If you have issues viewing or accessing this file contact us at NCJRS.gov.

STATE CRIME COMMISSION

CRIMINAL JUSTICE STANDARDS AND GOALS STUDY

Study Group: Corrections   Date: October 14, 1975

Position Paper title: Offender Classification
CR2-2

Issue Statement

How can diagnostic information about an offender best be used to benefit both the Georgia corrections system and the individual offender?

Conclusion

Existing diagnostic and classification procedures should be applied to the convicted offender prior to sentencing, instead of upon commitment of the offender to the state correctional system, so that these procedures can assist the sentencing judge in identifying appropriate alternatives to incarceration. Greater use of the information contained in the diagnostic and classifications reports should be made by the Department of Corrections/Offender Rehabilitation (DCOR), with adequate monitoring of information usage provided by immediately filling the Statewide Diagnostic Coordinator position which should be upgraded from a Merit System paygrade 19 to paygrade 21. Diagnostic information should be shared with the offender to help provide a basis for self-remedial action.

Research Findings

Problem Identification

Classification of offenders, based upon similarities and differences identified by physical characteristics, sentence, crime of conviction and/or psychometric testing, takes place within all modern

59159

GA .003 A

correctional systems. In fact, sex, number of previous convictions, age, and "incorrigibility", are all typical categories of classification mandated by law.[1]

Diagnosis, on the other hand, while sometimes required by law,[2] is never so clearly and unambiguously described. Laws and regulations often specify such terms as "mental diagnosis", "diagnostic study", and "diagnostic information". However, what is to be diagnosed, the goals of the diagnostic process, and the technology to be used are never clearly specified.

For the purposes of this paper, the term "diagnosis" is used to refer to the identification of characteristics of an individual offender which:

1. describe him as a unique person;

2. are (at least potentially) related to his criminal behavior;

3. may define his needs for security, placement, management; and

4. may permit specific remedial action to reduce future criminal behavior.

The Georgia Department of Corrections/Offender Rehabilitation (DCOR) conducts systematic, objective diagnostic evaluation of all incoming offenders. Still, there is limited use and coordination of diagnostic information obtained. Current overcrowding in all State institutions does hamper effective use of diagnostic data; however, overcrowding cannot account for the large number of recommendations that are not followed,[3] nor the feeling of institutional counselors that they do not have sufficient training in the use of diagnostic data.[4] Karl Menniger, in his book, The Crime of Punishment[5] indicates that the sophistication of the using institutions must be equal to that of the diagnostic center or much of the center's services will be wasted.

Another problem is that, despite current emphasis in Georgia upon alternatives to incarceration, community-based diagnostic services are available in only two Georgia cities, and then only on a small scale. The sentencing judge is urged to use pre-sentence investigation to help select the most appropriate disposition for the convicted offender, but that investigation, even when available, rarely includes adequate diagnosis.[6]

A third problem arises from DCOR's new emphasis upon inmate performance as a method of earning release from incarceration. The Youthful Offender Act of 1972,[7] the Adult Offender Act of

1975,[8] and Commissioner Ault's "Operation Performance"[9] all emphasize inmate participation in planning and demonstrating "responsible behavior". Determining what is "responsible behavior" for an individual offender, and how he may work to achieve such a goal, requires joint use of diagnostic information by the inmate and his counselor.

Such use of diagnostic data requires two features not currently a part of the Georgia system. One is communication of diagnostic findings to the inmate. The other is periodic reassessment so that the inmate and his counselor may monitor progress. Both of these steps require counselor training and supervision greater than is now available.

Other States' and Federal Experience

The concepts of inmates presenting different needs, of institutions offering different services, and of some reasonable matching of inmates to services, are fundamental to most state systems and to federal efforts. Methods of accomplishing the diagnosis of inmate needs, however, vary considerably.[10]

At the federal level, each correctional institution in the Bureau of Prisons has its own initial diagnostic capability. Institutional assignment is made by the Federal marshal who escorts the offender to the receiving institution.[11] This is possible as each institution has a population with specific determinable characteristics.[12] Reassignment is based upon changing needs and/or characteristics, and is accomplished by the inmate's current institution simply transferring him to one that better meets his needs, as those needs are perceived by the transferring institution.

