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All phases of preventive and correctional activities in delinquency and crime come within the fields of interest of FEDERAL PROBATION. The Quarterly wishes to share with its readers all constructively worthwhile points of view and welcomes the contributions of those engaged in the study of juvenile and adult offenders. Federal, state, and local organizations, institutions, and agencies — both public and private — are invited to submit any significant experience and findings related to the prevention and control of delinquency and crime.

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This Issue in Brief

ERRATUM: In Ted Palmer's article, "The 'Effectiveness' Issue Today: An Overview" (June 1983, pp. 5-10), the sentence on page 5, column 2, line 2, beginning with the words, "In contrast," and ending with "are also implied," should have read as follows: In contrast, the differential intervention view suggests that some offenders (BTA's amenables included) will respond positively to given approaches under certain conditions only, and that these individuals may respond *negatively* to other approaches under very similar conditions; other combinations of offender, approach, setting—and resulting outcome—are also implied.

The editors regret that the important missing words, "certain conditions only, and that these individuals may respond *negatively* to other approaches under," were inadvertently omitted.

Writing About Justice: An Essay Review.—This essay review by Dr. Benjamin Frank deals with what are generally considered the three most influential books on political and moral philosophy published in the past decade. They are, in effect, three competing theories of justice for contemporary liberal society. The focus of Dr. Frank's review is on the implications of each of these theories for penal policy.

Probation as a Reparative Sentence.—Probation as a reparative sentence should become the penalty of choice for property offenders, asserts Professor Burt Galaway of the University of Minnesota at Duluth. The reparative sentence requires offenders to restore victim losses either through monetary restitution or personal service. If there are no victim losses or the nature of the offense requires a more severe penalty, additional reparations can be made to the community in the form of unpaid service.

Selective Incapacitation: An Idea Whose Time Has Come?—Selective incapacitation is a popular, yet controversial new idea for dealing simultaneously with overpopulated prisons and jails and with the problem of high crime rates. Brian Forst of INSLAW, Inc., considers the pros and cons of the idea. His article focuses primarily on two issues: the compatibility of selective incapacitation with other strategies for determining criminal sanctions, and the problem of errors in predicting which offenders are the most dangerous.

Recent Case Law on Overcrowded Conditions of Confinement: An Assessment of Its Impact on Facility Decisionmaking.—Crowded prisons and

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The Mentally Retarded and Pseudoretarded Offender: A Clinical/Legal Dilemma

BY LAURENCE A. FRENCH, PH.D.

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Recently, jails and, to a lesser extent, prisons have replaced those institutions traditionally mandated to care for the mentally ill and mentally deficient. In a sense correctional facilities have become de facto institutions for the chronically impaired. This process reflects a number of factors—namely "deinstitutionalization," "decarceration," and "decriminalization." Unfortunately, without sufficient community care facilities, community mental health centers, group homes, halfway houses, detoxification centers . . ., these well intended philosophical models often merely provide the legal and political justification for the "dumping" of the mentally ill and mentally deficient prematurely and unprepared, back into society.

Without adequate followup and aftercare programming many of these former clients end up on the streets. Unwanted and untreated it is little wonder that many have come into contact with the criminal justice system as both victims and offenders. This article looks at this phenomenon from a clinical/legal perspective. Hopefully a discussion of the major clinical and behavioral factors characterizing this population (mentally retarded and pseudoretarded) will provide a useful guide to jail and prison personnel.

Characteristics of Deinstitutionalization

The post World War II adjustment period peaked during the mid-fifties—a phenomenon characterized by harsh correctional treatment and dense, custodial populations within mental facilities, including those for the mentally deficient. Indeed, our Nation's prisons and veteran and state hospitals and schools reached their peak populations during this era. A reaction to these institutional conditions emerged during the 1960's focusing on human rights and the quality of institutional care. The Warren Court initiated this effort by articulating the basic rights of the accused. Soon these concerns were extended to those deemed mentally incompetent (psychiatrically impaired, mentally retarded) to make reasonable decisions regarding their welfare and treatment. Here, the judiciary saw the need to provide legal advocacy for this class of citizens. Soon others followed suit and the three "D's" surfaced as the models for the 1970's: deinstitutionalization, decarceration, and decriminalization. And as these policies materialized the paradoxical interaction between the criminal justice and mental health systems became more evident and, some would argue, more complex.

