180

INTERSTATE INSTITUTE
ON
THE MANAGEMENT AND TREATMENT
OF
THE MENTALLY DISORDERED OFFENDER

THE MENNINGER FOUNDATION
Topeka, Kansas

January 11, 12, 13, 1967

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THE MENTALLY DISORDERED OFFENDER

Arizona, Colorado, Kansas, Nebraska
Nevada, New Mexico, Oklahoma, Utah

THE MENNINGER FOUNDATION
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INTRODUCTION

The papers to follow were presented at a three-day conference, January 11, 12 and 13, 1967, held at The Menninger Foundation in Topeka, Kansas.

The conference itself was an aftermath of a more informal seven-state meeting held in Albuquerque in January of 1966 at the invitation of the New Mexico Council of the National Council on Crime and Delinquency. Correctional and Mental Health representatives of these seven states (New Mexico, Arizona, Kansas, Oklahoma, Colorado, Utah and Nevada) spent two days at that meeting discussing the difficulties and the knotty problems which plague attempts at collaboration between Mental Health and Corrections. The discussions were far-ranging and uninhibited, covering such topics as, what is a mentally disordered offender, psychiatric services in correctional institutions, recruitment and manpower difficulties, psychiatric diagnostic services, programs for offenders in mental hospitals, alcoholism, the interstate compact on mentally disordered offenders, and many others. It cannot be said that monumental decisions were reached in Albuquerque, but issues were identified and discussed and the weakness generally of psychiatric treatment services for the mentally ill offender highlighted. The conference did decide that further sessions should be held. A steering committee was appointed and it is from its work, and the helpful collaboration of the Office of Law Enforcement Assistance, that the Topeka conference resulted.

At the Topeka conference the seven original states were joined by Nebraska. Funds were made available by the Office of Law Enforcement Assistance to bring to the conference four delegates from each state appointed by their respective governors, two from the correctional system and two from the Mental Health Agency.

An attempt was made in planning this conference, which hopefully is reflected in the following papers, to present the views of leaders in the field in orderly sequence. We begin with a statement of the issues as seen by corrections and follow with a presentation of the national picture by a National Institute of Mental Health representative. We move on then to an airing of new vistas in corrections by a specialist in correctional research, and devote the subsequent session to a psychiatric look at antisocial behavior and a consideration of the role of the psychiatrist in the correctional process. Finally and perhaps most importantly, there follows a description of a psychiatric institution operated within the framework of a state correctional system, and an example of mental health services being conducted within a

state correctional system by a state Division of Mental Hygiene. The closing sessions dealt with the correctional institution's responsibility to and relationships with the community, as it has to do with problems of the mentally ill offender, and a summary of the conference.

This volume is presented with confidence that the writers of the following papers address themselves to the issues from backgrounds of leadership, experience, and responsibility. Diversity of opinion and conceptionalization is expressed. The lack of unanimity which characterizes current thinking about criminal behavior is reflected here. There was no pretense of covering the field. Our focus was intended to be on institutions and their programs with special reference to the better identification and treatment of the sentenced offender with psychological disabilities. No attempt was made to consider the integration of mental health principles and services in other phases of the correctional process although inevitably this is touched on by the speakers and arose prominently in the discussions. The major question was, how can small population states especially, with only a handful of seriously disturbed offenders, provide a program of treatment and management which avoids being dehumanizing, repressive and simply controlling? Is the establishment of interstate institutions, or Federal Regional centers a solution? These questions lead to a host of others and we are aware that no definitive answers are here provided. Nevertheless it is our hope that these discussions will contribute to progress.

Russell O. Settle, Sr., M. D.
The Menninger Foundation
Project Director

CORRECTIONS LOOKS AT PSYCHIATRY

J. ROBERT WEBER

NATIONAL COUNCIL ON CRIME AND DELINQUENCY

Social and political pressures have mounted in American society for the inclusion of psychiatric services as an integral part of corrections. Whether we welcome this trend or whether we view it as silly and unwise, one cannot deny the fact that the pressures exist. The holding of this conference is but one example of this trend.

Pre-institute Survey

Prior to this meeting, 13 Western states were asked to report on the existence and adequacy of psychiatric services in their correction institutions. If I might borrow the term from the United Nations, which refers to the industrialized nations as "developed", and the non-industrialized, poor nations as "developing", I will apply these categories to survey findings in the 13 Western states. Two states reported no psychiatric services whatsoever; two states I would classify as "developed", that is, they have regular ongoing psychiatric services fairly well integrated within their total correction program. Nine states I would classify as "developing". Of these, four have extremely limited services. Thus, six, or nearly half of the Western states have no really meaningful psychiatric programs in adult corrections. Five states have some services for some inmates but they are as yet not integrated into the correction system.

In one survey question, administrators were asked about problems with psychiatric services within the institution. In reply the most frequent problem mentioned was the need for more psychiatric time. The reason, generally speaking, for what was considered inadequate psychiatric services, was lack of budget. Also mentioned was the costliness of psychiatric services in relation to the large numbers of the institution population. Thus, psychiatric services need to be provided more efficiently and economically to more adequately cover the total population. One state reported that its chief problem with psychiatric services was that it upset custodial staff and interfered with effective functioning of the guards. Another state said the psychiatric services were not sufficiently correctionally oriented. The psychiatrist did not understand the social system of the institution. Another state complained about the inadequacy and impracticality of diagnosis. "The information cannot be translated into practical program terms or in ways of altering the handling of the inmate."

Other comments noted:

"The major problem is the insufficient number of psychiatrists on the staff to perform an adequate service to management."

"It depends on the personality of the psychiatrist as to how effective service is."

"Often psychiatric diagnosis fails to pin down the individual problem to the specific available program. Thus, psychiatric help is not as practical as it might be."

These quotes are essentially correction administrators talking to psychiatrists, but I'm not at all sure the psychiatrists are hearing them. However, there is the other side; obviously correction administrators are not hearing what psychiatry has to say. Let me review briefly an experience of my own that may provide some insight into this problem from the vantage point of mental health rather than correction.

Several years ago, I was in the pioneering position of initiating a mental health service to a correction institution. The administrator was dubious, but the service wasn't going to cost him anything. He had doubts about what psychiatry could add to his program, and probably fears about what havoc such services might create. However, on occasions of increasing frequency he had been very defensive about the absence of any psychiatric services for his inmates... and ultimately agreed to accept two days a month of psychiatric servicds as offered by the state mental health agency.

The psychiatrist and I appeared at the appointed hour of the appointed day. At the administrator's office we learned that five young men had been selected to receive a psychiatric evaluation. Their jackets or case folders were given to us, and an office and a tape recorder made available. Each folder was so thick it would have taken us a couple of days to have read all five. We did not know the staff; had only fragmentary knowledge of the daily program; and we were unfamiliar with the formal and informal rules governing staff inmate relationships. We didn't even know why these five young men had been selected for evaluation, and we were not told.

I quickly summarized essential but skeletal data for our first appointment. Essentially, it appeared the inmate was being referred for infractuous behavior. I later wondered if he was being referred as a punishment for rule violations. The young man seemed to perceive the referral as punitive. When ushered into the office, he sat at attention and responded in monosyllables. "Yes, sir", "no, sir", and

"I don't know, sir" was about as much as we got out of him. I offered him a cigarette but later learned this was a violation of the rules. The psychiatrist asked leading questions which he thought would be innocuous and benign topics for conversation. For example, questions as "what do you like best about your daily program?" After 30 minutes of this kind of inane conversation, we dismissed the man but were unaware of the fact that we were supposted to notify a guard that we were through. For some reason, the line personnel were hesitant to instruct us as to procedures and we had to learn standards of behavior piecemeal and mostly through careful observation.

Subsequently, practically every report for the five men we talked with on this date began "This 18-year-old white man appeared tense, very guarded and uncommunicative." This was followed by a few more equally descriptive phrases. We were aware, frustratingly, that our services had been of no value to either the institution, the administrator or to the inmate. For one inmate, the psychiatrist wrote a prescription for an anti-convulsant drug, but I suspect this was more from his own frustration than from the medical situation of the inmate.

At the end of the day, we reported back to the administrator. Perhaps because the day had gone without any major disturbances, he was somewhat relaxed. We then learned a little more about the inmates we had seen - and their situations, than we had from talking to them and reading their folders. Unfortunately, we would not predict how they were going to behave tomorrow, and this seemed to be what was expected of us. After making arrangements for our next visit, we drove home somewhat depressed but refusing to be discouraged.

To make a long story short we continued on. To be sure, we knew the futility of our efforts, but we didn't rock the boat. The institution smoothly continued its daily repetitive patterns and the administrator could now brag about having "psychiatric services two days a month." The fact that they were intrinsically worthless was beside the point. The point was the administrator could say in all honesty that he had psychiatric services. They were of a limited nature, but for public consumption his institution could now do a better "treatment" job. In fact, what he had was a slight benign protuberance on the body politic of his institution; nothing else was changed.

It was somewhat to my astonishment when I learned during a recently concluded nation-wide study of program developments in juvenile corrections that what I have just described was not unique. Across the nation a rather accurate description of psychiatric services in many correctional institutions does not vary much from what I have just described.

The Problem of Communication

The biggest single problem from the viewpoint of corrections in looking at psychiatry is the problem of communication. I would like to mention six factors which contribute to this problem. These are factors that I believe must be dealt with, or at least understood, in any attempt to improve communication.

1. The first factor is geographic and administrative isolation. (a) The problem of geographic isolation, I think, is readily understood. It consists in the fact that state hospitals and prisons notoriously are located large distances from the population centers of our states. This creates difficulties in making institutions permeable to the community and isolates the institutions from our universities and training centers. (b) The problem of administrative isolation particularly relates to the fact of state hospitals and prisons operating largely as autonomous state agencies... and their consequent isolation from a parent agency responsible for a continuum of services between the institution and the community. This makes difficult the development of administrative concerns external to the daily functioning of the institution.

2. The second factor in communication springs from differences in educational background. Language differs, words have different connotations.

3. Of major importance are ideological or philosophical differences between correction and psychiatry. In general and at a rather abstract level, I will illustrate what I mean by mentioning the philosophic argument of determinism vs. free will in the motivation of human behavior.

Psychiatrists traditionally operate from a deterministic point of view regarding motivation. Corrections, however, tends to operate more from a notion that people are responsible for their behavior. To this extent, corrections is much closer to the operant conditioning theories of learning. There are also philosophic differences in relation to the concept of deterrence. Corrections views deterrence as a major component of program and offers a rather simplistic notion of deterrence. Psychiatry, on the other hand, has a much more sophisticated view of deterrence which has, however, proven difficult to translate into practical everyday management terms.

4. The fourth element that I would cite as contributing to the problem of communication is the lack of candor between correctional administrators and psychiatrists. I don't think I need to elaborate

on this point. In a sense, it is a reiteration of the problem. However, before better communication is established, psychiatrists and correctional administrators must learn to be more honest in their dialogue.

5. There are unrealistic expectations on both sides. Psychiatrists fail to understand the security concerns of correctional administrators, and the program limitations created by court sentencing practices over which corrections has no control. On the other hand, correctional administrators invest psychiatric diagnosis with almost magical properties.

6. The sixth factor in the problem of communication is what I would call on the part of psychiatrists a syndrome of snobishness, arrogance or superiority. Whether psychiatrists willingly accept this description is not as important as their realization that too often this is how correctional administrators perceive them. Perhaps this aura of superiority is an infectious affliction having its etiology in psychiatric training. I don't know. It is far too pervasive to dismiss on the basis of the individual personality of psychiatrists.

Let me discuss this last factor in more detail. First, few psychiatrists are professionally located in correctional systems. They often provide consultation from a base in private practice or from a state hospital in the state bureaucracy. They are, therefore, on a part-time basis in correction and as a result merely on the fringe of correction. This may contribute to the frequent perception by correctional staff and administrators of an apparent arrogant superiority. But I suspect that three other factors also contribute. These are beliefs or assumptions frequently held by psychiatrists. I think that they are fallacious assumptions that need close examination.

1. The first is that psychiatric care is more humane than correctional care of inmates... or to put it another way, a state mental hospital is a more benign milieu than a prison. This is a dubious assumption.

2. The second belief is that if psychiatrists were operating and managing correctional programs, corrections would be a more effective and efficient system. The limited evidence that we have is to the contrary.

3. That psychiatric services are appropriate to all personal-social problem solving situations. I doubt this. In fact, this last assumption is clearly inadequate for the shaping of public social policy regarding the handling of individuals who comprise major social problems in our society. I prefer to think that these people are not all sick.

The effectiveness of psychiatric services, in my opinion, is unfortunately further limited by the stigma attached to the receipt of service. I personally deplore this but that it is a fact, I cannot deny. In juvenile institutions around the country the common term for the psychiatrist, and not an affectionate one is the "shrink." To no small measure, the attitudes implied in this term have been, and continue to be, manifested by staff who themselves should know better. The negative consequences of stigmatizing services are significant and raise legitimate questions as to which individual, despite a definition of need, might be better off without service--and which persons are legitimately helped?

If, in fact, the three assumptions that I have just outlined do contribute to an aura of superiority in psychiatrists, then bringing them to light may result in some measure of humility.

I would now like to move on and discuss psychiatric services, I think of six functions. They are:

1. consultation to program and staff;
2. consultation to administration;
3. diagnostic evaluation;
4. staff training;
5. drug supervision;
6. treatment - meaning psychotherapy and group therapy

When I talk about psychiatric services, I am referring to these six functions. I am also referring to the performance of these six functions by a psychiatrically-trained physician who also on occasion functions in a team relationship with psychologists and social workers. Sometimes, certain functions are performed primarily by social workers and psychologists under the supervision of a psychiatrist or with psychiatric consultation.

I would like to discuss psychiatric evaluation first. This is the function most frequently available in correction settings and the function about which corrections expresses its greatest frustrations.

It doesn't take a psychiatrist to tell correctional staff that they have a management problem with an inmate. A sizeable number of management problems are clearly understandable to correction staff from the contest of the institutional system in which norm-violating behavior has occurred. There are, however, incidents of inmate behavior not easily explicable from the situational contest. Is the inmate ill? Or is the inmate playing games, putting on or malingering? If the latter, corrections staff generally have confidence in their ability to handle the problem. If the former, the question is -- should the inmate assume patient status and be cared for by a medical authority?

Depression, the "jail house blues", aggressive feelings, fantasies, are to some extent experienced by nearly every inmate. Usually this behavior is of a situational nature, and staff doesn't think of the need for psychiatric care. Other inmates, however, do present disturbed behavior over prolonged periods of time. The problems they present to management are of such a magnitude that the administrator seeks help wherever he can find it. Psychiatry is perhaps the most frequent of the professions to which the administrator turns for assistance. Frequently what the administrator wants is the psychiatrist to remove the inmate and care for him in a medical facility. This seldom happens and often should not. In relation to juveniles in training schools, it has been my experience that mentally disturbed youths are frequently more appropriately cared for in the training school than by transfer to a state hospital.

In explanation for this, we generally find inadequate or extremely underdeveloped services to adolescents in state hospitals. Moreover, there are therapeutic advantages in youths being able to relate to other youths in the training school rather than to patients of diverse ages in a hospital. The program of a training school, particularly education and recreation, are designed for adolescents.

Too frequently, facilities are lacking both in state hospitals and in prisons for the care and treatment of the obviously mentally ill offender. My own view is that this problem is not essentially a problem of conflict between corrections and psychiatry, but an administrative problem of state government. The question is essentially the allocation of responsibility to one or another state agency or to a regional facility on a contract basis. Required is appropriation of an adequate budget to fulfill the mission... which is the incarceration and treatment of the acutely ill offender.

Estimates by correction administrators from our cursory survey vary as to the number of inmates in prisons who are mentally disturbed. In institutions I have categorized as "developing", administrators generally estimate something like 5% of their population are in need of psychiatric care or services. But an interesting thing happens - in institutions where psychiatric services are integrated within total program. Here administrators estimate that "if we had the psychiatrists, nearly 2/3 of our population would benefit from their services." Obviously, these administrators are looking at psychiatric services differently.

The problem, as I see it, between psychiatry and corrections, is the "useful"definition of mental illness. Who is mentally ill? The principal problem with psychiatric diagnosis is not in determining the individual obviously out of contact with time and space, but the failure to differentiate between the "normal" and the "aberrant". Thus, the

problem of diagnosis is its inapplicability to the realities of the context in which the behavior occurs. The reason I think this is so, is the ideology psychiatry has developed regarding deviance.

Strategy to rehabilitate criminals and delinquents has often been shaped by one or another psychogenic theory which views criminal and delinquent acts as symptomatic of the offender's underlying psychic or emotional pathology. That this point of view is still deeply embedded in the approach of the clinical disciplines to these phenomena is evidenced by the following statement, taken from a recently published article by the psychiatrist, Philip Roche:[1]

> "In discussing mental illness and criminality, it would be well if at the outset I make clear certain assumptions with which we can work. Let me give you briefly what I believe them to be.
>
> First, we all seem to be more or less subscribing to the view that criminal behavior is a symptom of a kind of mental illness. We have reached a point in our thinking where certain kinds of criminal behavior are actually accepted as mental illness."

Within this frame of reference, criminals and delinquents have come to be viewed as "sick"people and the ideal correctional agent-offender relationship is seen as a therapeutic one. The direct analogy between the patient and his doctor on the one hand, and the offender and his psychiatrist or caseworker on the other has been directly stated and tenaciously defended for at least three decades.

This view of law violations as symptomatic of the offender's "mental illness"has developed out of the deep historical interest of psychiatry in crime and delinquency and has, by this time, been passed on to thousands of correctional workers. Indeed, there is reason to believe that, in America over the last several decades, this approach has become ideological in character. Michael Hakeem has stated:

> "The psychiatric approach proceeds on the basis of, and is interested in fostering, a certain ideology regarding juvenile delinquency. This can be referred to as the clinical ideology, and its theories and methods are analogous to those of clinical medicine. The major

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1. Philip Q. Roche, "Mental Health and Criminal Behavior. "Federal Probation, vol. XXIX, no. 3 (September, 1965), p. 7.

tenets of this ideology are that delinquency is a disease and that the delinquent is a sick person.[1]"

Within the "mental illness" scheme, the criminal or delinquent is seen to commit his act because of some underlying psychic problem or character trait. The particular act committed is significant to the diagnositc process principally insofar as it provides insight (often through symbolic interpretation) into the offenders emotional and psychic difficulties. This seems perfectly consistent with the assumption that the individual would not behave in such a "wrong" way unless he were "sick." The illness, whether it is the result of early, faulty parent-child relationships, or unchecked libidinous energy, is the cause of the criminal or delinquent behavior, and hence, must be removed or controlled before the individual can be expected to refrain from such behavior. Two social workers, Herschel Alt and Hyman Grossbard, writing about fifteen years ago, succinctly stated the essence of this approach in the following statement:

> "... delinquency appears to be primarily a psychological problem and is to a large extent independent of any given culture. ...treatment has to be primarily directed on an individual level and through a psychological approach."[2]

Another quotation from Harkeem:

> "Psychiatrists, in their approach to delinquency, have from the very beginning taken it for granted that the mental condition and personality of delinquents must deviate from the normal. It has been seen that this view is at the very foundation of their ideological position. This also accounts for the fact that so many psychiatric facilities for delinquents never diagnose a single 'patient' as 'normal'.[3]"

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1. Michael Hakeem, "A Critique of the Psychiatric Approach." in Juvenile Delinquency. Joseph S. Roucek (ed.), New York: Philosophical Library, 1958, p. 80.

2. Herschel Alt and Hyman Grossbard. "Professional Issues in the Institutional Treatment of Delinquent Children," American Journal of Orthopsychiatry. XIX (April, 1949), p. 280.

3. Michael Hakeem. op. cit., p. 84. For a similar statement regarding the aciomatic nature of the mental illness position, see. David Matsa, Delinquency and Drift, New York: John Wiley & Sons, Inc., 1964, Chap. 1.