In the states, diagnostic procedures may involve any degree of formality or lack thereof, and the process may take place at various stages in the correctional system.

In South Carolina and Illinois, inmates enter their system through a reception and diagnostic evaluation center.[14] In both states, three weeks is the minimum time required to complete social, psychological, and medical evaluations.[15] One state that does not currently operate a centralized diagnostic/reception center is Oklahoma.[16] However, they are attempting to obtain funds to construct such a center to fulfill their needs for a comprehensive assessment process to aid in diagnosis and classification of offenders.[17]

The use of community-based diagnostic evaluation services has appeared in several states in the past few years, and others are planning to initiate such services in the near future. A recent survey of community diagnostic capabilities in Pennsylvania, Maryland, North Carolina, Mississippi, California, and Oregon found significant differences in the procedures and instruments used to classify offenders.[18] Mississippi and Oregon used a rather simple approach of placing offenders under maximum supervision available and then reducing the level of supervision with the passage of time.[19] California and Pennsylvania, on the other hand, have attempted to use actuarial tables to screen offenders for community-based programs.[20]

Thus, most states conduct some type of diagnostic assessment of inmates. However, the various approaches have been fragmentary, even capricious, and the data gathered insufficiently used. Psychological tests have been given and scored, in some cases on a large scale. Data banks in Illinois include literally thousands of cases tested with various exemplary methods;[21] some research use of these has been undertaken. New York and California have attempted to involve the individual offender in determining his own plan to meet his diagnosed needs, but only on a limited scale.[22]

Research use of diagnostic information has increased. Pauton,[22] using the Minnesota Multiphasic Personality Inventory (MMPI)[23] has studied North Carolina prisoners and published extensively.[24] Fowler[25] has assembled research data from the MMPI and constructed a diagnostic computer program for correctional use.

What has been lacking in these attempts to apply diagnostic technology to correctional problems has been commitment to large scale, long-range application, and to systematic use of the information in working with individual offenders. This lack of commitment to remedial action has led some states to recommend that the whole diagnostic enterprise be discontinued.[26]

Current Georgia Experience

Georgia Law:

Georgia Code Annotated 77-310, requires the State Board of Corrections to classify and segregate all offenders under its' care. Segregation of prisoners with respect to race, age, first offenders, habitual criminals, and incorrigibles and disease is required although segregation by race has since been overruled by the courts. This section of the Georgia Code also authorizes

rehabilitation programs within the limits of the prisons, and requires the State Board of Corrections to provide "an opportunity for reasonable educational, religious, and recreational activities where practical".[27]

There are two provisions in the Georgia Criminal Code that require both diagnosis and classification of offenders convicted under the provisions. These are the Youthful Offender Act of 1972[28] and the Adult Offender Act of 1975.[29] A mental diagnosis "where possible and indicated" is required to be completed within sixty (60) days, in the absence of "exceptional circumstances", from the date of commitment. The information obtained from this diagnostic study is used in making a "contract for release" with the offender. In the case of the Adult Offender Act, this information can be requested by the sentencing judge if he feels that additional diagnostic information is necessary to validate the sentence.[30] If, upon receipt of the diagnostic information, the judge wishes to modify the sentence he can do so under the provisions of the Adult Offender Act.[31]

Current Practices:

The Georgia Department of Corrections/Offender Rehabilitation (DCOR) has three Diagnostic/Classification facilities. The Georgia Diagnostic and Classification Center at Jackson, Georgia, is the entering facility for male felons (above the age of 21), long-term misdemeanants, and those convicted under the provisions of the Youthful Offender Act of 1972. The Georgia Industrial Insitute is the State's other facility for males with initial diagnostic capability for males. This institution houses younger felons (17 to 21) and provides initial diagnostic and classification functions for this population. Diagnostic services for female inmates are conducted at the Georgia Rehabilitation Center for Women.[32]