Significant milestones in the deinstitutionalization/decarceration process include the Baxstrom (1966), Dixon (1971), Wyatt (1971), Davis (1974), Halderman (1977), and Youngberg (1982) cases. In *Baxstrom* v. *Herold* the U.S. Supreme Court ruled that Johnnie K. Baxstrom had been denied equal protection of the laws by the statutory procedures under which he was held at a New York State hospital for the criminally insane (Dannemora State Hospital). Deemed mentally ill while serving a criminal sentence, Baxstrom was held beyond the expiration of his maximum sentence. The Supreme Court held that this action and corresponding statutory justification violated Baxstrom's civil rights (14th amendment) and those of the entire class which his case represented.

This 1966 case was significant in that (1) it terminated the practice of extended institutionalization in New York, (2) established a critical precedent regarding both prisoners' and patients' rights, and (3) forced the immediate transfer of 967 patients from forensic (Dannemora and Matteawan) to civil mental health facilities (Steadman, 1972). Clearly the Baxstrom case served to illustrate the institutional dilemma regarding the "mad" and the "bad." Consequently the mentally ill criminal offender is likely to be confined for longer periods of time under the paradoxical justification that prolonged internment is needed for "treatment" and public protection from these "potentially dangerous" individuals.

Thus while Baxstrom initiated the decarceration process within forensic facilities, the Dixon (1971) case gave this movement additional fuel. The Dixon case went beyond its predecessor, Baxstrom, in that it challenged the assumption of dangerousness, the

single most critical factor determining long-termed forensic institutionalization (Thornberry, 1979). In 1969, Donald Dixon and six other plaintiffs filed a class action suit against Farview State Hospital (Pennsylvania) challenging the constitutionality of their confinement. In 1971 the Court ruled in favor of the plaintiffs ordering all members of the Dixon class either released outright or reevaluated for treatment in nonforensic mental health facilities. Drawing similar conclusions, the Baxstrom and Dixon cases required that sentence-expired mentally ill offenders be released from forensic (maximum security) institutions to civil facilities or to the community.

Another milestone in the deinstitutionalization movement was the 1971 *Wyatt* v. *Stickney* case. Wyatt involved the involuntary confinement of the mentally retarded in Alabama. Again, citing the 14th amendment, the Federal Court ruled: "that improved standards of institutional operation must be implemented by the state" (Braddock, 1981:609). Granted, this case did not address the immediate release of an institutionalized class. Nevertheless, it did specify the "quality of care" to be provided by treatment facilities, a criterion which eventually led to the deinstitutionalization process. Furthermore, the quality of care was spelled out in specific terms including: (1) a humane environment, (2) sufficient and qualified staff, (3) individualized treatment plans, and (4) residence in least restrictive environment. Indeed, the latter eventually became interpreted in such a fashion so as to signify community placement—a process which led to the advent of group homes for the mentally ill and mentally deficient.

The Wyatt decision influenced yet another forensic case: *Davis* v. *Watkins* (1974). By focusing on the quality of care issue articulated in Wyatt, the Davis class challenged the quality of their care at the Lima State Hospital, Ohio's only forensic hospital. The Federal Court ruled in favor of the plaintiff, in effect imposing Wyatt-type standards to Lima State Hospital. In this ruling Wyatt standards were summarized by three broad classifications: (1) humane physical and psychological environments, (2) improved quality and quantity of staff, and (3) individualized treatment plans (Heller, 1979). The Davis ruling also addressed the privacy, seclusion, educational and recreational issues as well as the documentation of institutional treatment and care.

And in *Halderman* v. *Pennhurst* (1977) a Federal Court ordered the first closing of a U.S. mental institution. Judge Broderick stated: "The confinement and isolation of the retarded in the institution called Pennhurst (Pennsylvania) is segregation. Equal protectection principles prohibit the segregation of the retarded in an isolated institution such as Pennhurst where habilitation does not measure up to minimally adequate standards (Broderick, 1980:37-38)." Pennsylvania appealed this decision all the way to the U.S. Supreme Court where final litigation is still pending (Pennhurst, 1981). Interestingly, a number of other states joined Pennsylvania in an amicus brief urging the court to reconsider judiciary fiat forcing the closing of mental facilities. As a group, these states argued for more time to progress toward the complex task of deinstitutionalization. The habilitation and treatment issues stood and were later reinforced by *Youngberg* v. *Romeo* (1982).