The trouble with all this is that there are not enough psychiatrists to go around, not to speak of psychologists and social workers. The shortage of professional manpower is one that we are going to live with for at least two decades. Within the reality of having to use scarce professional skills most effectively and efficiently, must the correction administrator ask the question, "How do we differentiate between 'normal'mentally ill and 'abnormal' mentally ill?" If we have to ask the question this way to determine how psychiatrists can best serve corrections, the question becomes rather silly. It would be more appropriate to ask, "what is meant by mental illness?" This deceptively simple question is without an adequate answer.

Although psychodynamic theory concerns itself with functional disorders--not organic ones,--the fact is the postulates and internal logic of the conceptual schemes of psychodynamic theory were derived from research by psysicians into behavioral disorder stemming from the organic malfunctioning of the brain. These constructs were extrapolated for the purpose of analyzing and explaining functional disorders --that is, what the physician, or the community, judges to be a behavioral disorder arising out of what is judged to be an individual's nonorganic psychic malfunctioning. For psychodynamic theory to provide a scientific base of psychiatry as an appropriate sphere of medicine, and for the maintenance of the expertese of the psychiatrist, the notion of mental illness ultimately must be tied to an anatomical and genetic context.

It is not credible for psychiatrists to insist that all law violations are a sympton of mental illness. The process of defining violators of law in society is much too complex to be explained on the basis of the genetic and organic structure of the human organism. While the anatomical and genetic context of human organisms is relatively fixed and uniform for individuals, the social context of human behavior and personality is not. Thus, in my opinion, much of the psychodynamic explanations of a law violator is in the category of fiction.

Let me move away briefly from the arena of psychiatric diagnosis and say a few words about diagnosis from a social work perspective in a correction setting. In my judgment, the most significant criterion for diagnosis is response to treatment. Diagnosis is an ongoing process not limited to a specific interview or testing period. Secondly, the only intent of diagnosis is to improve the quality of information available as a basis for decision making. Information not relevant to available placement alternatives or program options interferes with appropriate decision making. Many diagnostic processes function to obscure and blur legitimacy of available alternatives or options and leaves the decision-maker worse off than if he had initially decided on the basis of intuition.

I would make one further point, and that is the powerlessness of clients in the face of labeling by professional experts. There are negative consequences attached to this powerlessness. Traditionally, the client is in no position to argue about the diagnosis in the event he disagrees with it. In fact, such behavior, if engaged in by the client, merely tends to reinforce the diagnosis and provides additional justification for its validity. In corrections, particularly those programs with reintegration objectives, considerable experience in allowing the inmate to define his own problem in conjunction with staff and peers has been found useful. There is no imposition of a diagnosis by an expert. Thus, diagnosis as a mere process of defining problems, is a responsibility of the offender who accepts his problems, as they are defined, as credible.

Returning now to psychiatric evaluations, I suggest the value of diagnosis is twofold: 1) it can contribute to a more adequate information base for decision making: 2) it can provide justification for management decisions. To attain these values psychiatry needs to do some careful thinking about diagnostic labels.

Concepts like "schizophrenia" and "sociopathic personality disturbance" are psychiatric concepts widely borrowed by correctional experts and recommended as guidelines to the understanding of offenders. But they have not proven useful either in the prediction or the control of human behavior.

In the opinion of one of the most distinguished of American psychiatrists, Dr. Karl Menninger, the current official psychiatric diagnostic categories were sufficiently inadequate as of 1963 so that he was moved to propose a fresh start to which he devoted his book The Vital Balance. In the following year, 1964, the New York State Psychological Association was impelled to urge its parent body, the American Psychological Association "to create a task force" to provide a new diagnostic system. Among the reasons given for rejecting current procedures were:

> ...The descriptive nomenclature of the (current diagnostic) manual is conceptually confused; the term "psychiatric" is ambiguous (as Thomas S. Szasz has asked "does the term refer to physiochemical or behavioral events?"); the term "nosology" is misleading as it refers to diseases;...(it) has no predictive significance, does not state the conditions under which psychological change (and the direction of change) will occur and the descriptions have no dynamic significance which enlighten the psychologist to the silent meanings or causative factors underlying behavior.

The psychiatric label does not discriminate usefully between criminal and non-criminal populations nor does it accurately reveal rehabilitation potentialities of the offender.

Turning to the treatment techniques of psychotherapy and group therapy, these methods are psychoanalytic in derivation. These techniques have not been relevant or applicable in the correctional field on a number of counts. For instance, they are concerned primarily with (a) the understanding of intra-psychic phenomena for (b) the relief of subjective discomfort in (c) voluntary patients who are (d) free to choose their own goals, since typically they have not been identified as lawbreakers. In correctional work, on the other hand, the primary concern is with (a) the modification of overt behavior where (b) there may be no subjective discomfort to begin with and where its existence is of only incidental concern to the enforcement agency, in any case. In fact, given a choice, the agency would be required to discourage illegal behavior even where it significantly increases subjective discomfort, as in drug addiction, etc. Moreover, the clients (c) are not voluntary, (d) nor are they free to choose their own goals because such goals may previously have involved behavior threatening to the community.

As you see, I have grave reservations about the efficacy of coercion as related to psychotherapy and group therapy in correctional settings. On the other hand, the availability of these treatment services as a choice to inmates of correctional institutions in much the same manner as they might be to a citizen in our community may well be legitimate for the incarcerated offender. If they are to be made available, however, a wise management decision would be to tie assessment procedures to the availability of the services.

I shall skip over drug supervision as a function of psychiatric services and turn now to consultation.

1. Administrative

A model that I think has some relevance is the management consultant firm providing service to private industry. Psychiatry possesses special knowledge which can assist correctional management in program planning, development, and trouble shooting. A pre-requisite to this type of service from psychiatry is an intimate knowledge of the field of corrections which is precisely where there is the greatest paucity and inadequacy in administrative consultation by psychiatrists.

2. More common is what I term case-consultation. In this situation staff describes a problem situation around an individual inmate. The psychiatrist may or may not interview the individual in question. The function of the consultation is: 1) provide practical suggestions regarding how the individual might be handled differently in the future; 2) provide a more comprehensive understanding of the individual symptoms and personality structure; and, 3) increase the confidence and competence of staff in dealing with the individual in question.

In my observations of the juvenile field, staff and administrators of juvenile institutions have discovered a more productive use of available psychiatric time in consultation and staff training rather than in psychiatric evaluations. In the two developed states reporting in the pre-institute survey, there was also confirmation of this trend toward greater use of the psychiatrist in program and case consultation rather than solely in diagnosis. It has also been my observation that psychiatrists generally find this type of service to correction institutions more fun, more stimulating, and feel their services are better used than when they were seen only performing a narrow service of diagnosis.

Staff Training

The staff development consequences of consultation are not insignificant.

In formalized training programs mental health specialists are used in didactic type sessions in which they teach a designated subject matter.

Another method of staff training is small group discussions in which the psychiatrist sits as a participant. There is no agenda, and staff are free to discuss problems with each other and with the psychiatrist.

Many institutions have found these ongoing groups an effective staff development device and an effective way of using the special skills and knowledge of the psychiatrist in program.

Correctional Institutions

I am now going to say a few things about correctional institutions as a locus for psychiatric services. Most correctional institutions can be described by four characteristics (1) they are monolithic; (2) they care for an undifferentiated population; (3) there is a polarized social structure between the inmates and staff...the keepers

and the kept...and, (4) standards for inmate behavior are aimed to achieve inmate conformity to the social system of the institution. These characteristics also describe some mental hospitals I have observed. Obviously, all correctional institutions cannot be so characterized. To name some would include, forestry camps, group treatment centers, halfway houses, specialized correction institutions with screened intake, etc. But when a state provides a single prison for all sentenced felons or a single training school for all committed juveniles, more often than not the characteristics I have enunciated are appropriate. The program objective of congregate institutions, in practical, operational terms, is the incarceration of people for specified periods of time. This is generally referred to as custody, and I want to comment about the organizational objective of custody. It is my opinion that offenders should be incarcerated as a punishment and not for punishment. Further, in the interests of our society, the congregate institution should be held accountable for returning inmates to the community not more anti-social or criminally inclined than he was upon entering the institution. The institution should also operate programs geared to the prevention of personality deterioration. I think these objectives are realistic, practical, and capable of assessment. It's like saying that the institution is held responsible for the physical well being of inmates. This does not mean that some inmates will not be involved in accidents, contract pneumonia or die of cardiac failure, but the institution can meet specified health standards in its physical arrangements and daily program activities which are geared to maintaining the physical health of the total population. In order words, I think certain standards can be developed to maintain the mental health of inmates. I cannot tell you where these standards have been spelled out in specific detail, and there is much that we obviously need to learn. A step in this direction, I believe, has been made in the institutions chapter of the corrections section of the final report of President Johnson's Commission on Crime and Law Enforcement which should be published in the near future. Very briefly, a model of a collaborative prison is developed and discussed; the principle points are group process in daily programming, new disciplinary procedures, making the institution more permeable to the community, and the reduction of social distance between inmates and staff.

To hold the institution accountable for a more humane and benign custody of offenders to me appears reasonable, and to this end psychiatry can be a helping ally. It is only when the congregate institution has foisted on it the objective of behavioral change in inmates or is held accountable for subsequent law abiding adjustment of inmates that we get into trouble. Rehabilitation, treatment, or reintegration of the offender into the community, are all goals much talked about today. If I were a warden of a prison, however, they would

make me feel terribly uncomfortable if the only organizational arrangements I had as tools to achieve resocialization of offenders was the prison. I do not think the task of reintegration is a reasonable one to be achieved by a congregate institution all by itself. If I were that warden, however, I would probably get me a "house psychiatrist" so that I could brag about my "treatment" program. I would complain about my inadequate budget, and I would resist any cost benefit analysis of the post adjustment of inmates released to the community. If corrections is to be held responsible for the reintegration of offenders into the community, what is necessary are other organizational arrangements for the care and programming of offenders, than just a single congregate institution. What is required is an array of facilities comprising a total institutional system under coherent administration. One might conceive of these small institutions as links between the traditional prison and the community. The inmate would be provided stepping stones into the community before final release or discharge. Thus, the release process, which in most states is a rather abrupt prison-to-parole, would be more gradual. The institutional facilities would be designed to achieve a specific program objective with inmates screened as to appropriateness for programs, as well as active participants in the decision to enter. The ultimate sanction, of course, of the failure to adjust would be return of the inmate to the prison.

Thus a system, not a single institution, is held accountable for reintegration, and each facility that comprises the total system is held accountable for designated components of the reintegration process.

In the juvenile field, much progress has been made in some states toward the development of a diversified correctional institution system. Juveniles, however, are committed for an indeterminate period of time while many adult offenders have specified periods of time to serve before eligibility for parole is established. This factor has undoubtedly played a role in the slowness of adult corrections to develop a diversified array of institutional facilities. What we have in most states are satellite operations of a prison, such as a prison farm or a camp and other types of minimum security facilities which are essentially an extension of the main institution and are used for deserving inmates. The organizational structure and social system of these facilities in most states are not designed to enhance the achievement of a specific program objective such as vocational skill acquisition and community job placement, or attitudinal change, or clinical treatment.

With a diversified system with an objective of reintegration of the offender into the community, the use by corrections of the special knowledge and skills of psychiatry takes on new dimensions.

Concluding Statement

In conclusion, I would like to make three points which I believe corrections needs to say to psychiatry if a collaborative relationship is to be developed. In a sense, these three points are a summary of the implications from my preceding comments.

First, psychiatry needs to address itself to the problem of definition -- what is meant by mental health and what is meant by mental illness. I suggest that psychiatry scrutinize its services as a part of this examination. For instance, are services aimed at strengthening mental health the same as services used in treating mental illness? If so, what are the ethical, social, and political implications for our developing society? ...and this question needs to be asked.

My second point relates to the whole area of psychiatric evaluation or diagnosis. Psychiatric evaluation must be related to available program decisions. This will require on the part of psychiatrists intimate knowledge of correctional programs. Unfortunately, too often it appears psychiatrists do not have the time to pursue this knowledge. If diagnostic differentiation has no practical application to differences in the handling of inmates, of what value is diagnosis? For psychiatry to contribute to corrections, it must take an honest look at this question. Too often psychiatrists refuse to make practical, tangible suggestions concerning the management implications of diagnosis. Rather they tend to sit back and second guess correctional administrators for making management decisions concerning inmates which administrations must make on an every day basis. The issue is not that psychiatry may have nothing solid to offer corrections, but that it must be honest in what it does have to offer and provide it in terms meaningful to correction settings. Further, this entire problem must be approached on a partnership basis of equals rather than on the present superior-subordinate type of relationship commonly felt by corrections administrators.

My third and final point is the need for assessment of the results of psychiatric treatment and consultation in correctional settings within a total monitoring of the correction system itself. This will require the asking of precise and correct questions. I suspect that these questions have not yet been formulated. When they are, the organizational arrangements in which services are provided, may be a factor more important than that of diagnosis, treatment, or the education and skill level of staff. Fortunately, in recent years new ways of dealing with the thorny problem of program assessment have emerged. "Systems Analysis" is the best known method of those to which I refer. It is a method that selects its goals more deliberately, relates means to ends more systematically, and assesses results more candidly. But more than just efficiency is involved; objective monitoring of corrections and all its programs, in my opinion, will develop a stronger sense of direction and a stronger sense of purpose. To this end, let us have our symposium.

SOME PROBLEMS REGARDING THE LABELING AND HANDLING OF MENTALLY DISORDERED OFFENDERS

Saleem A. Shah, Ph.D.[1]

The term "mentally disordered offenders" has generally been used to include a rather broad range of persons, among them some who are not legally offenders, viz., defendants at the pretrial stage and persons acquitted by reason of insanity. However, the above label is used in this general fashion to include persons who have in common the manifestation of deviant behaviors described as mental disease.

Among those included in special programs for mentally disordered persons who have been accused or convicted of law violations, some have been defined by the judicial process, e.g., pretrial incompetents and those found not guilty by reason of insanity. Others have been labeled and placed in the above category by mental health professionals, e.g., convicted offenders found to be psychotic or otherwise in need of special care and treatment.

The following are the categories of persons generally included in programs designed for "mentally disordered offenders":

1. Persons accused of or defendants in criminal and related actions who have been sent for mental observation and examination in reference to some legal issues, e.g., competency to stand trial, criminal responsibility, determination of sexual psychopathy, etc.

2. Persons adjudged incompetent to stand trial and confined for treatment.

3. Persons acquitted by reason of insanity and confined for treatment.

4. Adjudicated criminal sexual psychopaths or defective defective delinquents.

5. Psychotic or otherwise seriously disturbed offenders transfered from correctional facilities - adult or juvenile - because of serious mental disorder.

6. Persons transfered from mental hospitals and related institutions because they are dangerous, serious custody problems, etc.

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**The views expressed here are the author's and not necessarily those of NIMH.

Since the definitions and questions involved in the aforementioned determinations pertain both to legal and to mental health criteria, it is not surprising that at times these criteria become confused and a number of problems arise.

Various studies have indicated that in many instances persons conducting court-ordered mental examinations are not well-informed about the particular legal questions and criteria involved. The issue of competency to stand trial may be confused with that of criminal responsibility, commitment, etc. Furthermore, mental health professionals often use their own rule-of-thumb criteria in the absence of clear and detailed instructions from the courts. Often, for example, psychosis is viewed as indicating incompetence to stand trial, with absence of psychosis seen as signifying competence. The fact that courts often tend to "rubber stamp" such conclusory reports by the examiners and do not hold hearings on the issue, further confounds the problem (7 & 11).

The Concept of Mental Disease

Since our concern here is with persons who are considered to be suffering from various types of "mental disease", a discussion of this concept and its meaning seems appropriate. Some understanding as to the nature of this concept, various consequences stemming from its use, and related considerations, seems necessary for later discussions pertaining to appropriate handling and treatment of mentally disordered offenders.

The concept of mental disease is often described as similar to the notion of disease as used in general medicine. However, while in medicine the term disease or illness is used in a nonfigurative sense to denote undesirable alterations or changes away from optimal levels of organic bodily functioning, no similar specific criteria are involved in the determination of mental disease. In contrast to the fairly specific, objective, and precise criteria and norms used for determining presence of physical diseases, the criteria used in defining mental diseases are neither very objective, nor specific, nor can they be separated from a multitude of ethical and sociopolitical considerations inherent in the social deviancy labeling process. Not surprisingly, therefore, the term "mental disease" may be applied in rather loose manner to deviant patterns of behavior judged to be maladaptive or inappropriate according to varying psychological, psychiatric, social or other norms used by the persons applying the label. Understandably, then, the definitions of mental disease tend to be vague, circular and lacking in uniformity. Indeed, at times the term seems to be used as a handy label and ready explanation for almost any type of behavior which does not make sense, reveals no clear or reasonable motives, or possibly offends our sensibilities. This appears to be in keeping with the trend over the past two or three decades increasingly to psychologize problems of living in our culture, by assigning various psychological causes to many of the ills of our society.

Davidson (6) tried to caution against the above tendencies and the serious problems connected with the indiscriminate use of the term mental disease. He remarked to his colleagues:

> ". . . As doctors, we see any major deviation from the norm as unhealthy; and therefore, any such deviation is ill-health or sickness. Thus, in our book we include as mental disorders such deviations as learning difficulties, stress reactions, sexual deviations, mental deficiency, antisocial behavior. By book, I mean the volume called Diagnostic and Statistical Manual of Mental Disorders, published by this Association (American Psychiatric Association). Now mark this well -- it is going to haunt us. This is a list of mental disorders. It says so on the cover. Therefore, "transient situational disturbances" -- so listed -- must be mental disorders; so are alcoholism, habit disturbances, dyssocial reaction, conduct disturbances, mental deficiency, speech disturbance, and so on.
>
> . . . . . .
>
> Our categories are so broad that we could squeeze into them such concepts as hostility to an employer, or marital discord over money." (Page 411)

Davidson goes on later in this article to further emphasize his warnings about such loose and expanding use of the mental disease label to an ever-increasing number of problems:

> ". . . As the word is generally used, 'sickness' does not include such deviations as stress reactions, personality disorders, and learning disturbances. We are practicing magic if we think that we can make these deviations into sicknesses merely by listing them in our own little book." (Page 413)

Despite the above warning by this distinguished psychiatrist some years ago, there does not seem to have been any discernible change in the looseness with which the label "mental disease" is applied by some mental health professionals.

There is often the assumption that patterns of deviant behavior described as mental disease reflect something inherently different; that such deviant acts occur because of some special characteristic of the persons engaging in them. However, it is important to note that the determination of deviancy implies some criteria or standards and that different social groups consider different things to be deviant. Hence, the determination of deviancy very much includes the person or group making the judgment, the societal criteria used, the particular process by which such a judgment is reached, and the situations in which such determinations are made. Therefore, deviancy is not simply a special or peculiar characteristic or tendency within certain individuals, nor does it lie in the behavior itself (2).

To ignore the complex and variable nature of the deviancy labeling process would logically tend to limit the kinds of theories that can be developed, the manner in which the deviant behavior is conceptualized, the understanding of the behavior, and the kinds of handling and interventions deemed appropriate.

The vagueness and loose application of the term mental disease not only creates serious problems in terms of the lack of uniformity in such labeling but, in addition, there are various consequences for the individual which stem directly from application of the particular label. When some socially deviant behavior is defined as a "mental disease," this carries the distinct implication that the psychiatric and other mental health disciplines have some special understanding of the particular problem and also have the appropriate treatment for it. Since the social movement aspects of Mental Health have led to the overselling of such information and applications, often such knowledge has been sought out by societal groups almost as a panacea for a host of personal, social and other human problems.