Initial diagnostic and classification procedures are standardized, and take from three to six weeks. Generally, the following events occur in this order:

1. Reception, ID, and fingerprinting
2. Medical examination
3. Orientation
4. Initial interview/referrals
5. Psychological testing
6. Vocational testing
7. Vocational interview
8. Social interview
9. Classification
10. Request for assignment[33]

Also, at some point during the process, a parole orientation is given, and, if desired, an inmate may receive a legal aid interview to provide criminal or civil legal assistance.[34] In addition, selected inmates are seen by the psychiatrist for evaluation. However, the number of inmates receiving this service is limited as the psychiatrist is available only one day a week and only sees five inmates during that day.[35]

Based on data obtained through various diagnostic methods,[36] a classification committee, composed of three members representing functions of security, administration, and treatment, makes recommendations as to:

1. Security (required surveillance)
2. Institutional assignment
3. Educational needs and type of program
4. Vocational needs and type of program
5. Work release eligibility
6. Occupational assignment
7. Counseling needs
8. Physical capability[37]

Each of the above recommendations is made in accordance with the criteria established by the State Board of Corrections' Rules and Regulations.[38] While the classification committee attempts to consider age, security requirements, and recommended program availability, severe overcrowding has limited actual institutional placement to bed space availability.[39]

As stated previously, more diagnostic information is currently being produced than is effectively utilized.[40] A small but well selected sample of inmates indicated that, among those whose diagnostic report contained specific program recommendations and who were in an institution which offered one or more of the programs recommended, only about 18 percent were assigned as recommended.[41] Counselors at these institutions attribute this lack of consistency, in part, to inadequate training in how to use the diagnostic information, especially the psychological test information.[42] However, since the diagnostic findings and recommendations are written in non-technical English, it is likely that reported "failure to understand" may, in reality, be a reflection of difficulty in systematic implementation; in other words, a management problem.[43]

Both the Department of Corrections/Offender Rehabilitation and the Judicial System of the State of Georgia desire diagnostic services at the community level.[44] DCOR currently operates two such diagnostic facilities, one in Macon, and one beginning in Gainesville, and it plans to open four more community-based

diagnostic facilities by Fiscal year 1976.[45] These community diagnostic facilities will be strategically located in cities within the State that are capable of providing resources necessary for diagnostic services.[46] A barrier to State-wide, community-based diagnostic services is that Georgia is a large state with very few population centers.

The Department of Corrections/Offender Rehabilitation is presently in the planning stage of implementing a positive, objective approach (Operation Performance) to their areas of primary concern within the Criminal Justice System.[47] Three components of this program are pre-trial diversion, intervention programs and a broader spectrum of probation. These alternatives to incarceration will require functional, community-based diagnosis prior to sentencing.[48] The institutional component of Operation Performance, Performance Earned Release Model (PERM) awards "time off from institutionalization" to responsible inmates.[49] Responsible is defined in terms of inmate completion of needed programs and "quality and quantity" of work while in prison.[50] Therefore, in order for an offender to be "responsible," it is necessary to have an accurate diagnosis of "needed programs" and to have individual offender participation in this assessment.[51]

In the area of research and the development of valid diagnostic information, much has been done and much more is underway. The standardization of the psychological test data base, producing at least the same 32 objective test scores for each inmate/offender, and the involvement of Georgia Department of Labor in producing an additional standard General Aptitude Test Battery (GATB) record on most inmates, has permitted large-scale research.[52] Some behavior exhibited by offenders, both while in prison and while in the community, have been found not only to be substantially predictable but also to be theoretically understandable and at least potentially remediable.[53] This means that some characteristics of offenders, which are associated with recidivism, have been identified by this research. A remedial action program based upon this knowledge has been implemented, on a small experimental scale, in one pre-trial diversion center.[54] Larger scale implementation awaits the administrative structure needed to carry out the recommendations.