The Youngberg case addressed the Wyatt standards (seclusion, restraints, right to treatment, least restrictive environment) as they applied to Nicholas Romeo, an involuntary resident of Pennhurst State School and Hospital. The court was considering, for the first time, the 14th amendment rights of the involuntarily committed retarded person. In essence the U.S. Supreme Court held that involuntarily committed mentally retarded residents have a constitutional right to habilitation and training relevant to their personal safety and freedom from restraints (Youngberg, 1982).

Ironically, judicial pressure for quality of institutional care has served to accelerate the deinstitutionalization process mainly because this (deinstitutionalization) represents the most economical solution to the problem. Unfortunately, deinstitutionalization without adequate community services and integration often results in "dumping"—a phenomenon widely discussed in the mental health literature (Bassuk, 1978; Braddock, 1981; Reich, 1978; Talbott, 1979; Throne, 1979). The theme is a similar one—impoverished, borderline ex-patients tend to drift toward that segment of society where they are most tolerated (Dunham, 1965). These areas, for the most part, are the slums where other marginals drift as well. Consequently, the ill-prepared, untreated mentally ill and mentally deficient are often frustrated and victimized under these circumstances and therefore are more likely to come into contact with the criminal justice system.

Criminal Proneness of the Mentally Deficient and Pseudoretarded

Criminal proneness and "dangerousness" are often seen as being related variables especially when associated with deinstitutionalized emotionally disturbed and/or mentally deficient ex-patients.

There is no consensus, however, regarding the interplay between these variables. Some view dangerousness as an innate variable—a characteristic of clinical syndromes or genetic factors per se while others, on the other hand, see dangerousness as being a consequence of institutionalization, notably long-termed institutionalization in isolated, custodial environments.

The belief in innate "madness" and "badness" is pervasive within Western society. Most of these theories are grounded in the Positive School progressing from Lombrosian activism to the current trend of social biology and the belief in genetically predetermined behavior. Indeed, the advent of special institutions for long-term custodial care for the criminally insane, chronically mentally ill and the mentally deficient, such as Farview, Dannemora, Matteawan, Lima, and Pennhurst mentioned earlier, was predicated, for the most part, on theories generated within the Positive School.

Alternatively, the premise that total institutions, notably "negative" facilities such as prisons, state hospitals and state schools, generated much of the asocial and antisocial behavior manifested by their wards is perhaps best illustrated by the works of Erving Goffman (1961). Essentially, Goffman discussed the artificial nature of total institutions and the subsequent consequences generated within these nonnormative environments. He noted that inmates (patients, criminal offenders, residents, clients) of total institutions are forced into a limited number of status adaptations and that these institutional adaptations deviate markedly from those normative, legitimate options available within the inmates' corresponding home world (noninstitutional social environment).

Besides, the status choices within mental hospitals, forensic facilities, state schools, prisons, and jails are generally restricted to those with negative stereotypes. These stereotypes and the derogation (negative institutionalization) process leave a lasting and significant scar (proactive scar) on these inmates' psyche, one they carry into their home world environment once released (Sykes, 1958; Goffman, 1961; Scheff, 1967; French, 1978; 1979).

The recent advent of deinstitutionalization, however, has added a new dimension to this discussion—the transferability of dangerousness from institutional to home world environments. Again there is no consensus, either among mental health or criminal justice personnel, that ex-mental patients and ex-residents of facilities for the mentally retarded pose a potential danger to themselves or to others. Nevertheless, sufficient concern has surfaced concerning the potential dangerousness and victimization of those mentally ill and mentally retarded clients unceremoniously dumped into society with minimal or no followup care (Lion, 1981; Mikolajczak, 1978; Frederick, 1978; Tardiff, 1981; Forttrell, 1980).

