop effective parenting skills, she will be more likely to continue in this role upon release.

Nonetheless, Consultants must point out that these arguments in favor of housing female prisoners with their young children would not apply to all female/mother prisoners. Some mothers are not interested in child-rearing, while others are simply not capable.

In order to gather data on women prisoners and their children, Consultants interviewed a number of knowledgeable criminal justice practitioners in California and nationally, in addition to reviewing literature. Consultants also obtained CDC data regarding the number of women with children, the number of children per woman, and the ages of the children.*

This section addresses both the needs of incarcerated mothers and the needs of their children. The needs of the child are viewed in terms of

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*A random sample of 89 cases was taken of women currently incarcerated at CIW. (See Volume II of Consultants' Final Report, section on Prisoner Profile Research Study, for further discussion of methodology and analysis of this sample.)

preventing harm to character and personality development; the needs of the mother are viewed in terms of developing and/or maintaining a positive and productive maternal role. Currently, there are no specific programs sponsored by the CDC which address the needs of mothers and their children.

Research in child psychology supports the contention that the mental health and character development of a child is directly related to the quality and continuity of the child/mother (or permanent mother figure substitute) relationship. British researcher John Bowlby concludes that "mother-love in infancy and childhood is as important for mental health as are vitamins and proteins for physical health."* According to Bowlby, separation from the mother constitutes varying degrees of deprivation to the child which can lead to future negative consequences (e.g., affectionless or delinquent behavior, lack of conscience or guilt). Although the effects of deprivation are greatest during the first three years, researchers seem to agree that serious damage may also occur to children from three to five years of age.** Additionally, it has been demonstrated that women prisoners suffer acutely from separation from family, and worry about their children while in prison (see, for example, Ward and Kassebaum, Women's Prison, 1965).

In the sample of 89 women at CIW taken by Consultants, 76 (75 percent) had one or more children; 16 of these had children three years old or younger, while another eight (9 percent) had children age four to five. (Although information on pregnant inmates was not collected, at any given time there may also be several pregnant women at CIW.) None of the children age five or under were adopted; 14 resided with grandparents; three with the father; four with other relatives; and three with foster parents; two were living out of state. These figures suggest that some mothers were caring for their children before incarceration, with the resulting separation likely to result in some deprivation to the child.

In light of the 27 percent of female prisoners who had children under age five for whom they may have been responsible before incarceration, Consultants have developed two program recommendations which are the minimum required to address the far-reaching issues of mother prisoners and children. The first calls for the formation of a community-based residential program for selected women prisoners and their young children, while the second calls for the establishment of a child development center at CIW.

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*John Bowlby, Child Care and the Growth of Love (London: Whitefriars, 1953), p. 182.

**Ibid., p. 29.

RECOMMENDATIONS

In the interests of preventing the negative results of maternal deprivation on the child (e.g., mental illness, criminal or maladjusted behavior) -- and providing the possibilities for mothers to continue their mothering role:

- Consultants recommend that when possible and desirable, and under specified circumstances, some mothers be allowed to keep their babies or young children when commited to the CDC.

A community-based residential program (similar to that proposed by A.B. 512) would accomplish this goal. The following characterize the recommended program:*

Location

The facility should be located in an urban area near generic resources (e.g., hospitals, social welfare services, and transportation).

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*Consultants refer to the State Department of Finance's analysis of A.B. 512 as a guideline for estimating program costs. The Finance Department estimated the program proposed by Assemblyman Goggin (which would be planned for 23 women) would cost at least $14,520 per prisoner (plus child) per year (costs are in 1977 prices). This compares to the 1977-78 per capita cost of $12,875 for women incarcerated at CIW.

The Finance Department also estimates an additional one-time only cost to construct a facility if an appropriate space could not be leased.

Based on a close working knowledge of a similar program in Santa Clara County, Consultants think that it is quite feasible to locate an appropriate facility.

Administration

The program should be administered on a contractual basis by a community agency; such an agency would have working knowledge of other needed community agencies, organizations and services. Staff should be sexually integrated to provide male role models for children.

Program Content

Women should have complete responsibility for their babies and pre-school age children. Special programs, directed by a child development specialist, should deal with parenting skills, child development, and family relationships. Additionally, pre-school programs and activities should be developed. After the babies reach a certain age (for example, six to nine months), the mothers should engage in part-time academic or work programs. Day care should be provided by mothers on a rotating basis.

Age of Children

Children should be accepted into the program from birth through pre-school. It is thought that the benefits of such a program would diminish for children entering kindergarten (approximately age 5). When children enter kindergarten, they begin to establish more lasting and intricate social relationships which would be uprooted if the child had to move.

Eligibility

Any woman prisoner with a young child (see item #4) who qualifies for community programs (as delineated in Volume II of Consultants' Final Report) should be eligible to participate.