Authoritative Opinions

With the advent of incarceration as a means of punishment for offenders, it became necessary to separate certain types of offenders if only for reasons of security. In the early 1900s a movement began which felt that criminals should be seen as individuals with illnesses that could be treated during their term of incarceration. The Positive School of Criminology, as

it was called, hoped that criminology could develop into the science that medicine had in the previous century.[55] Because of the desire to be scientific in the care of inmates, it was felt that each must receive a diagnosis to determine his exact illness and its amenability to treatment.[56]

Most correctional authorities agree that some type of diagnosis and classification of prisoners is necessary. The United Nation's Standard Minimum Rules for the Treatment of Prisoners calls for the separation of inmates by categories such as sex, tried and untried, young and old, criminal history, and legal reason for confinement.[57] The State Department of Corrections Act, developed by the Advisory Commission on Intergovernmental Relations in 1971, goes beyond these minimum standards and recommends that all persons committed to incarceration receive diagnostic services that include "social, medical, psychological, and other appropriate studies."[58] The need for specialized diagnosis is also clearly stated in standards established by the American Law Institute and the American Bar Association.[59]

Goals and content of diagnostics and classification, however, are not universally accepted. The Model Penal Code issued by the American Law Institute in 1962 calls for a separate center for the reception and classification of offenders.[60] Ronald L. Goldfarb and Linda R. Singer in their book, After Conviction: A Review of the American Correctional System, also support the use of centralized reception/diagnostic centers, and they use the Georgia Diagnostic and Classification Center as an example of a "diverse, well-equipped and professionally staffed" center.[61] Within the past few years, however, the benefits of these centralized centers have been questioned. The National Advisory Commission on Criminal Justice Standards and Goals recommends that the use of Reception-Diagnostic Centers be discontinued.[62] This is recommended because "the ceaseless repetition in the nature of its diagnostic entry work, becomes even more institutionalized than other forms of the classification process" and because of the fact that receiving institutions do not usually use the information provided by the center.[63] In fact, many re-test offenders upon receipt from the diagnostic center.[64]

The view that criminology could develop into a science such as medicine and that a diagnosis is needed to determine an individual's specific illness has also been questioned. In 1973 the National Advisory Commission on Criminal Justice Standards and Goals made the following recommendations:

1. The classificational system should be based on assessing risk and improving inmate management rather than on diagnosing cause.

This procedure should require that:

a. "No offender should receive more surveillance or 'help' than he requires; and

b. No offender should be kept in a more secure condition or status than his potential risk dictates."

2. The classification system should result from full participation from appropriate staff and the written procedures developed from this process should be made public.

3. All offenders should be provided the services of the diagnostic/classification system.

4. Individual dignity and rights should be accounted for by the system.

5. Individuals should be allowed "maximum involvement" when participating in the system.

6. Sufficient staff, properly trained, should be employed by the diagnostic/classification system.

7. Research needs must be taken into account in the design of the system.[65]

Undoubtedly, most correctional classification systems are designed to aid in inmate management, rather than to provide individualized treatment plans. The lack of knowledge of factors causing criminality, and the correctional system's inability to provide relevant treatment for many of the supposed factors are major limitations in providing causative treatment prescriptions. However, this does not mean that there has been a complete rejection of the treatment model. The American Correctional Association in the Manual of Correctional Standards views the primary aim of diagnostic and classifications systems to be the development and administration of integrated and realistic programs, and a basis for changing programs when indicated.[66] Rather than rejecting the treatment model, the American Correctional Association places diagnostic services at the focal point in the development of realistic programs that are tempered by the limitations of the environment in which they must occur.[67] In those areas where adequate knowledge is not presently available, ongoing research is recommended.[68]

The National Advisory Council on Criminal Justice Standards and Goals advises that the isolation period during initial classification should be no longer than 24 hours, and that the entire initial classification period should last no longer than one week.[69] The American Correctional Association indicates that the medical quarantine period should not exceed five days, but argues that segregation of new inmates for custody reasons may exceed the medical period.[70]