The Patuxent experiment perhaps best illustrates this dilemma. Patuxent was a total institution initiated in 1955 in Maryland for the treatment of mentally abnormal criminal offenders. The Patuxent controversy focused about its indeterminate sentence policy which provided for incarceration until it was felt that inmates no longer presented a threat to society. Again we are at the heart of the clinical/legal problems presented in the first section, that of ill-defined clinical labels being applied to criminal offenders who are also perceived as being dangerous. This status, in turn, was used as legal justification for involuntary institutionalization beyond original criminal sentences.

On July 1, 1977, Patuxent was closed by the Maryland Legislature and the remaining 33 inmates were released. Followup studies of released Patuxent inmates as well as those released due to the Baxstrom, Dixon, and similar suits seem to indicate that these individuals were not significantly more dangerous than were their social counterparts not labelled criminally insane, emotionally disturbed, or mentally deficient (Thornberry, 1979; Steadman, 1972; Hoffman, 1979).

The lack of a conclusive correlation between deinstitutionalization and potential dangerousness does not in itself totally rule out the criminal proneness premise. Indeed, the likelihood that long-term, chronically mentally ill and mentally retarded ex-patients will experience serious adjustment problems, especially among those dumped back into society without adequate transitional and followup care, is very high. Clearly, those with the greatest needs are the mentally deficient and pseudoretarded.

The mentally retardates are classified on a clinical continuum ranging from profound retardation to mild retardation with the former representing those individuals with the greatest degrees of mental deficiency. Both the American Psychiatric Association (APA) and the American Association on Mental Deficiencies (AAMD) recognize four levels of mental retardation: Profound (IQ=20 or less), Severe (IQ=20-34), Moderate (IQ=35-49), and Mild (IQ=50-70). Within this format the mildly retarded are seen as being "educable," and the moderately retarded "trainable," while the severely retarded

are seen as being "dependent," and the profoundly retarded as those needing 24-hour supervision and assistance in activities of daily living (Williams, 1980; Grossman, 1977).

The AFA Diagnostic and Statistical Manual (DSM-III) also recognizes a "borderline" classification. However, Borderline Intellectual Functioning (V62.89) is found under the V code supplementary classifications: "This category can be used when focus of attention or treatment is associated with Borderline Intellectual Functioning, i.e., an IQ in the 71-84 range. The differential diagnosis between Borderline Intellectual Functioning and Mental Retardation (an IQ of 70 or below) is especially difficult and important when certain mental disorders coexist. For example, when the diagnosis is of Schizophrenic Disorder. . ." (Williams, 1980:332).

This raises the issue of functional retardation—a phenomenon also termed "pseudoretardation." In their article, Reiss, Levitan, and McNally noted: "Mentally retarded people who are also emotionally disturbed may constitute one of the most underserved populations in the United States. . . . Low intelligence may increase the risk of emotional disturbance and decrease the opportunity for adequate treatment" (1982:361). Regarding pseudoretardation, they stated: "(This) category does not necessarily imply that successful resolution of the emotional problem would result in normal intellectual functioning. Instead, the concept permits the possibility that severe emotional disturbances can cause irreversible impairments in intellectual functioning" (1982:362).

Long-term institutionalization, whether in mental hospitals or state schools, represents a significant causal factor in the exacerbation of emotional instability among the organically and functionally retarded. Furthermore, those most likely to "pass" within society, usually as marginal, ex-patients, are the mild, moderate, borderline and functionally (pseudo) retarded. Certainly, the dependent retarded (severely and profoundly) are those least likely to be "dumped" onto the streets. Instead, they represent that segment of the mentally retarded population slated for intermediate care facilities and close supervision within habilitation-oriented community settings (Braddock, 1981).

Thus, the emotionally instable ex-patient with low intelligence, notably one suffering from a poverty of socialization and education, who has been dumped back into society with little supervision or treatment, portrays the MR or pseudoretarded individual most likely to come into contact with the criminal justice system either as a victim or offender, or both (Reich, 1978; Steadman, 1978; Wing, 1978; Stelovich, 1979; Tardiff, 1979; 1981; Braveman, 1980; Forget, 1980; Reiss, 1982).