In light of the above discussion it should be remembered that, because some deviant behavior is defined as mental disease this does not automatically imply the need for mental health treatment facilities. Thus, the distinction is often made that "psychological deviance" (i.e., mental disease) requires special psychiatric, psychological treatment procedures, while "social deviance" (i.e., most law violating behavior) requires typical correctional, rehabilitative services. In fact, however, when we deal with the various "personality and sociopathic disorders," problems in socialization manifested by the socially deviant individuals are viewed as symptoms of the mental disease. And, since the complex problems relating to cultural, educational and social deprivation, inadequate socialization, etc., are indeed multi-determined, a great deal more than mental health services are often necessary for helping many convicted and incarcerated offenders.

Conceptualization Regarding Treatment and Rehabilitation

Some conceptual scheme is necessary to determine the kinds of services and programs needed by those described as mentally disordered offenders. As was noted earlier, because an individual is viewed as suffering from some mental disease this does not automatically imply that psychotherapy and other mental health services are the only, or even the main programs needed. Neither, for example, would the offender who is illiterate necessarily require only remedial education for his rehabilitation. Since the manner in which the deviant behavior is conceptualized and labeled may well determine the kinds of interventions utilized, it becomes rather essential to view all of the individual's problems before deciding where the particular emphasis should be placed in terms of the treatment and rehabilitation.

The group referred to as mentally disordered offenders covers several categories and encompasses a wide variety of problems. No sharp distinctions can be drawn between persons who actually are distributed along various points of a continuum. Thus, it should be understood that many of the

services necessary for the mentally disordered group would also be useful for the general offender population.

We might note at the outset that treatment and rehabilitation are not the only objectives of the criminal-judicial-correctional process. There are often concerns about protection of the community, deterrence of other potential law violators and future law violations by the offender, and also some adherence to the notion of "just punishment" in relation to the seriousness of the offense committed against society. While there is a very definite shift away from the punitive philosophy underlying the criminal process and a strong movement toward greater emphasis on prevention, treatment and rehabilitation, the importance of protecting the community against certain dangerous persons has very much to be kept in mind.

Following adjudication specific evaluation should be made to determine the particular treatment and rehabilitative services needed to achieve the objectives involved. Certainly, evaluations designed to assist in determination of legal issues can hardly be expected to have direct relevance to considerations pertaining to treatment. Yet this is what does take place in some situations. For example, the adjudication "not guilty by reason of insanity" is obviously and clearly a social-moral judgment focused upon determination of blame. However, in many jurisdictions once an individual has been so adjudicated he is automatically committed to a mental hospital. The assumption seems to be that the aforementioned social-moral determination is in some way similar to - if not synonymous with - the medical and psychiatric criteria for commitment to a hospital. Even if the expert testimony indicates that the accused at the time of the offense was clearly and grossly psychotic, there is no reason to assume that at the time of adjudication - several months or even years later - he is equally disturbed. And, even if the person is found to still manifest some psychiatric problems it might be both possible and desirable in many cases to provide out-patient treatment and supervision. Commitment would certainly be indicated when the current psychopathology is severe and/or if the person is judged to be dangerous to himself or others. The failure to make the above distinctions in the judicial labeling and disposition often creates problems and may result in the long term confinement on back wards of understaffed mental hospitals of those acquitted by reason of insanity, and also pretrial incompetents and minor sex offenders confined under sexual psychopath statutes.

Thus, following adjudication the evaluations made should ascertain the overall complex of problems -- mental health, custodial, educational, and others -- to be dealt with in various correctional or related programs. The basic goal and objective of such interventions would be to bring about cessation of law violating behavior and to develop more constructive personal and social functioning in the community.

Correctional programs have the mission of dealing with the broad range of the offenders' problems while also meeting societal demands for protection of the community either through institutionalization or various degrees of supervision provided to the offender in the community. Correctional institutions have to address themselves to a variety of tasks in

addition to those of boarding and securely housing large populations at very low costs. There are also educational, vocational, social, medical, mental health, religious, recreational and other services to be provided. To a large extent such needs are met - and should be met - within correctional settings. For example, the semi-literate or illiterate offender does not have to be shipped out to some special educational facility. While there may well be a number of correctional clients having serious educational problems, the focus of handling is determined in the social system by the fact of the individual's convication of a crime, and the additional decision that he be confined to a correctional institution. The correctional facility is expected to and should have the resources to furnish the particular remedial educational and related programs needed by many of its clients. However, if the illiterate offender is also found to be severely retarded and thus requiring special care and handling, transfer would then be necessary to an appropriate facility. (To the writer's knowledge, there is a remarkable dearth - if not even complete absence - of correctional facilities especially designed to handle mentally retarded offenders.)

In this context, the overall assessment of the offender would not seek simply to detect the presence of some emotional or personality problem. Clinicians with their pathology-seeking set will rarely fail to uncover some degree of psychopathology. Neither should the main concern be to attach some diagnostic label to the problems noted. As discussed earlier, not only might such labeling tend to be unreliable and not suggestive of specific treatment needs, but such designation may tend unnecessarily and even inappropriately to slant or focus treatment along delimited lines and without due consideration to various other problems of the individual. Hence, the purpose of the assessment should be to determine the manner in which the specific psychological or psychiatric problems relate to other difficulties and handicaps, and whether the nature, degree, seriousness and also treatability of the psychopathology requires that this be made the focus of treatment efforts.

A variety of mental health facilities should be available within institutional correctional programs. When the nature and/or severity of the psychopathology is such as to require special handling, transfer to an appropriate mental hospital facility would be essential and legislative and administrative provisions for this should be available. Overt psychotics, severe depressives, suicidal risks, and others of this type would generally require transfer to a mental hospital. The need for such transfer would, of course, depend upon the adequacy of mental health staff and facilities within the correctional program. Thus, in order that only those persons who clearly need special care and treatment be transfered to the hospital, it will be most essential that correctional institutions have the facilities more effectively and adequately to meet various other mental health needs of its clients.

Thus, because an offender has some personality problems (which may readily be diagnosed as a personality trait disorder) does <u>not</u> necessarily suggest either the need for transfer to a mental hospital, nor even that special mental health services are required. Such an individual may also have serious educational, vocational, and general social deficits which

could well be made the focus of rehabilitative efforts. Such broadly focused treatment programs will often have positive affects on the personality disorder and, where indicated, individual or group counseling may be added. However, in cases where the criminal behavior is found to stem very directly from psychological problems, and/or where other educational, cultural and social problems are minimal, special therapeutic services may well be the appropriate and necessary focus of treatment. Various sex offenders - exhibitionists, voyeurs, pedophiles, etc., compulsive check-writers, arsonists, kleptomaniacs, and the like, would be among those who may require a particular focus on psychotherapeutic services. However, it should be noted that almost any offender could have such characteristics. Focus should be on the particular problems of the individual and not on the type of offense.

In view of the vastly different theoretical and practical orientations among correctional staff regarding the causes of criminal behavior and the appropriate treatment and rehabilitative services believed to be necessary, inter-disciplinary treatment and classification boards or committees in correctional institutions would generally have to make the aforementioned decisions on the basis of consensus. Hopefully, research efforts could in the near future provide more precise, objective and valid criteria for making such decisions. It will be essential to develop a treatment oriented typology of offenders, similar information about therapist characteristics, and careful matching of type of problem, with type of therapist, with the particular therapeutic technique having best probability for successful treatment. (Other issues pertaining to treatment and the evaluation of such interventions will be discussed later in this presentation.)

Conceptualization of Behavior

Generally, behavior is viewed essentially as something arising from within the individual and very much a function of his personality. Such a conceptualization of behavior would encompass various theoretical positions sharing the view that psychopathology is largely a function of "intrapsychic" problems. Such understanding would suggest the need for a variety of therapeutic approaches based upon intrapsychic orientations to treatment.

In some contrast to the above conceptualization, behavior may be viewed as involving an interaction between a particular individual and a specific environment. Such a conceptualization not only includes but indeed requires consideration of both "psychological" (individual) and also "social" (environmental) sets of variables determining the behavior in question.

Such a behavioral conceptualization would view the deviant behavior as stemming in large measure from specific distortions and/or deficits in the learning of various skills which are essential for adequate functioning in many societal situations. The deviant behavior may largely be a function of distortions in the complex social learning experienced by the person over

the years leading to a variety of psychological problems, for example, neuroses, sexual deviations, feelings of inadequacy, suspiciousness and other personality maladjustments. The socially deviant behaviors and related problems may also result from serious deficits or gaps in the acquisition of educational, vocational, social and interpersonal skills needed to adapt constructively in a complex and demanding societal environment. In particular cases there may, in addition, be various medical, organic and related factors also complicating the picture. In any event, in the absence of the above socially desirable and essential skills the person may develop other -albeit antisocial - skills in order to adjust to his particular problems and environment.

Where the problem behaviors result mainly from distortions in the learning process a variety of psychotherapeutic and related treatment measures would be necessary to modify behavior. The situation where the problems result largely from pronounced behavioral deficits would be different in some measure. In such cases treatment and rehabilitative programs would be required to develop the person's educational, vocational, and social repertoires, so that with such skills the person's self-concept and his functioning in the community may be improved. Often, both types of problems may be involved and the rehabilitative program would require a variety of treatment modalities.

A rather large number of confined offenders may be diagnosed as suffering from various personality and sociopathic disorders. In these cases it would generally be very difficult to distinguish between various manifestations of "psychological" and "social" deviance. In any event, the problems here often relate basically to inadequate socialization, poor impulse control, limited educational, vocational, and interpersonal skills, etc. The typical mental hospital is not set up to deal with such persons -- in terms both of the structure and nature of the facilities and as a function of the training and skills of the staff. Indeed, mental health professionals with much experience in the treatment and handling of such persons, viz., severe personality disorders, often feel that they may more effectively be treated within the firmer structure, controls, and explicit limits provided by correctional type facilities (16).

There is the added problem that many of the traditional psychotherapeutic concepts and techniques have been developed with and geared to a rather different group. The conventional therapy situations out of which most current theories and concepts of psychotherapy have developed, have been quite different from the therapeutic situations faced with most offenders. The typical neurotic or fairly socialized person with certain characterological problems, usually enters therapy voluntarily, is verbal and well motivated to change, his behavior considered troublesome is generally viewed as such by both the patient and the therapist, and, furthermore, this troublesome behavior is usually not so visible as to involve large segments of the community in its alteration. In distinct contrast, offenders (speaking here mainly about those with personality and sociopathic disorders) do not

typically present themselves voluntarily for treatment, they may not feel very troubled by their behavior - even though it is considered troublesome by others, nor do they regard their behavior as necessarily indicative of any maladjustment. Thus, when some of the traditional therapeutic techniques are applied - or rather misapplied - to this group the results have not been very encouraging. Likewise, many of these persons, especially those with a lower socio-economic background, are not able to conceive of the therapeutic value of "talking," and their orientation is often in terms of the here and now and prompt alleviation of whatever distress they may be experiencing. The notion of talking about problems, uncovering feelings and various background incidents, tolerating anxiety rather than expressing it behaviorally, forsaking immediate "sympton relief" for the sale of later insights about "underlying causes," etc., does not appear to suit many of these persons.

It has also been pointed out that, not only are the aforementioned therapeutic techniques class-oriented, but that some of the basic concepts are linked to social class factors (8, 9 & 14). There is, therefore, need for newer treatment models and approaches which would be more suited to this population, be more effective and efficient in terms of their cost and large scale utilization, and which could more readily be communicated to others and thereby allow much greater use of non-professionals.

In recent years a variety of behavioral techniques have been developed and used in individual, group and even institutional settings. In fact, the setting of the correctional institution would provide the kind of control of the environment and establishment of contingencies and other situations necessary for effective behavior modification. Much work has already been done with autistic children, hospitalized schizophrenics, the mentally retarded, and other such groups (18). Similar techniques have also been utilized with delinquents and offenders (4, 12, 14, 15 & 18). In addition, it has been possible to train a variety of non-professionals in fairly short time to assist in the behavior modification tasks. For example, college undergraduates, hospital aides and attendants, counselors in a training school, nurses, the patient's relatives, and others, have been used as change agents in various programs (18).

It should be emphasized that these are <u>not</u> the only effective or useful therapeutic approaches. However, the use of explicit and behavioral criteria, the application of rigorously developed principles of learning, and the experimental verification of some of the therapeutic principles, have led to considerable interest in and increasing utilization of these behavioral approaches.

Development of Special Mental Health Programs

Although there are a number of issues which could be discussed regarding the development, expansion and more efficient utilization of a wide range of community-based mental health programs (16), the concern here will be with development and expansion of such programs within institutional settings.

Various problems arise in regard to the management and treatment of some of the more disturbed, dangerous, and disruptive, mentally disordered offenders. Such persons rather typically are a thorn in the side of Corrections and Mental Health. They create many problems within the institution, place heavy demands on the already understaffed facilities, and disrupt other programs. Likewise, with the increasing trend toward "open door" policies in mental hospitals many such institutions are very reluctant to accept such persons.

There is, then, the need for special facilities to manage such persons. Many states have plans to build special institutions for such cases; some institutions are already under construction and others are in various stages of planning; some other jurisdictions are giving very serious consideration to the development of such special facilities.

With the increasing move toward greater reliance upon a variety of community-based correctional and mental health programs and decreased use of institutionalization, the building of newer institutions should be given very careful and diligent study. It must first be determined that building new institutions is the only feasible or the best alternative available. There are a number of programs across the country experimenting with intensive community-based treatment and close supervision as an alternative to institutionalization. An excellent example of such a program is the Community Treatment Project being conducted under an NIMH grant by the California Youth Authority.[1] It is quite possible that many mentally disordered offenders could safely and effectively be handled on probation or parole with outpatient treatment provided through community mental health facilities.

Unquestionably, there will remain those persons who will require close custody and special institutional programs. However, there is often the realistic fear expressed that such special institutions - which are always easier to build than to staff and equip adequately for the intended treatment programs - may become "warehouses" for holding a rather mixed group of hard-to-handle persons.

This particular issue was discussed at some length at a conference convened under the auspices of the President's Commission on Law Enforcement and Administration of Justice (16). The consensus of the conferees was that, before states begin to build new and special institutions for the aforementioned group, very serious attention should be given to improving mental health staff and facilities within existing correctional programs. It was felt that with improved staff and resources many of these mentally disordered offenders could more effectively be handled within correctional programs instead of having to be shunted back and forth between the prison and the state hospital.

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[1]Stark, H. G. A substitute for institutionalization of serious delinquents: a California Youth Authority experiment. Crime & Delinq., 9, 242-248 1963.

Warren, M. Q. & Palmer, T. B. Community treatment project: an evaluation of community treatment for delinquents. Fourth Progress Report, Oct. 1965. (Mimeo)

A number of different models are currently in existence for handling the above persons and those sometimes also referred to as the "socially hazardous mentally ill offenders." In some states such special facilities are administered by departments of mental health or mental hygiene, in others by corrections, in others on some joint basis, and elsewhere by public welfare or differently designated administrative structures. The following are four types of models in use.

1. Mental health facilities developed within and as a part of the correctional program or institution; this may be in terms of a separate building within the correctional facility. An example of this would be the Security Hospital attached to the Men's Reformatory in Iowa.

2. A separate mental hospital which is administered by the department of mental health but designated mainly, if not entirely, for special categories of mentally disordered offenders. An example of this would be Central State Hospital in Wisconsin.

3. In this model a separate building within a state mental hospital is used for handling pretrial incompetents, those acquitted by reason of insanity, psychotics and others transfered from correctional institutions, and persons sent for court-ordered examinations. An example of this type of facility would be the John Howard Pavilion (maximum security unit) attached to St. Elizabeths Hospital in Washington, D. C.

4. In a few states a separate mental hospital type of institution is designated specifically for mentally disordered offenders, is staffed by mental health trained personnel but is under the administrative authority of the department of corrections. Examples of this would be the California Medical Facility at Vacaville, and Dannemora and Matteawan State Hospitals in New York.

The interstate compact model has also been under consideration with the possibility of building a regional facility to be used by two or more states. While the idea is very good, in regard to its implementation there seems to be a number of legislative, administrative and related problems. There are also situations where use may be made of facilities in a neighboring state on a contractual basis. However, in view of the distinct desirability of developing programs to graduate release, to plan follow-up and treatment in the community after release, and also to work with the families of such persons, it would seem preferable - where at all possible - to keep the individual close to his home community. States with smaller offender populations and with limited resources should seriously consider modification of some existing correctional institution so as to have a psychiatric unit with appropriate staff and facilities. To obtain suitable mental health staffing and services it would seem essential to develop such programs in very close collaboration with mental health agencies.

Some Special Problems and Research Needs

Throughout the entire criminal-judicial-correctional process there are numerous critical decisions to be made - to determine whether a law violater should enter into the criminal process or be diverted and handled in some other fashion, various formal and informal dispositions, sentencing issues, etc. In almost all these areas there is a remarkable dearth of adequate follow-up and evaluation to determine the efficacy of the various decisions made. There is, therefore, a critical need for program monitoring and operations research to study the entire process and its actual effectiveness in light of the desired objectives.

The following are some particular problems and research needs deemed to be rather important.

1. It is often assumed that the more information we have in making decisions the better will be the decisions. This, however, remains to be demonstrated. There are situations where failure to communicate mental health information in clear and meaningful manner, or the less-than-realistic appraisal of such services, may lead to various problems. At times, professional jargon, unnecessary use of diagnostic terms, etc., make actually constitute "noise" and serve to confound the decision-making process. For example, where a probation or parole officer gets scared by the label schizophrenic or schizoid because he equates this with dangerousness and thus recommends against community supervision even though the thrust of the mental health recommendations were in the opposite direction. Often, there is rather disproportionate expenditure of mental health staff time in diagnostic interviews with hardly any time left for treatment, training, consultation and related services. In some mental health facilities the ratio of diagnostic to treatment interviews was found to be about 100:1 (11). Then, too, mental health professionals may tend to have an overly sanguine opinion as to the actual usefulness of the "treatment" which frequently may be recommended -- even though such treatment may seldom actually be available. There is also the feeling very often that even if the therapy does not help very much, it certainly can do no harm. However, the literature indicates that while psychotherapy does seem to help some treated persons to become better adjusted than comparable people not receiving such treatment, psychotherapy can and does make some people worse than their control counterparts.[1]

2. There is much need for more precise and carefully designed research to evaluate various predictions about behavior - in regard to probation, various sentencing alternatives, possible dangerousness, likely response to various treatment and rehabilitative interventions, etc. While mental health personnel will typically have a good deal to offer in these areas, the absence of careful follow-up makes it very difficult - if not impossible - for those making such predictions to continually improve their

[1]Bergin, A.E. Some implications of psychotherapy research for therapeutic practice. Jr. abnorm. Psychol., 71, 235-246, 1966.

criteria in the light of the feedback about their predictions. The development of base expectancy tables and similar base rates for various dispositional alternatives with various types of persons, may allow more objective and efficient decisions. The addition of reliable and carefully evaluated clinical data could further improve decision-making and enable more effective utilization of treatment and rehabilitative resources.

3. Increasing use can be made of trained non-professionals for a variety of significant roles in the treatment, rehabilitation, prevention programs. Under an NIMH grant the New Careers Project in California, directed by J. Douglas Grant, has been doing some very promising work toward training offenders and ex-offenders for various rehabilitative roles. Related to this, there have been some NIMH sponsored conferences which have produced valuable material pertaining to the training and use of non-professionals.[1] It should be emphasized that the main rationale for greater utilization of non-professionals is not simply to relieve professionals of some scut-work. Rather, there are various roles and functions for which certain trained non-professionals, particularly ex-offenders, for example, may much better be qualified than middle class professionals. For example, the kind of work done by detached, neighborhood, gang and community workers, roving leaders and similar change agents who can more easily establish contacts with the clientele and work more effectively in such neighborhoods.

4. Finally, there is the vexing problem of evaluating in fairly precise fashion the results of rehabilitative and therapeutic programs. There are several complicated and multifaceted sets of variables with which we have to contend.