As has been shown, there is considerable disagreement among correctional authorities as to the purpose of institutional diagnostics and the procedure that should be used to obtain the information. There are three major areas of agreement among the National Advisory Commission on Criminal Justice Standards and Goals, the American Correctional Association, the National Council on Crime and Delinquency, and the Advisory Commission on Intergovernmental Relations. These are:

1. Offenders should participate in decisions affecting them;

2. Diagnostic staff should have specialized training;

3. Diagnostic services, such as mental, emotional, and physical evaluations, are needed at the community level to supplement the pre-sentence report.[71]

Alternatives

1. Continue current program with normal evolutionary improvement.

Advantages:

A. Substantial additional funds will not be needed.

B. Institutional structures and procedures will not be forced into rapid change.

Disadvantages:

A. Growth of community-based diagnostic services will be slow and sporadic.

B. Diagnostic information will rarely contribute to consideration of alternatives to incarceration, will rarely contribute to active treatment.

C. Program assignment will continue to be barely relevant to most inmates' needs.

2. Scale back diagnostic program to produce only what the system can now use.

Advantages:

A. Consistent with the position taken by the National Advisory Commission on Criminal Justice Standards and Goals, which, however, did not envision an efficient, automated, low-cost diagnostic program.

B. Immediate costs would be somewhat reduced.

Disadvantages:

A. A major force impelling staff training and program development would be reduced as clear indications of inmate needs are no longer explicitly recorded.

B. Producing the information the system can, does, and must use would cost almost as much as what is now being produced.[73]

C. Continuing research would be impaired.

D. Treatment decisions would become more arbitrary, less easily defended under court challenge.

3. Mount substantial effort to train staff in using information and insure the achievement of such use is monitored by filling the position of Statewide Diagnostic Coordinator.

Advantages:

A. Increase diversity of programs and relevance to individual need.

B. Improve staff morale and inmate participation in remedial programs as specific, closely defined actions are undertaken.

C. Define unmet treatment, training and education needs.

D. Increase accountability of both treatment and security staff.

E. Generate an optimistic, problem-solving atmosphere that can attract highly competent professional workers.

F. Inmates "right to treatment", if current litigation should so dictate, would be met.[74]

Disadvantages:

Additional funds for training would be required.

4. Increase offender participation in the diagnostic process.

Advantages:

A. More responsibility would be placed on inmate/offender to use information to design program to meet own needs.

B. May lead to new, more relevant programs.

C. Help place responsibility for change on the offender, thus freeing treatment staff to pursue their designated function - treatment - rather than salesmanship.

Disadvantages:

A. Documented treatment demands could prove difficult to meet, requiring substantial resources.

B. If "right to treatment" is established by the courts, serious problems could arise, although reasonable standards for treatment eligibility could keep such problems within bounds.

C. Staff requirements for "real counseling competence"[75] would dictate more intensive training costs.

D. Inmates may try to use diagnostic (particularly re-evaluation) data to manipulate system; however, diagnostic data, once made available to the offender, should not be a method by which others judge his/her progress.

5. More diagnostic data gathering in the community, as part of pre-sentence investigation.

Advantages:

A. Can be combined with alternatives 1 or 3 above; consistent also with 4, but in a different time frame, as offender's data would become his tool for rehabilitation after decisions about incarceration, probation, restitution, etc., had been made.

B. Would provide routine pre-sentence information for judges who want it, and thus help use various alternatives to incarceration with all possible fairness to offender and safety to the community.

C. Would define rehabilitation and treatment needs for probationers as well as inmates.

D. Eventually would free the expensive facilities at Jackson for inmates who need the extensive security offered there.[76]

E. Would improve functioning of probation and parole officers; also their morale.

Disadvantages:

A. Susbstantial transporation costs (staff or offenders or both) in rural areas.

B. Some increased training costs for probation and parole officers.

C. May generate substantial demands for community treatment or training facilities.

Recommendations

Alternatives 3, 4, and 5 are recommended. The Department of Corrections/Offender Rehabilitation should immediately begin to identify staff training needs as regards the use of presently available diagnostic and classification data by institutional personnel. To insure the achievement of department-wide diagnostic information usage, the position of State-wide Diagnostic Coordinator should be upgraded from a Merit System paygrade 19 to a paygrade 21 - the professional level of qualification necessary to manage diagnostic information usage on a department-wide basis - and then filled immediately to help identify the needed staff training.