Clinical Factors in the Treatment of the Mentally Deficient and Pseudoretarded Offender

A paramount clinical factor is the awareness that jail and prison environments, especially following initial incarceration, generally serve to exacerbate the stress level of emotionally disturbed clients. The recent (November 8, 1982) fire at the Harrison County Jail in Biloxi, Mississippi, illustrates this phenomenon. Here 28 died and 45 others were injured when the padded cell of a psychiatrically impaired inmate was set on fire. French (1978; 1979; 1981; 1982) addressed the issue of penal stress in a number of articles. Essentially he noted that: "In holding jails the uncertainty of one's fate is conducive to excessive stress and normlessness and therefore more likely to result in rash behavior such as suicide, jailbreak, physical assault, sexual aggressiveness. . . . Psychologically, 'holding' jails are more disruptive than are serving jails, or any other penal facility for that fact, mainly because of the uncertainty associated with this ambivalent situation" (1981:43). This situation is even more devastating for the emotionally disturbed mentally retarded and pseudoretarded inmate. Often jail stress is sufficient in nature to initiate the onset of major clinical syndromes and personality disorders.

The challenge of determining relevant stressors among the emotionally disturbed, mentally deficient and pseudoretarded has only recently been sufficiently addressed. Reiss (1982) noted that: "some retarded people develop emotional disturbances similar to those found in intellectually average people. The assumption is that the problems are a function of psychosocial experiences. . . . Intellectual deficiencies may play an important, indirect role, insofar as they lead to difficult social adjustment problems, such as peer rejection, while limiting the individual's ability to understand and solve such problems" (1982:362).

Speaking on jail crises, French (1981) stated: "This situation is made worse by the absence of any viable inmate subcultural substitute for the inmate to identify with. . . . The magnitude of this problem (personal disorganization) is contingent upon a number of factors, the most significant being the individual's ability to cope with a crisis situation" (1981:44). Not only are emotionally disturbed retardates more likely to experience excessive stress in jail, their social environment may well be a major causal factor in their eventual incarceration.

Ciccone and Kaskey (1979) suggested that "Life Change Units" (LCU) offer reliable indicators of both arrest and incarceration. The subjects in their study experienced marked increases in their life experiences immediately prior to their arrest. They argued that these life change experiences manifest themselves in antisocial acts which, in turn, often lead to arrest. Moreover, continued emotional instability during the adjudication process greatly increases the likelihood of conviction and incarceration. A similar device, the "Legal Dangerousness Scale" (LDS) was used by Cocozza and Steadman (1974) in their study of dangerousness among released Baxstrom patients.

Others (Braveman, 1980; Frederick, 1978; Lion, 1981; Mikolajczak, 1978; Stelovich, 1979; Tardiff, 1979; Thornberry, 1979; Wing, 1978) see a relationship existing between long-termed institutionalization in psychiatric or retardation facilities and increased emotional instability, including violent behavior, once released. It is not uncommon for higher-level retardates and pseudoretardates to acquire chronic clinical syndromes. Ostensibly, these symptoms are not generally associated with any organic etiological factors associated with mental retardation or developmental disabilities. Instead, the development of chronic clinical syndromes (schizophrenia, paranoia, depression) are usually a consequence of the institutionalization process and the deprivations thereof. Certain elements of these clinical syndromes and personality disorders may become latent (in remission) during institutionalization as the retardates learn to adjust to their environment. Nevertheless, untreated, these symptoms and disorders are likely to resurface (acute exacerbation) as these individuals come into contact with new stressors such as those associated with sudden deinstitutionalization, social isolation and exposure to the criminal justice system. Clearly this phenomenon poses a serious dilemma for jail administrators and personnel especially when it is estimated that up to 30 percent of all offenders are afflicted by some degree of retardation (Forget, 1980).

Major clinical syndromes commonly associated with the emotionally disturbed, mentally retarded and pseudoretarded include Organic Brain Syndromes, Schizophrenic Disorders, Paranoid Disorders, Atypical Psychosis, as well as Affective, Anxiety, Psychosexual, Impulse Control and Adjustment Disorders. Most Personality Disorders (Paranoid, Schizoid, Schizotypol, Histrionic, Narcissistic, Antisocial, Borderline, Avoidant, Dependent, Compulsive, Passive-Aggressive, and Atypical) can also be found within this clinical population as can specific Development Disorders (reading, arithmetic, language, articulation) (Williams, 1980; Spitzer, 1980; Stellern, 1976).