We could conceptualize four complex sets of variables involved in determination of treatment results: 1) Individual variables - personality characteristics of the clients, nature of the problems, typology, behavioral skills and deficits, etc. 2) Social environment variables - familial, peer group, and various other influences in the physical and social environment. 3) Treatment variables - various kinds of treatment and rehabilitation, nature and intensity of supervision and follow-up in the community, etc. 4) Variables relating to release - kinds of facilities for graduated release to the community, etc.

Sound evaluative research becomes even more difficult because of the following problems:

1. There is no single "treatment" or "rehabilitative" method used. Rather, a whole variety of techniques - individual and group counseling,

[1] "Experiments in Culture Expansion. "Report of proceedings of a conference on "The use of products of a social problem in coping with the problem." Norco, Calif. July 10-12, 1964.

"The offender: An Answer to the Correctional Manpower Crisis." Report of a conference sponsored by the Institute for the Study of Crime and Delinquency (Calif.) and NIMH. Asilomar, Calif. Sept. 8-10, 1966.

remedial education, vocational training, etc. - are used in a wide range of facilities, by a variety of staff differing vastly in experience, training, personality characteristics, and competence.

2. There is no single type of offender upon whom these various techniques are applied; rather, there are a whole range of problems and different types of persons involved.

3. There are numerous interactional effects and constraints exerted by these many variables. For example, Type A offenders may be helped by Treatment X, while Type B offenders may actually be made worse by the same treatment. (See Bergin reference page 29.)

4. There are a number of different criteria on the basis of which outcome may be measured; these may include: educational, vocational, and social behaviors, marital and family adjustment, and a number of measures relating to troubles with the law.

5. The evaluation of outcome has to be in terms of the individual's adjustment to a particular social environment. Individuals with very similar problems, exposed to the same treatment situation and techniques, and showing similar progress in the institution, may yet have markedly different outcomes later on as a function of very different social environments to which they returned and the kinds of follow-up services they received.

In working with persons described as mentally disordered offenders we have to be more alert to the problems inherent in the deviancy labeling process and the difficulties relating to the vagueness of the concept of mental disease. It should be remembered that the labels attached often tend to determine the disposition the person received. Certainly, it should be clear that deviant behavior may be conceptualized in terms other than the presence or absence of psychopathology. Finally, whether we are talking about mental health, correctional or other programs, there is a crying need for precise evaluative research to determine the actual value of clinical hunches and various other practices hallowed by a tradition of long usage. In the absence of programmatic research and careful evaluation the possibility remains that ineffective and poor programs will continue to be used and sacred cows and dogmas will persist.

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CORRECTIONS AND THE PSYCHIATRIC FRONTIER

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Life on the frontier is always hard and full of perplexity. In the comfortable offices of the administrator or in the management of the inflexible routines of a security institution, we sometimes forget that in the past two decades we have pushed far into new territory. Let me illustrate from the report of a colleague, Lieutenant E. W. Broeker, outside lieutenant of Folsom State Prison:*

> On November 1, 1940, I received a telephone call at my home in Oakland from San Quentin Prison. My job application had been accepted, and I was to report that day to go to work as a guard.
>
> I immediately packed up and managed to arrive at San Quentin at noon. I was taken directly to the Captain's office and interviewed by the Captain himself. He explained to me what my position was.
>
> I was informed that I wasn't a regular guard as yet, but was what they called a sub-guard. I only worked when someone was sick or on vacation. I was assigned to a room in the personnel quarters and was told never to leave the prison grounds without authorization, as I was on 24-hour call.
>
> About 2 p. m. that afternoon I was notified that there would be a vacancy on the third watch--4 p. m. to midnight. I was to prepare myself to take over the vacant position. I was issued a uniform prison cap, about two sizes too small for me, and was told that if I didn't have any khaki clothing, whatever I had would do. At 3 p. m. I reported to the Sergeant in charge of the sub-station. I was told to line up in front of the arsenal a half hour later, along with the rest of the officers who would be there.
>
> At 3:30 p. m. a man came along and said, "Are you the new man?"
>
> I said, "Yes sir, I am."

*E. W. Broeker: "The Indoctrination of a Prison Guard--1940 Style," The Correctional Review, May-June 1966, pp. 15-19.

"I'm Sergeant King. Get into line. You have Post 11. Now move along to the arsenal," he ordered.

As I moved up into the arsenal proper, I noticed that a man behind a counter was giving out weapons. I asked the person next to me, "What do I ask for?"

"Fella," he replied, "just tell him you have Post 11 and take what he gives you."

"Yes sir," I said.

When I arrived at the counter, I said Post 11 and the man handed me two .38 revolvers and holsters and two lever-action carbine rifles.

"What do I do with all this," I asked.

"Get out of the way. We have a watch to put out," he answered.

I immediately stepped to one side and headed back to the sub-station.

I saw a rather kindly looking fellow standing to one side and asked him what I was supposed to do.

"With the weapons you have on you, you must have Post 11 on the wall. Those are the wall officers going up the stairs. Just fall in behind them," he said.

I thanked him very much, as his were the first kind words I had heard. I then proceeded on my way. The group passed through some iron doors into a large room. (I later learned this was called veranda post.) From this spot some of the officers went to the left and others went to the right.

I asked the man who apparently was on duty how I might find my way to Post 11.

"Do it the hard way, Mack," was his reply.

So I looked both ways and decided to go to the right. I walked down the long wall looking for Post 11.

Floundering along, I came to a gap in the wall and looking ahead about 100 yards, I spotted a big sign with the numeral 11. Unfortunately, there was no way to get across the gap. My right turn at the veranda was obviously a mistake.

I had to retrace my steps. By the time I reached Post 11, I must have been 10 to 15 minutes late. The officer on duty was very irate.

He questioned me as to where the devil I had been. I tried to explain that I had got lost.

"It took an awful stupid person to get lost on a wall," he suggested.

I then asked him about my work. "What in the world are my duties and what do I do with the extra rifle and revolver," I asked. (I felt that it would be wrong to set them down someplace.)

He proceeded to tell me that he didn't care what I did with the weapons.

I tried again to get some information as to the duties of the post and received what was apparently the standard answer, "Learn it the hard way, Mack."

We have come a long way in corrections during the last twenty years. We don't call them guards any more, and, in California at least, they don't get onto a wall, with or without a gun, without several days of intensive orientation. "Learning it the hard way" in this day of sensitivity training, flexible treatment roles, and free-floating sociology has taken on many new meanings on the guard lines of our prisons.

But the problems are much the same; so are the instinctive responses. Maybe we have some new frustrations when we see our enlightenment and our new-found goodwill colliding with the fury which the cages in which we keep prisoners seem to produce in some of them. We still find it hard to suppress the same kinds of responses to violence which our forebears in this system experienced. Let me illustrate.

A number of years ago, I went to work in a certain prison in what we now call a middle-management capacity. One of my duties was to serve as a member of the disciplinary committee. My indoctrination was swift. The proceedings took place in the usual austere little room just outside the isolation cells. The committee consisted of the two associate wardens and myself. On my first day at dispensing justice, we were all preoccupied with a young man who had produced considerable commotion on the night before in the maximum security wing. He was a large, muscular youth of about twenty, blond, crew-cut--a good-looking kid who should have been on somebody's football team. Instead he was standing before us, mute with staring blue eyes rolling about in a face contorted with tension.

The Associate Warden-Custody, a genial giant of vast experience and great charm, briefed us. On the day before, this kid had gone on a rampage in his cell, had broken up everything in it, especially the plumbing, and had been slinging bits of it through the grill at the correctional officers. The Associate Warden had been notified and had ambled down to the cell. Somehow he had talked the boy into putting down his armload of broken porcelain and coming out of his cell. Obviously, the Associate Warden-Custody believed this boy was psychotic and should be transferred to an institution with psychiatric staff available. The Associate Warden-Classification and Treatment and I agreed. I was making a note of the action to be taken to arrange an emergency transfer when the Warden stalked in.

The Warden was a tall, spare, humorless man who was noted for his cold eye. Those expressionless grey eyes would travel up and down one's person in a fashion which suggested that it didn't matter what you would decide to do, he would always have control over the situation. In my previous contacts with him, he had always conveyed an impression of great dignity and poise. I shall edit his remarks in the interest of propriety:

"When are you going to cut out this blank, you blank-of-a-blank?"

The question was delivered in an angry snarl. I was profoundly startled. Later I came to understand the Warden's reaction. This was a new prison, the building of which he had supervised. It expressed the culmination of many years' ambition and he felt personally outraged by the affrontry of this young man breaking up his toilet. He could hardly have been more incensed if a house guest had wrecked the bathroom fittings in his own home.

But I was appalled and so, I think, were my colleagues. This was no way to treat a psychotic! Everyone knew that a prisoner who was so obviously distrubed should be treated impersonally until he could be gotten into competent psychiatric hands. Who could tell what damage might have been done by the Warden's uncouth question?

The boy didn't reply. I fancied that a look of contempt came across his face, but in retrospect I am sure that I was reading much more than I was entitled to do into his features; he must have been mostly out of contact with us.

The Warden ordered him removed that day, and I never saw the boy again. I have no idea what the subsequent course of his illness was, but I doubt that this incident affected him particularly one way or another. I regarded the Warden's behavior as a prime example of the neanderthal treatment of the violent psychotic in our prisons, and I still do. Coercion is the only means of control available to the primitive. We were sadly close to our earliest ancestors that morning--both our captive and ourselves. Much worse things have been done in American prisons, and no doubt are still being done, but the principle is the same.

Now let me switch the scene to a hospital for the criminally insane, operated under the auspices of a state department of mental hygiene. There is in this hospital, as in all such establishments, a maximum security ward where otherwise unmanageable patients are maintained. There are perhaps forty patients there at any one time; the principle is that each man is on a leave of absence, so to speak, from the community living group of his assigned ward. The ward staff can arrange for such a leave but can't thereby get rid of the responsibility for the patient.

The group is a battered-looking lot. They are almost all of them in a dayroom. Some are dozing, some are sitting, a few are playing checkers with attendants. The fact that so many are out in the day room instead of in their cells is impressive to me. In prison, people like this tend to be kept in their cells, and allowed into exercise yards in small groups carefully selected according to what is known about who likes whom and who has it in for whom.

I once discussed my observation of this ward with a group of correctional officers, expressing a certain amount of respect for a system which could manage to keep people like these in a semblance of a group. One of the officers laughed and said he'd once worked at that hospital as a psychiatric aide and he thought there were things I ought to know. All those guys, he said, were tranquillized to the gills--"we slip the stuff into their mashed potatoes," he said, "and we keep them that way after they get off the ward. Nobody has to worry about them at all; they're too doped up to move a muscle against you."

Now here are two ways of handling a familiar and dangerous problem. In one, the patient is cursed and banished from the system; in the other, his fury is quenched with drugs. There are, of course, other ways; we could give them electric shock therapy or insulin therapy; we could lock them up in strip cells with oriental toilets; we could give them cold packs or hydrotherapy. When I first went to work in prisons, I heard about the sobering effect which transfers to the hospital for criminally insane used to have on refractory inmates. Those who hadn't been there were so terrified of that particular unknown that the mere thought of transfer had a profoundly calming affect on them; those who had been there and knew its terrors dreaded a return as a fate worse than anything which could befall them in prison. To this day I don't know the particulars, but it was said that the psychiatric aides at the hospital had a special way with towels which could not be allowed at a prison when medical supervision was not so readily available. I might add that that facility was reorganized shortly after my arrival in the system; the legend of the towels is now an ancient anddiscreditable history.

At this point, I was arriving at a generalization. In corrections, quite universally, we operate our systems as a process. Our objective is a smoothly functioning process in which trouble, scandal, escapes, fights,

contraband, and non-compliance with the rules and regulations are all kept to a minimum. The process is the goal; the means are the end.

Now I am not in favor of trouble; I am as uneasy as the next man when I encounter a violent youth whose conduct I can't predict. Nevertheless, I contend that we are letting ourselves off too easily. There must be a better way of dealing with those disturbed people and the hazards they present than merely buttoning them up as tightly as we know how!

Perhaps you are waiting for me to reveal a system which controls the violently disturbed offender while at the same time it cures him. I must disappoint you. I don't know of any such system, although I have looked, but I am sure we had better find one. The maintenance of a process for its own sake is inconsistent with the times. It is especially inconsistent with the expectations of the public which has learned from the examples of medicine and education a lesson about people-processing. This lesson is that people can be changed and that though coercion may be necessary, it isn't enough. The correctional institution in merely holding its inmates, for a while--no matter how humanely--is incapable of changing them, and it cannot hold many of them forever. We have seen in our schools and in our mental hospitals that people who are processed can be changed. People are exposed to the processes of education, more than ever before in human history. They are changed, and much is now known about changing them. People who are afflicted with mental illness, which used to be considered one of the most hopeless of maladies, are being changed into creative and contributing citizens. Better still, our colleagues in the hospitals and clinics have been emerging from their medical bailiwicks to apply what they have learned to the community as a whole. Every year, thousands of men and women, and boys and girls, are given the help which keeps them from submersion in the seas of psychosis. People can be changed, and the sooner we set about the task, the easier it is to accomplish it.

So the correctional process must be transformed from this aimless business of running people through as unpleasant an experience as we can contrive within the humanitarian constraints of civilized society. It will continue to be unpleasant--it begins unpleasantly with a crime, it continues unpleasantly with shock, anger, desire for revenge, and it will be a long time before we can eliminate coercive restraint as an element of the process. But we can and must transform corrections into a process with an objective.

Some think that this transformation was made a long time ago, when educators and shop instructors and clergymen and psychiatrists and parole officers invaded the prison. What were all those specialists doing if they weren't accomplishing objectives? Surely, teaching and counseling are processes which achieve goals. Weren't goals being achieved by these professionals?

The answer is that nobody knows. Caught in a process which needed them, they all found themselves moving through their professional paces without ever finding out what the consequences were for the system. Illiterates learned, unskilled men acquired skills of sorts, sick people got well, some psychiatric patients acquired some insight, but we have never known and to this day we don't know what all these benign effects had to do with the accomplishment of correctional goals. What we have is a process through which people go, in which certain things happen to them, and nobody has a clue as to what good it all does.

What we do know is that it is expensive. In most of the industrial states, the costs of keeping a man in prison for a year add up to more than $2,000; there are places where this figure is exceeding $3,000. Multiplied by the 210,000 people who are doing time in America's prisons, we have a figure which is getting close to half a billion dollars a year. We are a rich country, but this is an item in the national budget which is getting big enough to interest cost-accountants. You and I, as career specialists in corrections, owe the people some answers to questions about what they're getting for their money.

We also owe them some answers as to how well we are protecting them. We know that violent offenders are statistically good risks; they are much less likely to get into trouble than thieves and forgers and narcotics addicts. Unfortunately, when they do repeat their offenses, the result is all too often another disaster rather than another insurance claim. If we rely on statistics and solum statements about the calculated risks we have to take, we are letting ourselves off too easy. Statistics are information; they don't become enlightenment until we have made an effort to understand their meaning. Sometimes the only meaning we can find is that we haven't thought of the right questions to ask. As for the calculated risk, unless someone has actually found a way of making the calculations and formulating the risk in the way that an insurance actuary does, the term is close to fraudulent. I do not have more than limited confidence in the prediction tables of my own department, and I do not know of any better prediction system anywhere. Not many violent offenders go out to commit more violence, but some of them do, and the mistakes we make of this kind are not getting the study they deserve.

So far I seem to have subjected you to a denunciation of people-processing in corrections, both because of its evident ineffectiveness and because of the false security of providers. What are the alternatives, if any?

The short answer is that we must adopt a strategy of people-changing. During this last year, the President's Commission on Law Enforcement and the Administration of Justice has been engaged, among other things, in filling out the details of this answer. It has been my privilege to participate since last summer in this national stock-taking, this inventory of ideas and practice. The experience has been exciting enough but disturbing. The

trouble with managing by process is that it gives us few clues to improvement. We do not often ask ourselves what good these processes do; it is enough that we carry out the orders of the court. A few experiments have carried out projects which tend to show that with most prisoners it makes little difference how much time they do or even what they do while serving time. Here and there, some experiments are under way to improve probation and parole so that their aims will be people-changing rather than people-processing. But the data are thin; on the National Crime Commission we are not able to prove many points with solid conclusions, well fortified with research. There is one exception; everything we have seems to show that community-based programs are more effective than institutional confinement in restoring criminals to the community safely and soundly. We infer that a good many of the 210,000 now doing time could be better handled in the community and that this would be both a humane and an economical objective.

It is at this point that we begin to see some daylight. It comes in the form of a question. If people-processing doesn't accomplish significant ends for society, what will happen if we adopt the objective of people changing? How should we set about it? Let me briefly answer this question (and then return to the mentally disturbed offender).

We begin with the concept of reintegration. It is not enough to send a man through a term in prison, or even on probation. As an offender, he is a handicapped person; he is faced with a battery of problems in overcoming his handicaps. Our objective is to equip him for a return to that society as a non-offender. We are not necessarily changing a sick person to a well person, a bad person into a good person, although both these changes may be necessary in some cases. We are taking whatever steps may be necessary to reintegrate the offender with his social order.

It follows from the immense variety of offenders that different steps will be necessary to accomplish the goals of reintegration. We shall have to classify our caseloads in terms of what is needed to reintegrate them, but the classification will have to take place early and we must commence treatment as soon as adjudication is complete. The punishment is the restraint. It must not be allowed to interfere with reintegration insofar as we are able to define positively what the requirements of reintegration are. We must, in short, ask ourselves and ask the offender, too, what he needs in order to return him to the community as a safe person. There will be a large variety of answers, the sum total of which is a correctional program. Classify these answers by their common factors and we have the principle of differential treatment.

So far, you may be saying to yourself that nothing especially new is involved here. Reintegration is a fancy new term for rehabilitation and differential treatment is nothing more than the familiar process of classification. I agree that these inferences may be drawn, but my story isn't over.

Looking back over the history of the people-processing apparatus we have developed, we see how random our choices of program and procedures have been. We have allowed intuition and precedent to determine how much time offenders must serve and where. We have never stopped to make any analysis of whether more or less time would serve the same purpose. In the same spirit, we have insisted on education for unlettered offenders, group counseling for everybody, halfway houses for just about everybody, and so on. Now I share the common opinion that all of these programs and many others have their place in a reintegration-oriented system, but if we are serious about differentiating treatment to suit the individual, we must be particular about who gets how much of what treatment and why. For this reason we advocate a strategy of search by which we deal with all programs as though they were experimental and periodically review their results. If we use sufficiently sensitive methods, we are going to find differences in the effectiveness of different treatments in achieving the goals of reintegration with different people. The strategy of search not only puts existing programs to a continuing test, it also requires that ideas and knowledge from other agencies, from other branches of knowledge, from social science research in many fields be reviewed for their relevance. Do new ideas and new knowledge apply to our problems? If so, how can we test their usefulness in solving them? You will note that the strategy of search calls for a large measure of continuous research; you may well wonder if this isn't a case of me, as a researcher, comfortably feathering my own nest. I shall let you wonder--we all have a living to make!

Finally, we look about this incredible field in which we labor and take a perplexed note of all the artificial divisions we have imposed on ourselves. In the sausage factory, through which we send offenders, we transfer them hither and yon, usually with a bit of documentation but with little concern that he goes through identical processes and is subjected to unrelated experiences. Worse, the whole field is fragmented so that in any state any individual who is caught up in our clutches finds himself seldom in touch with a consistent plan which the system is seriously interested in carrying out. We hold that this fragmentation damages the offender by subjecting him to a meaningless experimentation for which claims are made which are simply not credible. It also wastes resources by not planning their use. Judges have no idea what programs are effective for what offenders, because we haven't gathered the information we need if we were asked to tell them. Counties run probation programs which range from the strictly nominal to the highly professional; only the chance of residence determines whether a man is committed to one or the other. Standards are solemnly promulgated by professional associations--on heaven only knows what criterion--but local adherence to them depends on the accidents involved and the right leaders being in the right places at the right times, which happens all too seldom. What I am arguing for here is not the state-wide management of local services but some minimum standards of coordination in standard-setting. It can be done; ideas and money are the two indispensable keys.