It is further recommended that, to the degree possible, diagnostic information be communicated to the offender so that he, together with the appropriate counselor or probation officer, can use the information in planning positive programs.

Finally, it is recommended that diagnostic and classification services be concentrated in the sentencing community and used for pre-sentence reporting so that sentencing judges, at their discretion, may fully explore various sentencing alternatives and so that the same information may form the basic data for inmate assignment where incarceration results. Information developed can thus include both social and family investigations conducted by probation, parole and court officers and the psychological/vocational/medical assessment system currently used at the diagnostic centers.

Implementation Strategy

1. The Commissioner of the Department of Corrections should fill, immediately, the state-level position to coordinate and monitor the use of diagnostic information. This position shall be upgraded from a Merit grade 19 to a Merit grade 21 to place it at the level of management necessary for the duties prescribed. The individual filling this position should be responsible directly to the Commissioner for the effective use of diagnostic and classification data within such limits as may be imposed by security, budget, etc., so that:

   A. Inmates go to institutions that reasonably match their classification;

   B. Inmates are given opportunities to participate in programs that match their needs;

   C. Needed non-existent programs are clearly identified for consideration as funding permits;

   D. Community and institutional staff training needs are identified and appropriate training is instituted;

   E. Unmet diagnostic and classification needs are identified and, following suitable research are provided.

While all these responsibilities are currently defined as important, they are scattered and not the primary responsibility of one person. This strategy suggests that they should be.

2. As training needs are identified, the Department of Corrections/ Offender Rehabilitation should arrange focused educational opportunities, in-service training, and on-the-job guidance for community and institutional diagnostic personnel.

3. Community-based diagnostic services are now developing in order to assure productive sentence disposition. The Department should pace this development through strategic shifts of emphasis and funding, taking advantage of those instances where communities are ready and able to provide some resources. As community-based diagnostic services become available in the larger cities of the State, DCOR should take steps to shift remaining intake classification/diagnostic procedures to the sentencing community by suitable transition of funds and personnel.

4. As the Department of Corrections/Offender Rehabilitation shifts responsibility for program management to the offender, diagnostic data should be provided for the offender's use, and more intensive counseling training made available for those personnel who work with the offender as he undertakes his planning.

Financial Impact

State level staff to monitor use of diagnostic data and effective programming for offenders involves administrative cost. The currently unfilled position of State-wide Diagnostic Coordinator could cost $13,000, though approximately $3000 in additional monies will be needed to place the position at the level of management which is necessary.

Training costs may be kept from increasing unduly by refocusing existing training programs. On-the-job guidance may require consultants beyond those currently available. This is particularly true in areas of treatment, but efficient use of high level professional consultants to train and assist correctional staff can keep costs reasonable.

Community-based diagnostic services will require some technicians who are not now budgeted. However, these persons do not need college-level education as they simply follow standard testing procedures. They will also relieve some pressure upon the time of community-based professionals.

There are two major cost savings from diagnosis at the community level:

1. Judges will be in a more comfortable position to use (cheaper) alternatives to incarceration.

2. An expensive institutional facility, the Georgia Diagnostic and Classification Center at Jackson, can be freed for its maximum security mission.

Footnotes

1. Georgia Code Ann., § 77-310.

2. See for example, Ga. Code Ann., § 77-345 and 77-360.

3. "The Interim Report of the Georgia Diagnostic Classification Process Study", Georgia Board of Corrections (unpublished Report, DCOR), p. 15.