Accurate assessments of these clinical features require additional input regarding the nature of the offender's retardation including the use of licit and illicit drug agents. Those afflicted by additional medical factors should have this information noted in their AAMD diagnosis. Here six categories, in addition to psychiatric impairments, are used to specify etiological factors relevant to the client's MR status: Genetic Component; Secondary Cranial Anomaly; Impairment of Special Senses; Disorders of Perception and Expression; Convulsive Disorders; and Motor Dysfunction (Grossman, 1977).

A diagnostic profile, based upon accurate and current data, provides an indication of the types of chemical agents likely to be needed in order to stabilize acute exacerbation of psychotic, behavioral, and/or organic conditions. Three critical factors are warranted here: (1) knowledge of chemical agents previously prescribed, if any, for clinical syndromes (psychotropic medications), or neurological dysfunctions (anticonvulsive drugs) and the interaction of these agents and other illicit or over-the counter medications; (2) knowledge of any illicit or social (alcohol, caffeine, nicotine) drugs used regularly by the MR client; and (3) knowledge of allergies, metabolic factors, dietary deficiencies, and dangerous interaction (adverse reactions, contraindications) of the composite chemical input by the MR client.

Diagnostic and medical information is very helpful especially when attempting to stabilize an MR client experiencing neuropsychiatric episodes. It also provides a format for appropriate treatment. Equally significant are clinical/behavioral relationships. For instance, both schizophrenia and paranoia are major clinical syndromes associated with assaultive behavior including seemingly unprovoked self- and/or other-directed violence. Consequently, jail routines can unintentionally fuel intrapsychic delusions which, in turn, exacerbate aggressive elements of the client's psychosis (Tardiff, 1979; French, 1981).

Aggression, including sexual assault and arson, is also a common behavioral feature associated with emotionally disturbed persons, including retardates, afflicted with clinical and/or personality disorders. Jail and forensic situations hold the potential for initiating anxiety neuroses and adjustment disorders

among emotionally disturbed psychiatrically impaired and mentally deficient clients. Panic disorders (attacks manifested by discrete periods of apprehension or fear), depression and mixed emotional states are commonly associated with these clinical syndromes. Those jail clients who previously experienced long-term psychiatric or MR institutionalization may also suffer post-traumatic stress disorders. Untreated, these anxiety and adjustment reactions could easily lead to self- or other-directed violence (Braverman, 1980; French, 1979; 1982; Spitzer, 1980).

Disorders of Impulse Control represent a significant clinical feature associated with stress, one often overlooked within jail and other penal environments. The most significant impulse control disorders associated with emotionally disturbed MR's and psuedoretardates are pyromania and explosive disorders. The rash of deadly jail and prison fires attest to the former while tantrum-like episodes (property damage, painting with human feces, physical assault) illustrate the latter (Williams, 1980).

Treatment modalities run the continuum from chemotherapy to psychotherapy. Traditional therapies, chemotherapy and behavioral management (operant, classical), are used mostly to "manage" retardates within custodial facilities. A major problem with this narrow perspective is that "treatment" is usually for the convenience of the staff and not the mental health and developmental growth of the clients (Goffman, 1961). Reiss, Levitan, and McNally articulated the treatment dilemma as such: "professional attitudes toward retarded people pose another problem in developing needed services. Neither clinical psychologists nor psychiatrists have shown sufficient interest in the retarded population. The overwhelming majority of psychologists in the field are operant conditioners, focusing primarily on behavior management and educational problems. Although the contribution of this group has been substantial, a much broader approach is needed" (1982:364).

The treatment dilemma carries over to jail and other penal environments and for good reason (Silvestri, 1977; Peck, 1977; Wasylenki, 1981; Gobert, 1981; Friedman, 1976). Penal facilities, notably jail environments, are primarily custodial and punitive in nature. Currently, efforts are being made to more effectively utilize community and contractual mental health services within penal environments. This poses a clinical paradox in that jails often represent the treatment facility of last resort for the substantial deinstitutionalized psychiatric and MR population—absorbing those clients not being effectively treated by those community mental health facilities mandated to care for these people.

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