Now what has all this to do with the mentally disturbed offender--those tragic figures cowering in strip cells or raging on maximum security blocks? In the rest of my time I want to deal with this problem in the light of the four part model for correctional management of the future--this model whose components are the objective of reintegration, the methods of differential treatment, the validation by research, and coherence in administration.

I think we begin by asserting that the containment of the mentally disturbed offender is not enough. We can contain; every system represented in this room can contain the mentally ill offender so that the community is safe from harm from him and he is safe from harm to himself. In the present state of the arts of psychiatry and of corrections, we cannot be satisfied with such an objective. Mental patients in most of our states are hospitalized and given hope; they do not merely vegetate as they used to. New hope has been given to them and to their families by new forms of treatment and by a new convication by the mental health professions that their task is to help their patients, not merely hold them. In ever-increasing numbers mental patients are being put on speedy and effective treatment to return them to their homes. We can do no less for the offenders we hold who are mentally ill. We know that we can coerce but that coercion alone will not cure. We must learn, just as psychiatrists have had to learn, that the prediction of chronicity produces chronicity; that the assumption that people can improve is the essential basis for improvement. Our objective of reintegration must be just as valid for the mentally ill as for those offenders who do not present grave problems in management.

It is here that the going becomes sticky. How do we differentiate the mentally ill offender for treatment aimed at reintegration? Hitherto, we have been willing in most jurisdictions that I know about--including California --to play a game of badminton in which the antagonists are the prison wardens and the mental hospital superintendent, and the shuttlecock is the unfortunate offender who is neither an ordinary prison inmate nor an ordinary hospital patient. The game ends when one side or the other wearies of the procedures required to keep it going. The patient himself unforgettably learns that he is unwanted, hopeless, and dangerous--just as he always thought.

There must be a better way. It begins with collaboration between the correctional administrator and the psychiatrist, a collaboration which demands that each speak intelligibly to the other. We begin with agreement on the objective of reintegration. We agree also that for some correctional inmates psychiatric intervention may be essential to the achievement of reintegration. This agreement side-steps for the time being the difficult and still unresolved controversy concerning the definition of mental illness. It is to recognize, however, that there are kinds of abnormal behavior in the presence of which the psychiatrist feels more secure than we do. He can change or at least control these kinds of behavior more effectively than we can do through the means available to us for the management of our general

populations. He does not have uniformly effective methods of people-changing as to these kinds of inmates. He can assist with problems of differentiation and suggest the more likely avenues toward successful change. Most important, we should be collaborating with him on a search for better ways of changing these alarming offenders for the better. Neither he nor we have much to boast about now.

Let us differentiate his caseload by beginning with those offenders for whom psychiatric treatment is an essential ingredient of a realistic plan for reintegration. These will be the offenders with whom we feel most insecure. We must defer a more precise definition of this caseload to the research which identifies the problem and evaluates the results of the treatment administered. But let us also concede that for this group special facilities and special planning will be needed.

We have tried this course in California. I don't think anyone is yet satisfied with what we are doing. During the last fifteen years we have built two institutions for the management of these kinds of offender. One is a correctional institution, the other is a mental hospital. Both are too large. Neither is well situated for its purpose. The division of labor between them is still unsettled. Nevertheless, we are accumulating experience, we are systematically studying our experience with them, and there is some reason to believe that their effectiveness is increasing. As treatment methods in the less specialized prisons improve, we are finding that we can discriminate better those who should be confined in the prison at Vacaville and the hospital at Atascadero. Better still, we can accept the return of patients from these institutions to the unspecialized correctional institutions with increasing confidence. In this way, an institution like Vacaville tends to play a role in our system as a hospital which enables patients to engage in ordinary correctional programs rather than as a place of containment for the otherwise un-containable.

California maintains the largest correctional system in the country. We confine less than ten percent of our inmates at Vacaville. Atascadero now accepts extremely few of our clients; most of its patients are civil commitments of sexual psychopaths and offenders who have been found not guilty by reason of insanity. It is unrealistic to assume that many states can adopt our model, which is perhaps a good basis for improvement but which has many imperfections still. In the National Crime Commission, considerable thought has been given to finding a model we can suggest to Congress and to the states for dealing with this minority of offenders in a way which facilitates acceptable minimum standards of treatment. One solution, for which there is some precedent, is the use of interstate compacts to built regional facilities shared by several contiguous states. The administrative problems are recognized and unsolved. Another possibility, for which less precedent exists, would be the use of the Bureau of Prisons to provide for these and other classes of offenders for whom long-term care or confinement is indicated.

Probably either of these solutions would work. Administrative difficulties have a way of disappearing when objectives are clearly agreed on, when the methods for reaching these objectives are accepted, when we study our experience and its results with a view to modifying methods in the light of their consequences, and when administrators aim at the development of systems in which there will be enough means to achieve their assigned goals.

I have described a hard way across a frontier which causes all of us a degree of concern far exceeding the numbers of people involved. We can indeed do it in this hard way; we can console ourselves that as correctional administrators and psychiatrists learn together our prisons will become safer and more hopeful places in which to work. Cell-wrecking and tranquillizers are not necessarily inevitable features of correctional practice.

SICK OR BAD?

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The object of this conference, the mentally disordered offender, is a person saddled with a dual label, two designations; sick and bad. We have simultaneously assigned him to two of our great social systems -- medicine and law -- for management. Both systems are charged by society with the care of those who falter in some manner, and who temporarily or chronically fail to meet certain norms of functioning as human beings.

He who has dripping sinuses, a spastic intestine, or delusional thinking has failed to adapt effectively to certain stresses. He who robs a filling station, embezzles trust funds, or commits homicide has failed to adjust "normally" to certain stresses. Our immediate concern is with him who may be afflicted by both delusional thinking and criminal behavior.

If we can clearly define a malfunctioning man as either sick or criminal, the standard procedures for his management are usually well-understood (although not necessarily effective in either case). If he is mentally ill, he is assigned to medicine, specifically to psychiatry, will be treated, possibly committed to a mental hospital. If he is an offender, he is assigned to the law, specifically to corrections, will be punished, sometimes rehabilitated and/or paroled, usually imprisoned.

If we relegate such a person at one and the same time to two systems of procedure, two frames of reference, it should not be surprising when we and he suffer uncertainty or even confusion.

Frames of reference are important in our daily activities. They give us a familiar base to operate from and goals to aspire to. They provide guidelines for the enactment of given social roles, and they help define our responsibilities and authority. My frame of reference, for example, is medicine. Within this context I perform in the familiar social role of physician. The people I serve professionally are largely patients; the exchanges between my patient and me are confidential; my task is to combat illness and to promote health.

Frames of reference also have potential negative value. They can be used to reinforce closed-mindedness, promote pessimism, side step responsibility, and resist change. If constructive results are to be accomplished, a frame of reference must be relevant to a particular social problem, such as criminal behavior, must be used responsibly with full awareness of its appropriateness to the task, its validity, and its limitations.

Let us study briefly an exercise in the application of differing frames of reference to a single problem. I may be requested, as a consultant to the police department, to examine a man labeled "offender" in the custody of a detective. The detective may discover in conducting his interrogation that the man was discharged from a state hospital two years ago or he may be impressed by an uncommonly bizarre aspect of the crime committed, or he may note incongruity between the appearance of this well-dressed, obviously affluent person and the shoplifting he committed at the corner drugstore.

I interview the man and immediately label him "patient." I talk to him within the doctor-patient relationship as I understand it. I take a medical history, I observe, examine and evaluate his mental functionings. I may get records from a family doctor or hospital, and I may interview his wife. From all these data I write out a report which I send to the detective. The report will characteristically begin "The patient is a 32-year-old, white, married unemployed man from Topeka who...."

While I am proceeding in this accustomed fashion, I must have in mind, however, that the detective sees my "patient" from another frame of reference, law enforcement, and has labeled him "offender". The man is, for the moment at least, subject to the detective's social institution; and the detective's frame of reference takes precedence over mine. I am called in from the outside as a consultant regarding the mental health aspects of the case.

Subsequently the "offender-patient" is visited by the pastor of his church who views him from still another frame of reference and labels him "sinner". At the same time this man is well-known to the local Welfare Department and is labeled in their files as "indigent" or "unemployed."

The handling of such a person, then, with his accumulated variety of labels, depending on who has assessed him, can lead to confusion, stalemated communication, contention and arbitrary action. The healing measure in such a situation consists in determining whose is to be the chief decision-making authority and the primary responsibility for management and/or care within which frame of reference and for what social purpose at a particular point in time.

To carry the example a bit farther; I may be able to persuade the detective that my frame of reference should supersede his. We agree to give him the primary label "patient," and I arrange for his admission to a mental hospital. Or, after interviewing the patient-offender and his wife, the detective and I agree that his misbehavior stems from an acute domestic problem; so, after sizing up community facilities, we refer him and his wife to their pastor for marriage counseling. We drop the labels "offender" and "patient," and ease him into a system of social management with a frame of reference differing from either of ours. He ends up with the label of "client" or "parishioner."

Thus through this flexible interplay among dissimilar frames of reference is found the most reasonable and workable solution to a social problem -- a solution which safeguards the law-abiding citizens and serves the best interests of the violator. Such social justice, then, can sometimes be achieved. This requires, however, a mutual understanding among social institutions ordinarily tending to be somewhat competitive, a desire to be constructively helpful to the deviant one, an accurate appraisal of the total situation, and the cooperative resources available in the community.

Let me retreat for a few minutes to my frame of reference and make what contribution I can to further our understanding of the mentally disordered offender. As a generality, when a psychiatrist views criminal behavior he tends to see mental illness: this is the gist of my presentation. Will you now join me in examining, analyzing, modifying and testing the validity of what may strike you as dogmatic in my statement.

Criminal behavior is, by common social definition, deviant behavior -- a departure from average, expected behavior. Particularly is this concept applicable to those who engage in lawbreaking repeatedly. Since only a very small percentage of the total population are habitual lawbreakers, they are, therefore, proper subjects for studies in abnormal psychology.

Mental illness is, by common social definition, deviant behavior -- a departure from a norm of mental health. Note that the statement of the preceding sentence began exactly as the opening statement of the preceding paragraph except that "criminal behavior" is replaced by "mental illness" in the second statement. This is not to be syllogistically interpreted to mean that criminal behavior is invariably mental illness any more than it follows that since snow is white and a lamb is white, snow is a lamb.

A broad definition of mental illness will include many varieties of inadequacy and failure, minor and major, in the ill one's adaptation to the customary vicissitudes of growth in a changing environment. Some forms of mental illness are primarily personal or private -- intrapsychic in our jargon -- and do not, of a necessity, unduly disturb members of the community in which the sick person lives. Many whom we psychiatrists consider ill suffer quietly with a mild depression, an uncomfortable phobia, or weekend alcoholism. They well may upset the equilibrium of their family but not encounter condemnation by the community. Assuredly, some prison inmates are ill in this way.

A second group of the mentally ill are more flagrantly disturbed. They suffer considerable personality disorganization that adversely affects daily activities such as work, family obligations and social deportment. They may experience bizarre perceptions or peculiar ideas, emotional excesses, such as severe depression or elation, and may exhibit unconventional behavior. They may become social problems and, by legal action, may be committed to mental hospitals. Some of them act on their irrational perceptions, thoughts, and emotions, and in so doing, incidentally become offenders

against the law. A sizeable number of mentally disordered prisoners are from this group.

A third group of the mentally ill manifest their psychological deviance more in chronically troublesome behavior than in grossly altered thinking. They may be called alcoholic, promiscuous, kleptomaniacal, reckless, delinquent, or criminal. They act out their inner conflicts in social situations and are frequently called antisocial or sociopathic. They use (or, more accurately, misuse) and exploit others, seem highly self-centered and indifferent to the property rights or well-being of fellow citizens. Police courts, parole officers and prison wardens, to their sorrow, are well acquainted with this group.

All these people may acquire a diagnostic label derived from words in our standard psychiatric lexicon -- neurotic, schizophrenic, paranoid, sociopathic -- yet they all suffer from a common ailment, mental illness. The subcategory-labels are frequently not very useful and in some respects are downright harmful.

The foregoing brief and incomplete clinical remarks have been presented to introduce the crucial question, "Who are the mentally disordered offenders?" There is a corollary question -- "Aren't all offenders mentally disordered to some degree?" Our reasonable consideration of these questions depends upon an agreement of definitions. We must somehow contrive to mean the same thing when we use the same words and phrases.

Psychiatric understanding of deviant psychosocial behavior rests on the keystone concept of the unconscious mind. Through the body of knowledge we have gained by careful study and disciplined scientific method, and validation by a vast pooling of results from experience, we psychiatrists have been emboldened to explain the irrational in human conduct on the basis of this concept. Mental illness, even in mild form, stems from irrational drives and motives. One does not become ill from adding two and two to make four. When two plus one equals four or two plus two equals five and one-half, then we say such results are incorrect, illogical, wrong. When common sense and logic fail to explain behavior or add sums to right totals, then where else can we turn for explanations but to "uncommon sense," the life of unreason, the unconscious mind?

Whenever we ask "Why does he behave that way; why, for example, does he act to get himself locked behind bars for the third time?", we are usually voicing wonderment concerning behavior which baffles ordinary understanding. We are attempting to grasp the meaning expressed in behavior which is not characteristic of most of us. Particularly if we stop to think what his antisocial behavior costs the offender, how much punishment, privation, indignity, and public anger he has brought upon himself, we grope for a descriptive new word and call him "antiself" as well as "antisocial."

The source or motivation toward irrational behavior lies in the unconscious mind. We hypothesize a conscious layer of the mind in contact with reality and capable of judging, thinking and learning; of controlling and adapting the behavior of the human organism of which it is a part. There is also an unconscious layer of the mind inaccessible to the awareness of both the possessor and the untrained observer. Stored deep in this unconscious stratum are repressed and forgotten memories, painful experiences, unacceptable desires, antisocial strivings, and powerful primitive feelings. We have learned from decades of clinical work and research that the ideas and emotions of the unconscious mind are held in check, controlled, and do not usually enter the conscious layer of mental activity. Nevertheless, these repressed ideas and emotions are not dead. They retain much vital psychic energy and in subtle ways constantly clamor for a vote on how the organism behaves. One might ask why it matters whether it is the conscious or unconscious processes that motivate a human being.

The thoughts, feelings, and desires of which we are conscious are known to us, and we can communicate them to our fellows; they can be directed and revised by learning, education, intelligence, and the exercise of will power. They can be affected by the experience of success or failure, by rewards and punishment, or by appeals to reason. Therefore, that part of the human personality its host is aware of and can recognize as an existing element of himself which he can use, has the capacity for change and for flexible adaptation to external realities. To the extent, then, that conscious processes govern our lives, we are free to enlarge our experiencing, to learn and grow in wisdom and understanding.

In contrast, those ideas, emotions, behaviors and personality traits which are determined predominatly by unconscious psychological processes are for that very reason rigid and fixed. Precisely because the determining forces are unconscious, they cannot learn; they cannot be swayed by modifying influences such as argument, reason, education; they cannot be persuaded or dissuaded by appeals to conscience or altruism or compassion, by rewards or punishments. Therefore, to the extent that the source of energy activating behavior is unconscious, we are indeed chained and not responsive to pitiable pleas and moral preachments, not deterred by punitive threats and coercions.

The words "conscious" and "unconscious" as traditionally used in our language, are easily comprehensible. One goes to sleep and is not conscious; one suffers a blow on the head which knocks him out, renders him "unconscious." In the psychological sense, however, we mean by the term "unconscious" those processes of thinking and feeling which are beyond the awareness of our cognitive powers. I am, in effect, asking you to credit with your conscious mind, to strive to accept intellectually, to understand (through conceptualization) an aspect of mental functioning which by definition is unknown to you. Calling upon our minds' marvelous capacity for abstract thought, we must accept the usefulness of this first principle (the

unconscious) of psychodynamic theory before turning our focus to the conscious levels of evidence where we can actually demonstrate facts and confidently proceed in building upon them toward further progress in understanding, explaining, and coping knowledgeably with the realities of human behavior.

For the purposes of the clearest communication possible, it is convenient to divide personality into three large sets of functions. One of these consists of the instinctual drives, biologically based on the physical nature of the organism, continually suffused with energy, and driving us on to varieties of observable behavior. The instinctual drives are unconscious; that is, not directly known to the person being driven. We do, however, have considerable familiarity with various derivatives of the instinctual drives. The drives are dynamic; that is, they have a quantity of energy and constantly strive to be expressed by the personality.

The unsleeping instinctual drives (id) operate according to the pleasure principle; that is, the gratification of instinctual drives usually produces organismic pleasure or satisfaction; and the denial of id gratification usually produces tension, frustration and irritability. These drives have no interest in self-preservation; no interest in, indeed no awareness of, other people, standards or values, or consequences of action. They blindly seek release from the organism and have no other concern. Unbridled instinctual drives, then, can easily get the organism into trouble, can even effect its destruction.

A second large set of personality functions, the conscience, was termed by Freud the superego. He pointed out that there is a special part of us which seems to perform the duties of an internal censor or watchdog. Some of the conscience is, however, unconscious; that is, not susceptible to our sensible reasoning maneuvers; and it also, therefore, can contribute irrational energy to human behavior on occasion. The unconscious part of our conscience is a rather harsh, primitive, accusatory agent; and being unconscious, is not in contact with the environment about us, does not operate according to everyday rules of common sense. It may be stubbornly narrow and cruelly punitive, and generate considerable turmoil within the individual personality.

Freud named the third large set of personality functions the ego or the self. Much of ego functioning also in unconscious and not readily accessible for observation and discussion. From infancy on, we automatically acquire certain unconscious mechanisms which variously control and modify the instinctual drives and in various measures of success prevent their being expressed through the personality in their wholly basic raw, primitive form. Some of these unconscious mechanisms also operate to maintain a kind of psychological balance with the conscience by mediating a series of compromises between the demands, both of the incorrigible id and the stern superego. In the ego then are the executive-planning, decision-making, action-controlling, reality-confronting, stimulus-handling functionings of psychological man.

Our conscious mentation, our awareness of ourselves and the world around us, are accomplished functions of our egos. It is, therefore, that part of our personality most prominently in contact with the external environment. In the sense that instinctual drives operate by the pleasure principle, the ego operates by the reality principle, and as we grow into adulthood, we become more and more facile in adequate adaptation to the demands of reality. Among the ego's staggering load of psychological functions are memory, learning, perceiving, judging, weighing, sorting, selecting, delaying, testing. The ego is the seat of intelligence, the timer bell and governor guage on action of various sorts; not only intentional action with the body's skeletal muscles but action in fantasy, in imagination, in goal-planning; and action involving us in relationships with each other. The ego has the task of controlling and modifying the instinctual drives and letting them out in an attenuated socially acceptable form. The ego has the problem of appeasing the superego, attempting to parry the superego's primary weapon -- the sense of guilt. It has also, at the same time, to keep the total organism in a tenable state of balance with the myriad conflicting pressures, demands and stimuli of its environment.

In many adults, conscience remains infantile, and ego may be essentially weak and deficient. In such cases psychological imbalance and deviant behavior -- mental, emotional, or behavioral -- constantly threaten. The degree of deviance in behavior emerging from a poorly integrated personality or inadequately developed ego will depend considerably on the strength and capacity of the ego to effect compromises -- neurotic, psychotic, or antisocial symptoms will announce its failure.

At one time in our history, it was socially acceptable to end an argument by bashing in the opponent's skull with a rock. In that caveman era, it was also permissible to carry off any desired female provided one were strong enough to defeat the competition. Such direct means to obtain instinctual gratification we no longer consider compatible with the refinements of civilization, the enlightenments of education and the attainments we can realize through growth to psychological maturity. Consequently, relatively few among us are likely to become arsonists, rapists, embezzlers, wife-beaters, murderers, or anarchists. But a few are.