The program proposed under A.B. 512 is more restrictive than that set forth by Consultants, most significantly in the area of eligibility for prisoners, and the age of participating children.* Moreover, A.B. 512 would repeal Section 3401 of the Penal Code, which allows women to keep their children under age two at CIW, although the provision has never been implemented.

Consultants recommend against repeal of the existing section. The option should remain open for developing a program for women at CIW who would not be eligible for community-based programs.

Consultants are not recommending a live-in program for mothers and babies at CIW; however, the idea warrants further discussion.

Several issues arise when considering this complicated concept. Many interviewed prison administrators were opposed to live-in prison programs, since in their view, prison is not an appropriate or safe setting for raising children.

Consultants are aware that the prison environment can adversely effect the development of children;** nonetheless, some administrators contacted by Consultants were amenable to the possibility of separate live-in quarters on the prison grounds specifically designated for mothers and their children.

One researcher thinks that "since the traditional prison environment is not very conducive to the rearing of a child, it should be altered to accommodate (this) special program. This can be accomplished by placing

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*Under A.B. 512, only women who have sentences that are two years or less (calculated after deducting good time) and who are serving their first prison term, are eligible. According to the bill, the child cannot be older than two months if the mother's term is two years, because the bill calls for placement of the child elsewhere when he or she reaches two years two months of age.

**It is also recognized that some aspects of the prison environment (e.g., noise and stress/anxiety level) may be harmful to the developing fetus. Presently there is research in the area of prenatal conditions and child birthing processes which have attracted the interest of at least one legislator. Pursuant to 1976 legislation, the Committee to Study Alternatives in Maternity Care is charged with studying alternatives in health and health care methods; and procedures prior to birth, during birth, and after birth.

the mothers and children in quarters separate from the main prison population."*

This type of program is used in New York State; currently, at the Bedford Hills Correctional Facility, children born while their mother is incarcerated can be housed in the hospital with their mother for up to one year.

Consultants think that a proper environment for both pregnant mothers and mothers with babies could be created at CIW. In this instance, of course, parenting would be a chosen and primary responsibility of the incarcerated mother, as well as a privilege. By accepting this responsibility, the mothers would be committed not only to caring for her child, but to developing the necessary skills to become an effective parent.

- In order to reinforce and preserve the mother-child relationship through the incarceration period, Consultants recommend that a child development center be established where inmate/mothers could receive training in child care and parenting techniques, and where opportunities for interaction between parent and child through an extended overnight visiting program** could occur. ***

In the sixties, a study was conducted at CIW concerning certain problems confronted by mothers and their minor children. Referring to this study, criminologist Joy S. Eyman notes that: "Analysis of the data collected concerning the families disclosed, among other things, that the inmate-mother's own rehabilitation and adjustment are sharply affected by her maternal role and her continuing relationship relative to her children. Unless there is clarification and stabilization of the role she is to play in the rearing of her children, she will be faced with demands and

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*Richard D. Palmer, "The Prison-Mother and Her Child," Capital University Law Review, Vol. 1, No. 1 (Capital University: Columbus, Ohio), p. 139.

**A similar program, funded through a grant from LEAA, has been operating at the Nebraska Center for Women since 1975. At Purdy Treatment Center for Women in Washington, a nursery school program has been in effect since 1975, with an initial appropriation from ESEA Title I monies.

***See Appendix C for cost analysis.

crises that adversely affect her ability to utilize the institutional program or successfully complete parole."*

The recommended program should be characterized by the following features:

1. Location. The program should be located at CIW in a special building to include classroom space and an activity/play visiting area for children.

2. Administration. The program should be directed by a full-time child development specialist. The specialist should be assisted by at least two permanently assigned inmate workers who would assist with maintaining the center and planning and facilitating activities and programs for visiting children. The child-care aspect of the program could be expanded to include children of staff members, who would pay for the care provided.

3. Program Content. Inmate/mother participants should take courses and workshops in child care, child development, family dynamics, and parent effectiveness training, to be offered or coordinated by the child development specialist. Additionally, mothers enrolled in the child development center program should receive academic credit for attending and completing the prescribed curriculum. Participants should be required to schedule coursework around their work assignments and other responsibilities.

Additionally, mothers enrolled in the program would resume responsibility for maintaining and enhancing their relationship with their child or children through an expanded child-visiting program.

Children should be allowed to visit overnight at the facility as appropriate, lasting up to a specified number of days per month.