4. Ibid., p. 13.

5. Karl Menniger, The Crime of Punishment (University of Kansas Press, 1968,) p.

6. Richard Longfellow, Deputy Commission Community Services, DCOR, Personal Interview, June 1975.

7. Ga. Code Ann., § 77-345 through 77-360.

8. Ga. Code Ann., § 77-365 through 77-384.

9. Allen Ault, Public letter, undated.
"Operation Performance" is Dr. Ault's plan to make the corrections system both positive and objective. The four major areas covered by this plan are Pre-trial diversion, a broader Spectrum of Probation, a performance-based institutional system, and pre-release and after-care services for all offenders released from incarceration.

10. Oklahoma Department of Corrections, Special Community Supervision Project (SCSP). A Study of Probation and Parole Supervision in Oklahoma, 1969-1972.

11. Donald Laughlin, Assistant Deputy Commissioner, DCOR (Previously with Federal Bureau of Prisons), Personal Interview, Atlanta, Ga., June 1975.

12. Ibid.

13. Ibid.

14. South Carolina Department of Corrections, Masterplan (State of South Carolina, 1975) p. 301 and Illinois Department of Corrections "Inmate Fact Sheet" (Unpublished internal distribution) p. 2.

15. Ibid.

16. Oklahoma Department of Corrections, Oklahoma Corrections Masterplan (National Clearinghouse for Criminal Justice Planning and Architecture, Urbana-Champaign, Ill.), p. 117.

17. Ibid., p. 118.

18. Oklahoma, A Study of Probation Parole, p. 14.

19. Ibid.

20. Ibid.

21. James F. Mitchell, Psychologist Illinois Department of Corrections, Personal Letter, 13 August 1974.

22. "Mutual Agreement Programming".

23. S.R. McKinily and S.R. Hathaway, The Minnesota Multiphasic Personality Inventory Manual (Revised) (New York: The Psychological Corporation, 1951).

24. J.H. Pauton and R.C. Brisson, "Characteristics Associated with Drug Abuse Within a State Prison Population", Journal of Correctional Psychiatry, 1971,4, 3-32.

25. Ibid.

26. See for example, David Fogel, Untitled, unpublished manuscript, 1975, and June and September R. McGee articles in Federal Probation.

27. Ga. Code Ann., § 77-310.

28. Ga. Code Ann., § 77-345 through 77-360.

29. Ga. Code Ann., § 77-365 through 77-384.

30. Ga. Code Ann., § 77-380.

31. Ibid.

32. William Lowe, Deputy Commission Offender Administration, DCOR, Personal Interview, Atlanta, Ga., August 1975.

33. Board of Corrections, Classification Process Study, p. Attachment X.

34. Ibid.

35. Edward Bugg, Correctional Psychologist, GDCC, DCOR, Personal Interview, Jackson, Ga., July 1975.

36. Diagnostic Testing consists of the following psychological, social and vocational tests:

    1. Culture Fair Intelligence Test:

       This test provide measures of general intelligence that are relatively free of cultural and educational influences. For this reason, is is particularly well-adapted for use with a wide range of people, from retardace to genius, as well as for the culturally, educationally and socially disadvantaged.

2. Wide Range Achievement Test (WRAT):

   This test is used as a convenient tool for the study of the basic school subjects as reading (word recognition and pronunciation), written spelling, and arithmetic computation. It was designed as an adjunct to test of intelligence and behavior adjustment.

3. Sixteen Personality Factor Questionnaire (16 PF):

   This test is factor analytically designed to measure 16 traits of the normal adult personality.

4. Clinical Analysis Questionnaire, Part II (CAQ):

   This is a factored questionnaire of 12 scales which extends the 16 normal behavior scales of the 16 PF test by 12 new dimensions of pathological development.

5. General Aptitude Test Battery (GATB):

   This test is a collection of 12 exercises which is given to measure nine vocational aptitude areas.

37. Board of Corrections, *Classification Process Study*, p. Attachment X.

38. State Board of Corrections, *Rules and Regulations* (Atlanta, Ga. DCOR, 1975 rev.)

39. James Jester, Classification Analysist DCOR, Personal Interview, September 1975.

40. Board of Corrections, *Classification Process Study*, p. 17.

41. *Ibid.*, p. 15.