Considered in this theoretical context of conscious and unconscious, what then is mental illness? In a broad and sweeping sense, it is (1) a condition of prematurely arrested emotional development which might be compared to the arrestment of a child's school career after he has learned to add and subtract but before he has been taught to multiply and divide; after he has learned to print letters but before he has learned to arrange them in sequences to spell words; or (2) a condition of distorted emotional development which might be compared to a child's having been so skillfully indoctrinated with false teachings as to believe for the rest of his life (against all contrary evidence presented to his senses) that Caucasian males of Teutonic blood, alone, constitute a super-race ordained by Nature to hold power of

life or death over all other forms of earth's creatures; or (3) a breakdown of previously effective functioning of the defensive, controlling, reality-oriented components of the personality.

Two conditions are necessary for the production of neurotic, psychotic, psychosomatic, or antisocial behavior: first, the existence of a basic developmental defect in a given organism's internal controls; and second, the superimposition of stimulus or stress sufficiently strong to overwhelm that particular organism's tolerance limits, whereupon the ego desperately resorts to second-rate (maladaptive) methods of coping with the organism's painful condition of psychological imbalance.

A single case history presents some of these points. The patient we are to examine is a 36-year-old single man facing his third penitentiary sentence. His life of crime began at about age six when he stole milk bottles and turned them in at the neighborhood grocery store for nickles with which he bought candy bars. By age seven or eight, he was being used by a gang of older boys who would give him a nickel for throwing a rock through a house window, and a dime for breaking a store window. By age twelve, he was consigned to the State Industrial School for Boys from which he escaped three times within two years. When he was fifteen, he was psychiatrically examined at the State Receiving Home for Children. There, as at the Industrial School, he was described as bright, restless, aggressive, curious, irritating, and not well liked by his peers.

At the time I saw this man, 65 arrests were on his record; and he had served penitentiary sentences in two states. Subsequent to my examination of him, he became a convict in the federal penal system.

A noteworthy item in this case history: for a five-year period, 1960-1965, he committed no crimes. He declared a kind of moratorium on criminality. Why? He met a woman!

The young woman evidenced a considerable amount of interest in him; divorced her husband to go with him; a close relationship developed. The patient settled down; went to a trade school; became an expert air-conditioning repairman; and earned more money than he ever had before. Their relationship gradually deteriorated primarily because, for reasons he still does not understand, he procrastinated about marriage. Finally she left him, stating that she needed time alone to think out what their future would be. He accepted her decision to move to a city some 100 miles distant. He wrote to her and telephoned her frequently. One vignette is dramatically illustrative of this man's irrational personality functioning: he wrote her that he would telephone on a certain evening; he called but no response. He sat with a buddy, drinking beer, while calling repeatedly but unsuccessfully. His friend teased him about her probably being out with another man; by midnight he was in a high state of tension. On an impulse he left his apartment, broke into the house next door and stole a woman's purse. His anxiety drained away, he went to bed and slept soundly. The psychodynamic symbolism of this behavior is not difficult to understand.

His mistress returned shortly thereafter; and there were stormy scenes. She finally left for good, taking their car and their joint bank account. On the following day he stole a car, drove it across a state line, and was arrested. After five years of "going straight," he is now again subject to the correctional system.

Is this a mentally disordered offender? Breathing a prayer for semantic skill I must reply: from my frame of reference he is neurotically ill. Detailed studies reveal similar stories from many men at present being held in our correctional institutions.

Let us return for a moment to the central question -- "Who is the mentally disordered offender?" I should be surprised if you have learned the answer from my dissertation. I don't presume to know it. My aim has been to examine the question with you, raise some issues for consideration, and suggest the possible value of psychiatric contribution to an understanding of correctional work which is essentially the management and rehabilitation of faulty, failing people. Most of them have failed in several ways. It is convenient to consider those on one end of a continuum mostly offenders and somewhat sick; those on the other end mostly sick, though also lawbreakers. What about those in the middle -- the great majority of the prison population? It seems to me that no single frame of reference by itself is of much pragmatic value.

Perhaps through a new frame of inter-reference welded from genuine social concern, noblesse oblige, open-mindedness, objective altruism, and earnest seeking to learn from each other, we can together learn further from our patient-offenders themselves. Perhaps we may reasonably aspire to draw into an ever enlarging frame of reference, an effective participation of many disciplines, of many interested and enlightened and energetic citizens. Perhaps if we try, we can soon devise a new scheme, new words, new concepts, and new institutions more appropriate to the task of changing lawbreakers; but, changing them from what to what, and by what means? These, I submit, are the significant and challenging questions we should be asking.

THE ROLE OF PSYCHIATRY IN THE TREATMENT OF THE OFFENDER

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Although considerable debate is still going on about the extent to which defenders are mentally disturbed and should be considered "sick", those who deal with offenders after conviction have become increasingly aware of the importance of individual psychological factors as determinants of behavior. No where is this more important than in dealing with what is increasingly being called "the mentally disordered offender." Although the exact characteristics of offenders fitting into this group are not entirely agreed upon, there is general agreement that approximately 15 to 20 percent of the total number of offenders coming into correctional institutions, although they do not show signs of traditional mental illness, are significantly disturbed in their thinking, feeling, and behavior; they also respond poorly to ordinary correctional programs and often become major management problems within institutions.

The mentally disordered offender represents a challenge both to psychiatry and corrections. Neither field has been able to deal adequately with this problem and each has often suggested that the problem should be handled by the other. Psychiatric hospitals have felt that the secure facilities of correctional settings were needed for the treatment of such cases and have often refused to accept them for admission, much less hold them for treatment; correctional institutions have generally felt that, because of the unavailability of psychiatrists, their institutions were not equipped to treat such cases. In the face of such generally held attitudes, one can find, in most every state system, the situation of cases being shuttled back and forth from prison to psychiatric hospital, with the staffs of the institutions being frustrated and angry with each other and the patient not benefitting at all.

The fact that an interdisciplinary conference on the handling of the mentally disordered offender is being held is a step beyond the unproductive conflict and mutual criticism I have just described. The conference itself is an attempt to find real solutions to a problem we are increasingly recognizing cannot be ignored. Real solutions almost always fall short of ideal solutions; and have to be based upon compromise. This is especially true when the ideal solution involved major changes in attitude within the community and expenditures of large amounts of money.

The problem of the mentally disordered offender is a good example, I believe, of where we will have to be satisfied with a compromise solution. A good case can perhaps be made on a theoretical basis for the state mental hospital system taking responsibility for this class of offenders, in addition to its responsibility for grossly psychotic offenders currently being treated in security hospitals throughout the nation. But excellent as these arguments

might be, it is unlikely that the management and treatment of mentally disordered offenders -- either in regular state hospitals or in special institutions -- will become the responsibility of psychiatry or the mental hospitals. For one thing, psychiatrists themselves are far from enthusiastic about these cased from a control and management point of view; they tend to feel that psychiatry has enough unsolved problems in handling the traditionally mentally ill and the so-called criminally insane. Secondly, the community at large, whether psychiatrists like it or not, still remains somewhat dubious about psychiatry and about sending offenders to mental institutions. For these and other reasons, it is unlikely that this chore will soon be thrust upon psychiatry.

If the mentally disordered offender is to be treated properly, a satisfactory cooperative arrangement needs to be worked out between corrections and psychiatry. But what is required for such cooperation? It is a truism that effective cooperation, or partnership, involves a genuine give and take, but how is this give and take illustrated in the handling of the mentally disordered offender? First, each field has to understand and respect the other, but that is not enough. Each has to recognize that the other field has something essential to contribute to the joint effort. For example, psychiatry has to respect the practical knowledge and sincere interest in rehabilitation represented by corrections, but psychiatry also has to recognize that the institutional facilities at the command of corrections, with the potentiality for establishing total communities, are essential in the treatment of the mentally disordered offender. Corrections, in its turn, must recognize that psychiatry, as much as itself, wishes to protect the community, and that in addition, psychiatry has a technical knowledge about the twists of the human mind which is essential for the treatment of the mentally disordered offender. Furthermore, both must cooperate to establish a satisfactory field of operations. Psychiatry must be prepared to work outside of the office or hospital setting -- in the correctional institution -- and the correctional institution must be prepared to develop a climate within which psychiatrists can work effectively toward the mutual goal of corrections and psychiatry -- the protection of the community. Both must recognize society's special stake in the handling of the mentally disordered offender. He is the offender who is most feared, and for good reason, since he tends to be the most unpredictable and the most dangerous.

The concept of the scientific treatment of disordered minds is relatively new in our civilization, in contrast to the vengeful ways of handling criminals which are as old as civilization itself. But even in the relatively short history of psychiatry one can see parallels with the problems of handling offenders. There was a time when psychiatry was so fearful of, and angry toward, mentally ill persons that their handling was as harsh and punitive as anything seen in corrections today. One example is the handling of those unfortunates called "witches." Psychiatry, however, did move to a better understanding of the forces involved in mental illness and was able

to become less fearful of patients and more able to use its understanding for the benefit of patients. It was through a shift of attitude, based on knowledge, that the use of threats, abuse, deprivation, degradation, and retaliation for disapproved behavior were gradually eliminated, since it was found that their use generally made the problem more difficult rather than easier.

The handling of offenders against society, before there was a field of corrections as such, was dominated by concepts of vengeance and retaliation. Although some of the more brutal forms of retailiation have been given up by our Western society, the basic principle of retaliation remains in the administration of our criminal law; to a large extent, we still think of fitting the punishment to the crime rather than to the individual who committed the crime. Without getting into the debate of how to handle all offenders, I would like to point out that, in the handling of mentally disordered offenderders, procedure based on concepts of vengeance and retribution will continue to fail, just as they did in the earlier history of the treatment of the mentally ill.

The major contribution of psychiatry to the handling of the mentally disordered offender is that of potentially understanding him and his behavior and then helping to devise a treatment program based on that understanding. For example, the psychiatrist looks at any piece of behavior, whether it appears to be rational or is obviously irrational, as an expression of the individual's reaction to the forces inside of himself and in his environment. If the psychiatrist wants to understand why the individual acts the way that he did, he first asks "why," and then he pays serious attention to the answers. This is not to say that the psychiatrist takes everything that the individual says at face value, neither does he reject out of hand anything that the individual may say. Ideally, he tries to develop empathy, which is an attitude of feeling for the individual and understanding him while retaining some perspective. To put it another way, the psychiatrist tries to put one foot in the patient's camp, so that he can have some sense of how the patient thinks and feels, but the psychiatrist also keeps one foot firmly anchored in reality so that he can understand the way the patient distorts reality, with the goal of helping the patient readjust his perceptions to those of reality. The psychiatrist has to avoid being oversympathetic, that is, putting both feet in the prisoner's camp, just as much as he has to avoid being unfeeling, that is, not allowing himself to put even one foot in the prisoner's camp. Being human the psychiatrist occasionally may slip into being overly sympathetic or insensitive, but this is infrequent, even though he is often accused of one or the other. It seems more likely that, being "in the middle," the patient frequently complains that the psychiatrist is not sympathetic enough and society often thinks the psychiatrist is too sympathetic. This is perhaps an occupational hazard of psychiatry.

What does the psychiatrist bring to the correctional scene? First and foremost, he brings the healing tradition of the physician which, in its best moments, has transcended national boundaries and social prejudices and

which is especially important in the treatment of social outcasts. He also brings a highly technical knowledge of what makes a given individual think, feel, and act the way he does, and the ability to work with others in translating this knowledge into an effective treatment program.

While most, if not all, of the treatment skills can be learned by non-psychiatrists the important problem is that of assigning the person requiring treatment to the "right" treatment. In a broad sense, that is what one might call diagnosis. The ability to do this, to integrate the findings from all the professions about the behavior of a given person and to make proper recommendations about further treatment is the key role for which psychiatrists are trained today; it is also a role for which no other profession is currently being trained. On the other hand, many professions are training individuals to do treatment, and these individuals have demonstrated that they can do so quite successfully when given appropriate patients or clients. For example, many clinical psychologists and psychiatric social workers are doing psychotherapy, many ministers are doing counseling, and many nurses and activities therapists are broadening their roles much beyond their original training. In some places, on an experimental basis, ordinary housewives who are sensitive and intuitive are being trained to do counseling.

In the treatment of the mentally disordered offender, the role of psychiatry should be that of supplying a beginning understanding of the mental twists that underlie his behavior with a view to developing programs that can reverse these mental twists or lead to more constructive patterns of behavior. This means that psychiatrists have to play a much more active part in the development of institutional programs that influence the prisoner's day-to-day behavior, as well as being available for the more specialized types of treatment such as group psychotherapy or individual psychotherapy. As in most mental hospitals, however, the bulk of the "treatment" must be carried out by the people that are in contact with the patients or the prisoners twenty-four hours a day. Even where a person is having psychotherapy one hour a day, the way he is handled the other twenty-three hours can either negate any progress made in that one hour or greatly potentiate it. Therefore, the amount of time spent by the psychiatrist in instructing personnel about the meaning of behavior is infinitely more important than the amount of time spent in individual or group psychotherapy.

The importance of this educational role of the psychiatrist in the treatment of the mentally disordered offender cannot be overemphasized, since this offender presents special problems from the treatment point of view. The most serious special problem he presents, in contrast to other mentally ill persons, is that his mental twist or emotional disorder is not immediately apparent. These offenders demonstrate a facade of normality or "mask of sanity," if they are looked at casually or superficially. A second factor that complicates the problem is that, like many other mentally disordered people, these offenders have a strong need to deny that they are mentally ill. This denial of illness, however, is more difficult to deal with

when the mental twist is not obvious. This need to deny, moreover, reflects itself often in their insistence that they are "bad" and should simply be punished, rather than in their accepting the fact that they are disabled and need help. While everyone hates to admit that he is or has been irrational, the wish to deny mental disorder in some offenders is so great that, at trial, they refuse to let their attorneys present a defense of insanity. In a few, the insistence that they are "sane" continues up to execution. A third special characteristic of these offenders is a suspicious, almost paranoid, orientation to the rest of the world by which they deny their own failures by blaming others for misunderstanding them or for not giving them enough of a chance, etc. A fourth special problem that they present, related in part to all the others, is their ability to provoke frustration and anger in the staff that attempts to deal with them, a tendency which serves the double purpose of convincing them that their suspicions of others are well founded, and hence they should not cooperate, and of convincing staff that they are so "ornery" that staff will give up in its attempt to induce change in them.

Mentally disordered offenders have many other characteristics to a greater or lesser degree, and I am sure you are aware of them. These offenders tend to be impulsive rather than reflective. They seem not to be able to learn from experience. They appear to be very much self-involved, with little concern or consideration for other people. They seem relatively unconcerned about their body or own safety, and often have very unrealistic ideas about their own capacity. Under the surface, however, they often feel themselves to be weak, inadequate, and unworthy; sometimes they feel they are "doomed."

One question that might well be asked is whether psychiatry has the understanding and the techniques to deal with these kinds of persons. It is true that psychiatry has traditionally shied away from the treatment of such offenders, particularly the more serious cases that tend to get into the correctional system, but since the end of World War II, there has been an increasing interest in psychiatry in the treatment of patients that show disturbances in behavior. An increasing number of patients that come to psychiatrists in private practice, or who are admitted to mental hospitals, exhibit disturbances in behavior as a major complaint; it seems even that the proportion of more traditional kinds of mental illness is diminishing. It is now possible to say that there is knowledge and expertise in psychiatry about these kinds of offenders, although not all psychiatrists are interested in getting involved.

If it is to be accepted that psychiatry has the expertise to work with these kinds of cases, what is it then that psychiatry can and should do? As suggested earlier, the first job of psychiatry is a diagnostic job, that is, the job of understanding the mentally disordered offender and establishing goals to treat him. This means getting behind the facade that he presents to his real weaknesses and disabilities. The extent and degree of the weakness

and disability needs to be accurately mapped out. Sometimes the offense itself is a clue to the seriousness of the mental disorder; often it is not, and a single offense like car theft may be a reflection of different kinds of difficulties. For example, a specific instance of car theft in the case of an adolescent may be related to an attempt to get peer approval, or to a lapse in judgment in the face of the temptation of a car with a key in it, or to an impulsive running away from feelings with regard to the loss of a parent, or to a long-standing pervasive disorder in judgment.

One important assumption made by psychiatrists is that, regardless of the social forces influencing any piece of behavior, it is the individual who experiences these forces, and that if we want the individual to change we must influence him to change his attitudes, perceptions, and feelings. But if we accept as our goal changing the attitudes and perceptions of offenders, certain corollaries follow. For example, we become interested in the building of internal self-control rather than simply encouraging passive compliance with rules. In order for individuals with disturbed self-control to develop self-control they must have graduated opportunities for independence and responsibility, in a setting which protects them from their own self-destructiveness at the times they are incapable of handling independence and responsibility. In fact, there may be times when we have to hold some offenders under "tight rein" so that they can come to grips with their fears and inadequacies and not run under the impact of the panic that so often develops from looking at one's inadequacies. Secondly, institutions must give offenders opportunities to buttress their education in areas where it has been neglected and to learn marketable skills. But consonant with the development of any skills should be an ongoing emphasis in dealing with the patterns of failure and self-destructiveness that are so frequently present. A third objective involves helping offenders match their aspirations with their real capacities. Almost all offenders have severe distortions of their self-image; many think too much of themselves and some too little. It is the disparity between aspiration and real potentiality which often causes so much difficulty. Finally, the institution should be geared to helping the offender develop some self-understanding, a better perception of himself and the rest of the world, so the repetitive pattern of self-destructive behavior is broken. The offender should be helped to see the extent to which his perception of the world as hostile may be a misperception or may be provoked and precipitated by himself, sometimes in relationship to his own feelings of unworthiness and unconscious guilt. With regard to the latter, one of the more important contributions of psychiatry is a recognition of the extent to which offenders are dominated by a sense of unconscious guilt hidden by a hedonistic and pleasure-oriented facade.

In order to achieve the above mentioned objectives, institutions treating mentally ill offenders should function along the following general principles:

1. There must be an atmosphere of real interest in the offender and in helping him to change in a positive direction. This means that

he must be respected as a person in spite of the fact that his behavior sometimes is not acceptable, and that policies based on degrading him or breaking his spirit have to be given up entirely. The approach should be one of welfare rather than warfare, with a sophisticated awareness of the feelings of alienation and inadequacy behind the offender's unacceptable behavior.

2. In addition to the atmosphere of genuine interest, the program specifics should be based on the old medical maxim, "primum non nocere," which, freely translated, means "first of all, do no harm." In practice, this means developing policies and procedures which can avoid the "tit for tat" response to the provocative aggressiveness of offenders. The institution needs to be able to understand the extent to which the offender's current behavior is a futile repetitive attempt to master earlier traumas. Staff members need to understand that the aggression is not directed personally against them, but that it represents a chronic attempt to deal, albeit in a distorted way, with significant figures of the past, for example, father or mother. This understanding, however, does not mean that all kinds of misbehavior are to be tolerated. It simply means that the response to misbehavior should be dictated by the reality of the situation and not by the anger provoked in the staff. In other words, the offender needs to be shown that his "rebellion without a cause" is not necessary, that staff will react appropriately, rationally, and consistently, even in the face of inappropriate and irrational provocation.

3. A third basic principle is the recognition that people can change on the basis of examples set for them by figures they respect. If we want offenders to use reason, learn self-control, and forego violence, the staff has to be prepared to act in a way that fulfills all these criteria. These same principles are involved in the rearing of children; we all know that the parent who says, "Do as I say, not as I do" may be disappointed, for his child may well grow up doing as he does and not as he says. The same is true in institutions dealing with mentally disturbed people.

4. There needs to be a recognition that the offender does not exist in isolation and that any attempt to work with him must include working with his family and, ideally, with other forces of the community, such as his employer. Mental hospitals have learned the hard way that if a patient is treated in a vacuum, without concern for his family or the community to which he is to return, all treatment efforts may be in vain.

5. If possible, the architecture should be such that potentially dangerous offenders cannot run away and destroy the treatment efforts. The architecture should be able to do most of the holding function so that the staff can concentrate on the helping function.