During the day, children would stay at the center and participate in programs and activities jointly planned by the mother, child development specialist, and inmate workers. However, each mother should undertake the overall responsibility for planning the child's visit and activities while at the facility, as well as for supervision, safety and health precautions, and liability. In addition, mothers should be responsible

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*Eyman, Joy S., Prisons for Women (Charles C. Thomas: Publisher, 1971), p. 123.

for maintaining their own academic and work commitments. Depending on their age, children could sleep with their mothers in the cottages.*

Another recommended feature of the child development center program should be one-on-one counseling between participating mothers and the child development specialist. During these sessions, the nature of the mother/child relationship should be fully discussed, as should such practical matters as what the child will do when visiting the facility. The specialist should also assist the mothers in planning her free time with the child.

Age of Children. Following the Nebraska model, girls up to 12 and boys up to 8 years should be able to visit overnight.

*Children could sleep in bunkbeds, cribs, or in roll-away beds in the dayrooms.

APPENDIX A
COST ANALYSIS: ESCORT SERVICE

Estimated costs for establishing the escort service include the following items:*

1. Operating Costs

   a. Staff

Average of 9 half-time coordinators: (at $5,000 per year)	$45,000
b. Overhead (15%):	6,750
TOTAL:	$51,750

2. Reimbursable Expenses

Meals plus collection costs (bringing child from home to point of transit, and then to facility; or, bringing child directly to facility, depending on distance and existing transportation (e.g., there is no airport near Susanville or Jamestown).	
Consultants estimate that the average reimbursement costs would approximate $50.00 per trip x 1,000** trips per year:	$50,000
TOTAL ROUGH ESTIMATE:	$101,750

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*Note that transit costs for child (e.g., bus and air fares) are not included in the estimation. Consultants recommend that prisoners assume these expenses, and that a furlough/visiting fund be established so that inmates can borrow money to pay for transportation expenses.
(continued on next page)

Prisoner's ability to assume these costs would be increased if they were paid higher wages than they currently are (see Volume IV of Consultants' Final Report).

**Because the program is in the concept stage only, there is no data on usage -- or how many prisoners have children needing escort services, and how frequently. Consultants selcted 1,000 trips for the first year to give an approximation of what it might cost to start the program, with expectations that the service will increase in the years to come. As a point of reference, it should be pointed out that Iowa found that 25 percent of the women prisoners had problems related to child visiting, and thus decided to institute a transport service similar to the one described herein.

APPENDIX B
COST ANALYSIS: INDEPENDENT LIVING SKILLS PROGRAM

In operating this program, costs would be incurred for staff salaries and fees; supplies and educational materials; and, equipment.

The following costs, based on 1977-78 dollars, are estimated from existing community-based rehabilitation and training programs.* A range of therapy costs are presented because a detailed study would be needed to determine the exact amount of therapy the clients would require. (Consultants note that there is a diversity of federal, state, and regional programs which could possibly be tapped for demonstration or matching monies for this type of program.

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*Costs are adapted from a "semi-independent living program" in Stockton, California, and an Easter Seal Rehabilitation program in Oakland, California.

APPENDIX B (cont.)

Capital Outlay Costs

Equipment (e.g., typewriters and calculators):	$9,000	
ESTIMATED TOTAL:	$9,000	

Operating Costs

Staff:		
Coordinator: ($17,000 x 2 coordinators)	$ 34,000	
Trainers:* ($650/mo. x 12 x 16 for trainer/client ratio of 10:1 with 160 expected clients.)	124,800	
Therapists:**		
(104 visits per year per 80*** clients x $25.00 total assigned cost per visit.):		$208,000
or		
(52 visits per client per year):	104,000	
Supplies and Educational Materials (e.g., training manuals):	9,000	
ESTIMATED TOTALS:		
(52 therapy visits):	$271,800	
(104 therapy visits):		$375,800

*Part-time graduate students.

**These therapists would only provide physical and speech therapy which would not require the use of expensive equipment, unless the CDC deems it necessary to procure this equipment.

***In order to roughly estimate costs, Consultants assume that half the population (or 80 clients) will need professional therapy.

APPENDIX C
COST ANALYSIS: CHILD DEVELOPMENT CENTER PROGRAM

The major costs for this program would include the following roughly estimated items:

Capital Outlay Costs

Building: (1,200 square feet x $35.00 per square foot.*)	$42,000
Equipment: (Recreational equipment, beds, appliances (stove and refrigerator).)	4,000
ESTIMATED TOTAL:	$46,000

Operating Costs

Plant maintenance and utilities:	$ 1,800
Staff:	
Child development specialist: (full time)	17,000
Two inmate "trainees": (30 hrs. per week, each, @$1.50/hr.**)	4,680
Equipment: (Toys, educational supplies, games, and food.)	4,000
ESTIMATED TOTAL:	$27,480

*Another strategy would be to convert an existing building into a child development center, thereby eliminating much of the capital outlay costs.

**This is based on the assumption that Consultants' recommendation to raise inmates' wages is implemented.

END