42. *Ibid.*, p. 13.

43. Herbert W. Eber, DCOR Consultant, Personal Interview, July 1975.

44. Albert Dutton, Deputy Commissioner, Community Facilities, DCOR, Personal Interview, July 1975.

45. *Ibid.*

46. *Ibid.*

47. Ault, letter.

48. *Ibid.*

49. *Ibid.*

50. *Ibid.*

51. *Ibid.*

52. Herbert W. Eber,"Some Psychometic Correlates of Inmate Behavior", Georgia Journal of Corrections, Vol. IV, February 1975, p. 36.

53. Ibid.

54. Floyd Goodman, Director Atlanta Pre-trial Intervention Project, Personal Interview, August 1975.

55. See for example, Stanley E. Grupp, ed., The Positive School of Criminology (University of Pittsburg Press, 1968.)

56. Ibid., p. 98

57. Fourth United Nations Congress on Prevention of Crime and Treatment of Offenders, Standard Minimum Rules for the Treatment of Prisoners, (Rev. 1970) p. 10.

58. Advisory Commission on Intergovernmental Relations, State Department of Corrections Act (1971) p. 16.

59. See the American Bar Association, Standards Relating to Sentencing Alternatives and Procedures (1968) and the American Law Institute, The Model Penal Code (1962).

60. Law Institute, Code, p. 35.

61. Ronald L. Goldfarb and Linda R. Singer, After Conviction: A Review of the American Correctional System (New York: Simon and Schuster, 1973), p. 92.

62. The National Advisory Commission on Criminal Justice Standards and Goals, Corrections, (U.S. Government Priting Office, 1973) p. 213.

63. Ibid., p. 207.

64. Ibid.

65. Ibid., p. 210.

66. The American Correctional Association, Manual of Correctional Standards (Washington DC: American Correctional Association, 1966) p. 360.

67. Ibid., p. 361.

68. Ibid.

69. Advisory Commission, Corrections, p. 213.

70. Correctional Association, Manual, p. 354.

71. See footnotes 59, 62, and 66, and National Council on Crime and Delinquency, Model Sentencing Act (rev. 1972).

72. Testing materials, computerized scoring and mail costs are $10.00 per offender. The cost of additional, diagnostic staff and admini-

strative support of these personnel and their efforts cost between $20.00 and $40.00 per offender.

73. The diagnostic information now being produced is used both as a tool for management as well as program recommendations. If program considerations were eliminated, diagnostic information would still be required for management purposes.

74. O'Conner v. Donaldson - U.S. -, S.Ct. -, - L.Ed. 2d - , (Case No. 74-8) (June 26, 1975). See also Wyatt v. Stickney, 325 F. Supp. 781 (M.D. Ala. 1972), aff'd sub nom., Wyatt v. Aderholt, 503 F. 2d 1305 (5th Cir., 1974), Davis v. Watkins, 384 F. Supp. 1196 (N.D. Ohio, 1974), and U.S. v. Moore, 486 F. 2d 1139 at 1246 (D.C.C.A., 1973) (Wright, J. dissenting).

75. Offender involvement in determining his needs and what programs best fulfill those needs will require counselors to aid the offender in finding and accepting the reality of the offender's situation and his capabilities for correcting that situation, rather than telling the offender what his needs are and what he must do to correct them and then just administratively monitoring progress as now occurs. As offender demands on counselors increase this necessitates that counselors receive extended training in counseling skills and may lead to professional certification for correctional counselors.

76. The Georgia Department of Corrections and Offender Rehabilitation, Annual Report 1974, shows the total cost per inmate day (excluding capital outlay at the Georgia Diagnostic and Classification Center to be $10.44 which is well above the $7.86 state average total cost per inmate day. Also, if the need for maximum security for an increasing number of inmates is not met by GDCC, new maximum security prisons would have to be constructed which currently could cost well over 20 million dollars.

END