6. The needs of staff must be met to the extent that these needs are legitimate. If a high quality professional staff is wanted, the atmosphere of the institution must be one that allows the full development of professional skills and the use of professional judgment. This should include the awareness that staff members may make mistakes at times. The obligation of the staff should be one of learning from mistakes rather than trying to avoid mistakes at all costs. The latter attitude results only in a sterile sterotyped operation. In addition, the staff needs to be sufficient in size that its members are not overburdened with work to the extent that things become routine and perfunctory. Staff members must have a good relationship with each other, and be able to respect each other, else they will not respect their patients.

7. Finally, the staff ought to be capable enough and secure enough to accept its responsibility in the complex process of psychological change. Psychiatry does not yet have techniques to cure patients against their wishes, and I doubt that it ever will. But most people do want to change for the better, although some may have to protest the opposite. The job of psychiatry is to uncover the wish for positive change and deal with the fears that inhibit its expression. With that idea in mind, the staff should avoid blaming patients for its "failures" by calling these patients "not motivated" or "untreatable." While staff members must recognize that they will not always succeed, even when they have done their best, their goal should be to learn from their failures and not take refuge in blaming the patients.

I want to close with some thoughts about implementing the positive relationship between psychiatry and corrections. It is true that many psychiatrists, including myself, have been critical of the way corrections has, up to recently, tended to ignore psychiatric concepts in the handling of offenders. From private conversations, I have become aware that corrections has interpreted these criticisms as representing a wish on the part of psychiatry to "take over" the field of corrections. But this point of view ignores two realities: (1) there are not enough psychiatrists to supply the needs of the mental health fields, and (2) most psychiatrists feel they have enough unsolved problems without taking on the problems of corrections.

You all know that there are many demands for psychiatrists, usually with pay and status higher than in most psychiatric jobs in corrections. Psychiatrists, being as human as anyone else, tend to move to the jobs with the highest pay and the highest status, but even so, many psychiatrists do acquire an interest in problems of crime and delinquency. If correctional officials really feel that psychiatric services are essential for the handling of the mentally disturbed offender, they must devise ways of preserving and utilizing this interest of psychiatrists. For example, at any

given time, there are relatively few psychiatrists working in correctional settings, but there is a high turnover in such positions, with many psychiatrists leaving corrections after a brief period. While many factors may be involved in any individual psychiatrist's decision to leave corrections, the most important one appears to be the lack of opportunity to practice good psychiatry, at least as perceived by him. It is incumbent upon correctional officials to develop policies that will halt this loss of valuable personnel.

The developing community mental health movement represents another potential opportunity for corrections to develop working relations with psychiatry, since psychiatrists working in community mental health centers are often quite interested in problems of crime and eelinquency. Correctional administrators, however, will need to find ways to use psychiatrists on a consultative and part-time basis. While there are disadvantages from the point of view of corrections, the advantages should be carefully considered. Part-time arrangements can be extremely helpful in holding the interest of psychiatric personnel, since they will have the opportunity to derive status and professional gratification in areas other than corrections. Moreover, the use of consultants and part-time personnel, in addition to providing specific services, offers an opportunity to improve morale by virture of their support of and encouragement to the full-time personnel.

In conclusion, it seems to me that the trend toward the involvement of psychiatrists in correctional work is clear. No one seriously questions that the psychiatrist has an essential contribution to make toward the identification and treatment of the mentally disordered offender. As we move toward the implementation of a working partnership, it seems to me that corrections does not yet realize how severe the shortage of psychiatrists is and how much the trend in modern psychiatry is that of offering help to other professions via consultation and part-time work. What psychiatrists want from corrections is that it become in fact a more effective "helping profession" by incorporating into its practices those psychiatric principles which are essential for the helping process to take place. This is particularly true of the care of the mentally disturbed offender who so often is a severe management problem in a traditional penal institution and who, everyone recognizes, simply gets worse and worse there. The proper handling of such individuals -- if attention is to be paid to correcting their mental twists -- demands an abandonment of policies of retribution and an acceptance of the principles described earlier. But this commitment to help cannot be halfhearted; unless it is total it is unsatisfactory.

It is this wholehearted commitment to helping offenders that psychiatrists are striving for, not for control of the correctional institutions. We psychiatrists are aware that such a commitment is a reversal of the older approaches. But for us to work effectively in the penal system, and in particular with the mentally disturbed offender, the penal system will have to

make some basic changes. In our opinion, these changes will not take away the responsibility and authority of correctional administrators. Instead, these changes will shift the basis of that prestige and authority from one based on force and power to one based on a more scientific understanding of the offender, and I am convinced that corrections will welcome this shift.

THE CALIFORNIA MEDICAL FACILITY, VACAVILLE

Thomas L. Clannon, M.D., Assistant Superintendent

I am here this afternoon to describe the Medical Facility of the California Department of Corrections. As I understand it, the special interest in this institution is that it represents almost the only example of a psychiatric hospital which is under a department of corrections and all of whose staff are employees of a department of corrections. Since my opinion about the advisability of such an arrangement will become apparent anyway, I might as well declare myself in favor of such arrangements for the "mentally ill offender." While presenting some of the history and present functioning of the Medical Facility reasons for this opinion will be brought out.

At the outset I would like to take issue with the philosophy or approach which is implied by the title of this conference. The title identifies the problem as that of "the mentally ill offender." I think the problem should be stated as that of mental illness among offenders. The reason is that if one accepts the idea of the mentally ill offender it leads to the conslusion that the problem should be solved by identifying those individuals who somehow need this classification and isolating them in some special facility or program. It assumes that mental illness is a quality of certain individuals and that mental illness in a population can be dealt with by identifying who these individuals are and dealing with them. The truth is that mental illness is a state of ill health that comes and goes in individuals, taking many and varied forms. In any population it is occurring and provision needs to be made for its recognition and management and treatment. In the population of any community of people, whether in prison, in the courtroom, or in any community, at a given time there are some people who are suffering minor mental disturbances, some people suffering major disturbances of temporary duration, and people with chronic mental illnesses in various stages of illness.

Do you recall the childhood game of "Button, button, who's got the button?" A group of children arrange themselves in a circle around someone who is "It" and they hold the button behind their backs while the It person tries to guess who has the button, which is being passed back and forth. This process of trying to single out the mentally ill person and remove him from the population I would like to term "The game of button, button, who's lost his buttons." In our efforts to do this we suffer the same frustration as the individual who is It, since the button (being mentally ill) keeps getting passed back and forth between individuals out of our sight.

The idea that mental illness can be dealt with by identifying those individuals who "have it" and isolating them receives some reinforcement from the fact that there are individuals who suffer chronic illnesses and are never in a state of good mental health. Recent advances in community psychiatry have clearly demonstrated, however, that the chronicity of mental

illness is favored by the process of isolation and segregation in state hospitals away from the life situation with which they must contend. The direction of development of community mental health concepts and practices suggests that in the future we will be talking about increasing the level of mental health in prisoners rather than "managing the mentally ill offender or mental illness among offenders." Looking from this standpoint of mental health rather than mental illness, accentuates the need for a department of corrections to take responsibility for providing the necessary services for its mentally ill inmates. As one provides for the more seriously mentally ill by adding mental health personnel to the staff and modifying the prison milieu, other inmates benefit who would never have been thought of as needing psychiatric treatment. Demonstration of this can be seen in Vacaville or at the Federal institution at Springfield, Missouri, where some prisoners in constant difficulty in other prisons are able to make satisfactory adjustments even though they are not mentally disturbed by ordinary standards. Such men respond to some salutary effects of the treatment milieu by improvements in their behavior and adjustment.

At Vacaville we view ourselves as operating a hospital for the community of offenders committed to the Department of Corrections. We serve this community in the same way that a state hospital serves its surrounding community. We receive men from other prisons who have become acutely ill, treat them, and return them to appropriate correctional programs. The other prisons often have psychiatrists on their staff who are able to provide follow-up attention and who may often avert the need for their hospitalization at the Medical Facility. The relationship between ourselves and other institutions is direct and immediate, since we belong to the same Department, and the man who receives treatment remains in prison under correctional authority throughout this process. The treatment of acute mental disturbances occupies about half of our overall program. The other half is occupied with providing psychiatric treatment, primarily group psychotherapy, to a group of men selected from the whole Department as being in need of, and able to benefit from, psychotherapy. Many of these men do not have the usual psychiatric symptomatology and would not necessarily be seen as psychiatric patients in other settings. We have been striving, however, to use psychiatric techniques in the service of rehabilitating the sociopathic individual or those with disordered personalities.

The concept that the Department of Corrections should take care of its own has been difficult for me to trace historically. The Medical Facility had its beginning in the recognition that there were an estimated 12 percent of the prison population with easily recognizable mental illness. In the early documents which I have been able to see from this time, there was no serious debate over the question of whether the Department of Corrections should assume responsibility for providing this kind of service. The advice and experience of Dr. Dave Schmidt who has been Chief Psychiatrist at San Quentin since 1932 was a major factor along with the thrust of a vigorous correctional program which had the leadership of Richard McGee and the support of the governor and the legislature. The next important decision

historically in the development of the Medical Facility was the decision not to wait until a physical plant had been completed to begin operation. Temporary quarters were leased from the federal government at Terminal Island, near Los Angeles, and the Medical Facility began there in 1950. I am compelled to recall the slogan of the late Dr. Will Menninger, who, in speaking of mental health needs, always said, "Brains before bricks." This is especially true of a prison-hospital. The advantages of a psychiatric hospital being in the prison system I have already described; the primary disadvantage is the difficulty in staffing such a facility. Where do you find people who are able to work with the mentally disturbed, have the capabilities and experience of dealing with disturbed men under stress that is required of the correctional worker, and the willingness to be innovators in prisons which can be a no-man's land between society and the individual where one can get shot at from all sides?

In thinking of staff, one must begin with the correctional officer and the psychiatric technician and with their immediate supervisors, since this is the basis and the heart of any program. The answer in the case of the Medical Facility is that this staffing came from men being released from the Armed Services, many of whom had been introduced to the wonders of the California climate. The problem of staffing was considerably helped by the fact that the temporary quarters were quite near to Los Angeles and could draw upon a large population of people. In a remarkably short time this staff was able to put into operation a prison-hospital program which has merited the respect and confidence of the Department and of the inmates in the Department.

This is not to say that the institution has not had its ups and downs or that there have not been staffing problems. Possibly the biggest problem in staffing has been that of obtaining a staff of psychiatrists. I think I have been in this field long enough to permit me to express the opinion that the contribution of psychiatry and psychiatrists to the field of corrections has been less than notable. Relatively few psychiatrists have worked in a correctional setting. This has in part been a product of the fact that there has been a shortage of psychiatrists and they could choose to work in more familiar and better charted areas. Some have approached the correctional field as a territory to be conquered and depart when the initial thrill has passed and the day-to-day work has begun. Others come to the prison setting in an effort to work out some personal or social problem and oftentimes are not able to function competently because of these personal problems or preoccupations.

The Medical Facility, therefore, as tends to be true with other similar institutions, has suffered from having a psychiatric staff most of whom tended to be in the process of either coming or going. The exceptions being a few individuals who have stayed with the problems and have gradually improved the program. The staffing problems, by the way, became most acute after the institution moved to the new physical plant in Vacaville, which

is just far enough away from the San Francisco Bay Area to make it difficult to obtain professional staff.

This problem of staffing is best approached through training. A successful program has been that of offering medical officers already working in the Department of Corrections the opportunity to take a psychiatric residency under the auspices of the Department.

This has resulted in obtaining men who are already experienced in the correctional field and have established relationships with correctional administrators in the institutions where they will be functioning as psychiatrists. This prevents the attrition which takes place in new staff who may after a time decide they do not wish to work in corrections. Our experience with this program would suggest that it would generally be a good thing to look among existing correctional personnel for people who would be able and willing to undergo training in the needed professional disciplines. Programs for exchange of personnel between Corrections and Mental Hygiene also seem to offer some potential.

We have devoted a good deal of time to talking about staff and its development because it is this which deserves the most attention. From this point on we will proceed to list in a more or less random fashion some of the things we have learned about treatment in our setting and about the management of such a facility. A philosophy which underlies much of my thinking about our treatment program is that psychiatric treatment proceeds in the interactions between the patient and staff members and in the interactions between the patient and the various groups with which he may identify himself either negatively or positively. It is further my philosophy that such therapeutic interactions cannot be prescribed or programmed in detail, but rather may be encouraged by a climate in which individual creativity is fostered. This is pretty general, but I think that what I mean will become clear as I proceed.

One of our observations is that small group psychotherapy has some special value in the treatment of sociopathic individuals, or the modification of sociopathic behavior patterns in individuals with varying kinds of mental disorder. In brief, the reasons for this are the fact that an individual's system of values and his motivations are most responsive to group influences. This subject is too broad to cover here, and a good deal has been written about it already. Perhaps it has not been sufficiently emphasized, however, that sociopathic patterns of behavior can be altered by group psychotherapy. One of the things we have observed is that one must not look only at the small psychotherapy group consisting of 8 or 9 people. One must also be aware of the influence of the larger groups of the prison staff and population. Inmate-patients who are in psychotherapy should live and be identified with some part of the prison in which most other men are similarly engaged. The larger group influence tends to encourage the individual and to preserve his motivation. We have accordingly designated units for psychotherapy and

encourage staff and inmates to identify themselves with this unit. A caution here is that psychotherapy must be the real agenda of the unit and not simply receive lip service. Our units can and do include staff and inmates who freely express their lack of confidence in the value of psychotherapy. We do not necessarily ask individuals whether they want to be assigned to a particular unit or program, and we feel that this works out fairly well. Once in such a unit an individual is not compelled to give lip service to the program, and if he is not involved after a time then he will be dropped out or leave the program. Avenues for dissent we see as an essential part of a unit program milieu in which personal commitment can take place. Commitment to the therapeutic process with all that it implies, especially identification with a group and hope for change, needs constant encouragement. Some freedom of movement from one group to another is therefore allowed so that the individual inmate-patient has some choice of therapist and group to give him further opportunity for commitment.

Some discussion of the prisoner versus patient role may be in order at this point. In our setting the man remains an inmate or prisoner all the time but may be a patient in addition at various times. That is, his role as a prisoner vis-a-via his family, society, etc., is not blurred or altered. In the acute treatment unit, for example, he may be viewed as a patient, and all the staff, including correctional officers, may be treating him and addressing him as a patient 24-hours a day, but as regards the wider society, he remains a prisoner. In other programs he may be addressed and thought of as a patient only a few hours a week - during psychotherapy sessions - and during the rest of the time his program may be essentially the same as that of any inmate of the Department of Corrections.

Some of this discussion of inmate versus patient which one hears in prison-hospitals has to do with a conflict of authority between the medical and correctional staff. There is a real duality here which I think must be recognized in order to be dealt with. The correctional personnel have their training oriented toward primary responsibility to discharge their obligations toward the man as an inmate needing to be contained and undergo correctional processes. The medical doctor is more oriented toward his one-to-one responsibility to the inmate-patient. These are by no means mutually exclusive nor are they often in conflict. It is a rare individual, however, whose background and orientation prepares him for carrying the combined responsibilities. We are perforce presented with the necessity for them to be able to work together.

Our unofficial organizational structure contains at all levels pairs of people, one of whom is primarily clinically trained and one of whom is primarily correctionally trained. The individuals in these pairs have in addition to their individual responsibilities the responsibility to work with each other to effectively carry out the function of the unit. Where problems arise

it is almost always because the clinical person fancies himself a better custodial decision-maker than his partner or the custodial member fancies himself a better treatment decision-maker. Higher administrative levels need to be careful not to get caught up in this kind of conflict.

It is also necessary for administration to provide fairly clear-cut delineation of responsibility for decisions and to define unit functions and goals. An example of what I mean here can be drawn from a psychiatric treatment unit which I recently had occasion to examine. As is often unfortunately the case, the segregated maximum security cells for disturbed patients and the facilities for disciplinary and controlled protective housing were in the same housing unit. In this particular program there was a psychiatrist and a correctional administrator, but there was no delineation of responsibility as to who bore the primary responsibility for placing people in these cells or who bore the primary responsibility for releasing them. In our own similar housing unit, men as they are admitted are designated as either psychiatric segregation cases, in which case their housing must be approved by the psychiatrist and their further management is his primary responsibility; or they may be administrative segregation cases, in which case their admission is the responsibility of the correctional administrator and their subsequent management and release are under his direction. No amount of definition of responsibility will substitute for good working relationships but, on the other hand, no working relationship - no matter how good - will substitute for assignment of responsibility.

We have a number of psychotherapists on our staff, and they are encouraged to follow their own training and experience in the methods they employ. It is my own impression that the effectiveness of psychotherapy is partly in proportion to the enthusiasm and investment of the therapist and that therefore these need to be encouraged. We likewise encourage a high degree of sharing between therapists, which takes the form of people working together in groups and participating in seminars, etc. As a result, there are some general areas of agreement and consensus which have developed over the years. Most people settle on a group size of approximately 8 to be the most effective. Most people spend relatively little time in selection of individuals for the groups, rather using a trial basis for evaluation. For most purposes or goals, a heterogeneous group is preferred. Such groups made up of men of different personality characteristics and somewhat different backgrounds have greater difficulty in getting started and in communication but have a greater potential for facilitating changes in the individuals. Most therapists assume a degree of authority in their group role that is consistent with the actual amount of authority they exercise in a situation. For example, the therapist's role as an evaluator of the individual for the paroling authority is recognized and the recommendations and reports that the therapist makes are shared with the patients and the groups to a considerable degree.

We point out to therapists beginning in our setting that they will be functioning as "therapists in a fish bowl." A prison is like a small community; their functioning and their results will be readily apparent and freely discussed, and if they are not prepared for this kind of scrutiny they had better seek another setting. By the same token, the therapist in our situation is asked to accept responsibility for his treatment and his recommendations to a degree that is often eschewed by psychotherapists. The therapist who does not wish to be confronted with difficult decisions nor to become aware of his mistakes nor confront his failures should seek some other kind of practice.

What are the results of our program? If you were to visit us you would find an institution with a good level of morale among staff and inmates. The Department finds that we are able to manage many people who are not able to get along in other institutions. This is a mixed blessing so far as we are concerned, but we take some satisfaction in being able to do this. In the past few years our program has become well enough staffed and sufficiently developed to permit us to look at long-range goals and begin to assess how well we are doing. We have also been able to develop some small special programs to meet specific needs. One such is a Stress Assessment unit of 44 beds. This unit was developed with close liaison with the paroling authority. It receives men who are being considered for parole, who have in the past demonstrated a potential for violent behavior but are presently making good prison adjustments. It is well known to prison and parole authorities that some such men after years of peaceful prison adjustment, again become violent when released. The Stress Assessment unit both tests ability to handle the stress of freedom, and prepares the individual for this freedom, by a step-wise withdrawal of the structure of the prison culture and life. Another small unit provides a 90-day psychiatric or neurological study which may guide the paroling authority or classification committees in making decisions about some individuals. We have also recently established a small intensive treatment center for withdrawn and chronically psychotic patients. We had observed that numbers of our patients recovered from their acute mental illnesses but remained unable to cope with ordinary prison living and tended to spend much time in individual cell, segregated housing. Under these isolated conditions in prison, their mental condition tended to worsen. The new unit was designed to have a small dormitory for housing and a rich staff of correctional officers and nursing personnel to provide necessary support, supervision and maintain motivation. This unit is enjoying success in bridging the gap between recovery from acute psychotic illness and return to normal social functioning in the prison community.

Our acute psychiatric unit, with approximately 275 beds is receiving approximately 1200 admissions per year and returning a like number to other institutions or to the main population of our own institution. A few men are released to parole or to hospitals elsewhere directly from this unit. It is interesting to note, by the way, that the more chronically mentally ill men who are paroled from this unit have a higher than average rate of success in completing parole and avoiding future arrests. Approximately 500 men are

involved in the group psychotherapy program, their average stay being one year. We have, in addition, some small programs which are specifically designed to assess difficult cases and provide information to the decision-making classification or parole bodies. Our group psychotherapy program is being developed towards more selection of patients and more diversification of the treatment program. For several years we have been following a group of 260 men who were in this program. These men were selected without any very clear idea of what kind of people we might be able to help. As a group they have been more successful than the average parolee in avoiding further arrests and imprisonments, although this difference is a small one, of the order of 5 to 10 percent. It is difficult to interpret the meaning of these comparisons, since our population had undergone a considerable degree of selection by factors which we are unable to specify. These comparisons of statistics combined with our clinical experience are the best available guidelines however. When we consider various sub-groups within the total group of offenders, we have observed an interesting and somewhat unexpected result. The more sociopathic property-offenders among our group, especially those who have been recidivists, have done considerably better than would be expected, with a success rate which is quite similar to the first termers in our group. A good many men included in this 260 were men considered to have a high potential for violence. As you probably know, crimes of violence are rarely repeated, so it is difficult to assess the effectiveness of treatment. After four years, however, we found that our 260 men had been responsible for one murder, two rapes, and five assaults; or at least these are the number of convictions for these crimes which had occurred. There are no good figures available for comparison here, but the best I have been able to find indicate that the one murder and the one rape is about what would be expected from an unselected group of parolees. The five assaults seem to be more than the expected number. Since the population we were treating has a higher than average violence potential, the results are at least not discouraging. We are, by the way, engaged in a research effort which over a period of years we anticipate will give us more precise answers to many of these problems. We also find indications that some men are more likely to return to prison with psychotherapy than without. We are trying to identify such cases and prescribe different approaches. A number of considerations, including these follow-up results, have encouraged us to feel that we can have considerable success with a group of recividists who have farily high intelligence and who have become motivated for change by their repeated returns to prison. We are accordingly giving such men a higher priority than they had previously received. I think it is time to pause at this point and turn this into a question-and-answer or discussion period.

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STEPS IN SYNERGISM - THE CORRECTIONAL PROGRAM OF THE MASSACHUSETTS DIVISION OF LEGAL MEDICINE

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Introduction

Synergism of security and rehabilitative elements in the management of imprisoned public offenders has been a continuing and difficult task, growing in importance as the essential failure of the application of either element singly has become evident. The Division of Legal Medicine of the Department of Mental Health of the Commonwealth of Massachusetts was organized to pursue this goal and task in 1954. This paper presents an account of the development of its institutional program in the area as they have been influenced by a variety of psychosocial vectors.

History

To understand the recent events, historical perspective is necessary. In the face of a national population explosion, the population of Massachusetts is relatively slowly increasing. The state government is old, traditional, and conservative as compared to many other states. The executive branch is organized into many separate departments of which the Departments of Mental Health and of Corrections are but two. Each department is administratively independent despite their overlapping mandates with regard to the care and charge of persons coming within their jurisdictions. There are but few legal requirements for functional interaction at levels below the Governor.

In the Department of Mental Health, the appointment of Commissioners has been for many years along professional, non-political lines. Indeed, these Commissioners have been among the leaders in American psychiatry with Winfred Overholser, Harry Solomon and Jack Ewalt being the most recent examples. In Corrections, the appointments have more recently been moving from the area of politics to a more professional direction. The last four Massachusetts Commissioners of Correction, likewise of national prominence, have been Russell Oswald, Arthur Lyman, George McGrath and John Gavin.

In Massachusetts the Department of Corrections is responsible for sentenced felons who serve time in correctional institutions. Sentenced

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persons who are granted probation or who are granted parole following incarceration fall into other administrative hands. An additional complication is that each correctional institution in Massachusetts has a history of marked autonomy with relatively little central administrative control or mutually communicated policy. In the past 10 years this has changed progressively with increased centralization of policy and philosophy that influences the treatment of offenders.

Adult and juvenile placements in Massachusetts Correctional Institutions are decreasing at this time due partly to the slow population increase and partly to the development of alternatives to imprisonment.

Setting[3]

The correctional institutions within the Department of Corrections consist of installations at Bridgewater, Concord, Framingham, Norfolk, and Walpole, as well as several minimal security prison camps. Each of these institutions serves a specific function. The Massachusetts Correctional Institution at Bridgewater is essentially four separate institutions under one roof. It consists of first, a defective delinquent center; second, a sexually danger persons center; third, an alcoholism center; and fourth, a hospital for both the criminally insane and insane criminals. This last houses males who prior to trial are judged incompetent to stand trial, males adjudged not guilty of felony by virtue of insanity, males who, in the course of imprisonment, have become sufficiently psychotic to warrant transfer to a specifically adapted facility, and males who are mentally ill and adjudged too dangerous to remain in other mental hospitals. Physically the facility is old, frightful, and inadequate. The leadership is harried, enlightened, and currently working at improving the living conditions.

The Massachusetts Correctional Institution at Concord is a receiving institution of the Department of Corrections for offenders with indeterminate sentences and/or reformatory sentences. To Concord are sent primarily young adult offenders for such crimes as auto theft, breaking and entering, and assault. The census is approximately 350. The average length of stay is 14 months. From the physical point of view it is an antiquated facility although a new treatment building and classification building has been opened just recently. The correctional personnel have a tradition of quasi-military organization emphasizing a blend of realism and idealized leadership.

The Massachusetts Correctional Institution at Framingham is the sole State facility for sentenced female offenders with a population ranging from drunks to murderers. At the present time its census is 130. The average

3. Powers, Edwin. "The Basic Structure of the Administration of Criminal Justice in Massachusetts." Publication of Commonwealth of Massachusetts, 1959.

length of stay is nine months. It is a relatively modern establishment in terms of housing and industrial placement although the main building was opened in 1879. It is essentially an open, decentralized cottage facility where interactive relationship, social programming, delegation of responsibility and division of labor are dominant correctional modes.

The Massachusetts Correctional Institution at Norfolk is a large dormitory type, medium security installation. It is not a receiving institution, but holds transfers from both Concord and Walpole. As a result it does control its intake, which the receiving institutions cannot. It has a relatively more stable population of about 850 with over 100 lifers. The correctional staff is more settled and centralized with emphasis on religous, educational and hospital programs.

The Massachusetts Correctional Institution at Walpole, the State's prison, holds newly received inmates prior to transfer to other institutions and retains a chronic hard core population of repetitive dangerous offenders. Its count is 575, and average stay is several years. Built in 1955, it is the most recent fully-walled penal institution in the United States. Its leadership is concretely focussed and security minded.

The Department of Corrections also operates three small prison camps. These are of minimal security type and treat highly screened offenders close to termination of sentence. They are small, traditional honor camps of about 50 members. Their run-away rate is low, reflective of a good screening process. Their recidivism rate however parallels that of similar risk categories retained at the prisons from which they came.[4]

In working with public offenders in Massachusetts, the Division of Legal Medicine operates under the general statutes prescribing functional areas of the Department of Mental Health, and under two specific laws referring to public offenders found by the courts to have committed a crime. One is the Sexually Dangerous Persons Act[5] which instructs the Department of Mental Health to set up a research and treatment center for the assessment and treatment of persons adjudged sexually dangerous. The other states that the Department of Mental Health shall have responsibility for the mental and physical well-being of inmates confined in a special Departmental Segregation Unit located at the Massachusetts Correctional Institution at Walpole - a maximum security isolation section where the Commissioner of Corrections is empowered to place any chronically dangerous or troublesome inmate.

4. Carney, Francis, "Recidivism in the Prison Camps of the Department of Corrections." In press, 1967.
5. General Laws of Massachusetts, C.646, Acts of 1958; C.615, Acts of 1959.

While the Division of Legal Medicine[6] has active programs relating to the courts, the Youth Service Board, and the Division of Parole, focus here will center on its adult institutional programs undertaken in conjunction with the Department of Corrections.

At the Massachusetts Correctional Institution at Bridgewater, Division of Legal Medicine personnel function mainly in relation to transfers between Bridgewater and the other prisons or between Bridgewater and one of the state mental hospitals. The Sexually Dangerous Persons Center housed at Bridgewater is the only institutional facility under the direct administrative control of the Division of Legal Medicine, but there too security is provided by the M.C.I.-Bridgewater correctional personnel.

At M.C.I.-Concord, Framingham, Norfolk, and Walpole, the Division of Legal Medicine has stationed a varying complement of full and part-time social workers, psychologists and psychiatrist. Each of these mental health units has its own personnel and its own personality. In the prison camps there are no current services due to a combination of short sentences, selected offender placement and geographical remoteness.

The Population

The operation of the Division of Legal Medicine programs for offenders derives in part from a psychosocial definition of the personalities of the offenders with whom we deal. We view them as people who commit crimes to relieve un-met emotional needs and developmental failures. In them we see confusion and lacks of control over their behavior, childlike attitudes and goals, immediacy and primitivity of action, and deficits in mature relationships between themselves and/or others. Beneath the realistic and rationalized criminal activity, these offenses have symbolic and emotional elements, sometimes general and sometimes specific. The crime is a symptom or a sign depending on whether the criminal experiences it as suffering or not. There are distinct differences between repetitive criminal failures who come to prison and "successful criminals" who live in the extra-mural community, i.e., the Division of Legal Medicine deals in the main with unsuccessful criminals. These criminals establish and maintain personal and social structures that express magical beliefs in their narcissistic entitlement, an inability to achieve and attain a consistent expression of normal love impulses with normal love objects. They feel at liberty to use others inconsiderately in their selfish pleasures. At the same time many show a hunger for ways and means of controlling their behavior. They appreciate feeling cared about and experiencing affectional relationships which they have previously been unable to initiate and/or maintain. Beneath apparent equanimity, many criminals have deep anxiety. This anxiety becomes manifest as upsurges of primitive emotions and leads in the direction of uncontrollable explosive action. It is seen most clearly

6. Shapiro, L.M. "Psychiatry in the Correctional Process"; Crime and Delinquency, January, 1966; pp. 9-16.

in the overwhelming anxiety experience of the individual undergoing psychotic breakdown - the experience of feeling the loss of relations with people. Way stations along this route are the acute exacerbations of the condition - the criminality, violence, suicide and riots inside or outside the prison. By and large, in social terms, these offenders have poor job records, impoverished family backgrounds, marital failures, and little education. They have little capacity to have basic trust and tend to flee quickly from emotional closeness and from treatment. In summary, they have shown their criminal acts to represent various developmental maladjustments.[7,8,9]

Zeitgeist

Within the context of the settings, the personalities of the inmates, and the structure, function and personnel of the Division of Legal Medicine, role development and program development have proceeded together. Leadership has reflected growth as growth has reflected leadership. There was an initial phase of revolutionary fervor, in which dedication to getting to know the inmates as individuals promoted a joining with them in impatience at restraints and in the conviction that we could do the job better if only we had more power. The over-identification with the inmates fed into the correctional stereotype of mental health professionals as naive do-gooders. At that point, the Division of Legal Medicine was defensively psychoanalytically oriented, charismatically organized, and rapidly expanding from a pre-existing service void. It utilized mainly part-time mental health personnel, many of whom worked at night on a one-to-one basis with inmates when they could get to see them through the roadblock of resistance put up by both the inmates and the correctional personnel. At that time we had some trouble taking into account that we were guests in other people's houses. We had problems inherent in the lack of recognition and respect for the separate development and history of the Department of Corrections and the correctional responsibility to evaluate everything in terms of security. We were concerned about confidentiality and perverse in insisting on a defensively medical model of confidentiality between patient and doctor, which paid insufficient attention to their mutual social welfare. In this phase we learned through trial and error and came to function under broader and more skeptical leadership. We talked more freely with correctional personnel at all levels and placed ourselves more clearly at their service. We moved from the status of guests toward the status of friends while still functioning in "other people's houses." These developments took place in fits and starts rather than smoothly and continuously and depended much on the tolerance, understanding, and needs of all parties involved.

7. Erikson, Eric. "Childhood and Society. W. W. Norton Co., New York, 1950.
8. Murray, John J. "The Problem of Mental Health in a Prison Population" in the Chatham Conference on Mental Health Applications in Correctional Practice, Boston University Press, 1960.
9. Shapiro, Leon N. "Psychiatric Care and the Public Offender", Casebook on Community Psychiatry, The Free Press, Glencoe, Illinois (In press)

Recently with longer experience and more work together, with more settled leadership, and with the development of a nucleus of committed career people, we find an increasing and changing form of collaboration as joint members of the treatment team.

Examples

Examples of some ways we have been utilized over the past eleven years illustrate the movement from our utilization by the highest state authority least directly self-involved in the treatment relationship toward our utilization by the nearest, most intimately concerned, most self-involved persons.

I. The first systematic use of mental health personnel in Massachusetts for the in-prison management of offenders (other than for transfer by commitment to mental hospitals) occurred following the so-called Cherry Hill riot of 1954, one of a series of nation-wide prison unrests at the time.[10] The combination of public interest in the living conditions of the inmates, the particular dangers inherent in these same criminals, and the forthcoming opening of the State's prison at Walpole, led the Governor to request of the Commissioner of Mental Health evaluations and recommendations on each of the inmates in the segregation section of the old Charlestown State's prison - the Cherry Hill Section. The gravity of the situation and the circumstances of the request prompted the Commissioner to assign two man teams of psychiatrists and psychologists experienced in mental health evaluation though not in prison work. Each inmate was visited independently in prison by these two professionals. A joint report was formed and submitted for the use of the correctional personnel in the understanding and management of the inmate. The correctional personnel were very appreciative of the formulations offered. Since these inmates were long termers, we have been able to follow their course fairly well. Twelve years later it is seen that the reports were on the whole accurate and useful. Where recommendations were clearly made and followed by correctional personnel, the inmates have ceased to be major behavioral problems in the prison.

II. In Massachusetts, as in other states, the problem of capital punishment contains intense political, moral and humanitarian considerations. In 1956 a young man 21 years of age murdered his girl friend in a bizarre crime. The trial occupied the newspapers for many weeks and resulted in his conviction of murder in the first degree. The case focused on the issue of capital punishment. The Governor's Advisory Board on Pardons requested that the Department of Mental Health conduct an evaluation of this convicted murderer. The request was forwarded to the then new Division of Legal Medicine. Even prior to the

10. Reports of the Governor's Committee to Study the Massachusetts Correctional System presented to the General Court of Massachusetts, June 9, 1955 and July 19, 1956.

request, the inmate had shown signs of agitation during his stay on death row and had been assigned a worker to see him on a supportive basis within the framework of M. C. I. -Walpole's counselling project. The evaluation was conducted by senior professional personnel.[11] A final report was synthesized and forwarded to the Pardon Board. The report among other things mentioned that this was a man who was determined to destroy himself and that he would bear watching if the State commuted the death penalty. The death penalty was commuted and the following day the man succeeded in hanging himself in his cell. Since then we have been called upon regularly in similar cases.

III. About 1957, a 24 year old man was brought to our attention by the Superintendent of M. C. I. -Concord as a severe behavioral problem. He had repeated in prison the assaultive and potentially murderous behavior for which he had been sentenced. He had repeatedly made escape attempts in the course of which he had assaulted correctional personnel as well as other inmates. Placed in segregation, he had continued for a long time to be defiant, dangerous and destructive. In this case the referral came to the Director of the Division of Legal Medicine mental health unit in the prison. A psychologist made persistent, warm and reality-orienting visits to the segregation unit, eventually developing a relationship with the inmate which motivated the latter to seek treatment on his own. The behavioral disturbance ceased, manipulative threats lessened and the benefit from the treatment relationship was so clear to all that when the therapist was transferred to M. C. I. -Walpole, the patient was transferred there as well, both to continue treatment and because he was no longer the same kind of behavior problem in the institution. After nearly two years of individual treatment, the inmate was paroled and seen by the same therapist in after care. The inmate terminated his treatment unilaterally within a few months. He married, has been working, and has been in no known legal difficulties since.

Clinically, this case illustrates three points which are applicable to many of our cases. First, the close confinement of the institution and even closer confinement of the segregation unit was required to hold the patient securely enough so that the treatment relationship could be developed. Second, continuation with the same therapist following release eases the transition process. Third, in the course of the patient's conversion or return from regression, or development from fixation, he underwent severe somatic symptoms for which medication and dispensary care were necessary to contain his tension and to illustrate the intensity of therapeutic interest of the therapist. The social payoff in this case is obvious in its contrast with the same inmate's history and with the follow-up histories of other untreated inmates with similar behavior and high recidivism rates. According to our

11. Neiberg, Norman A. "Murder and Suicide", Archives of Criminal Psychodynamics, Vol. 4, No. 2, 1960.

basic expectancy tables, he would have had a 50% chance of returning to prison within two years without treatment.

IV. In 1961, a 30 year old lifer serving a sentence for murder of a woman referred himself to the mental health unit following a psychotic episode. He wanted help with his feelings to prevent a recurrence of psychotic break. He has been seen in individual therapy ever since by a succession of psychiatric residents and career staff. As to be expected, he has developed a transference psychosis which has been manageable in the prison setting. The clinical course has raised thought-provoking treatment and training issues. He was treated initially by three young therapists in training whose high anxiety was a limiting factor. First he was seen by a woman psychiatrist who developed an intense working relationship with him which he has never fully digested. The next therapist mainly served to work with the patient on his grief at losing the first one, a recapitulation of earlier familial traumatic losses. The next therapist functioned mainly as an identification figure with whom the patient began an intense competitive struggle. Since an intense and manifest transference psychosis requires long-term working through of the conflicts, the patient is now assigned to a career mental health professional with whom he has shown clear evidence of progress.

V. A female offender was referred in 1962 when she was nineteen years old. She was the daughter of alcoholic parents involved in a long term sadomasochistic relationship. Her trouble with the law dated to age thirteen when she was seen by the court as a stubborn child. There followed five court appearances, the last two for the crime of robbery. Before sentence to M.C.I.-Framingham, she had been confined in a juvenile institution. She was known as a brash, provocative, troublesome inmate. As in the preceeding case, she referred herself. At the intake conference it became clear that she was very close to being a confirmed alcoholic. She was seen for two years in combined group and individual therapy. She developed a close relationship with both therapists, one male and one female. When the female individual therapist was abroad for a year, the patient became illegitimately pregnant while on parole in the community and called the group therapist following an illegal abortion. Since she was toxic, arrangements were made for immediate hospitalization. At the hospital she was for several weeks in a precarious physical and emotional state during which she was seen in individual psychotherapy at least twice a week by the group therapist. The demonstration of active support, plus the long term relationship within the prison, was followed by a major behavioral change. She altered her social affiliations, became more affable and began to make long term plans. For the past several years she has communicated by letter with both therapists. She is now living in Seattle, married, and has two children. The last letter received in October, 1966 stated: "If you are ever out this way, I sure hope you will

stop off and see us. We live about seven miles from Seattle Air Port. Well, I guess that's all for now. I hope we will hear from you. I wrote to you about a year and half ago and you answered it, so I wrote to you again and you didn't answer, so I thought maybe you were mad at us or something, Love." Enclosed were several pictures of the children.

This case likewise illustrates the need of both continuity of care and intensity of the treatment experience. It further illustrates an evolution from a psychotherapeutic relationship toward a long term friendship pattern where the former therapist continues to be overtly meaningful after treatment is formally terminated. It is our experience with many chronic character problems that this type of resolution is to be expected and that the attempt to resolve this as a transference state does not do justice to the reality intensity of the relationship. Finally, the tangible assistance around the abortion illustrates another frequently occurring phenomena; that is, the need at some point in the treatment for the therapist to be of concrete, specific, actional help, that is, to depart from the classic psychotherapeutic model.

The preceding five illustrations present a transition in time from referrals by persons far removed from direct patient care, i.e., governors, commissioners and pardon boards, to referral by persons intimately involved in offender care, such as correctional officers and social workers, and finally to self-referral by the troubled inmate. We have illustrated diagnostic and treatment courses in some inmate character types. We have described kinds of inmates typically confined in the variety of our institutions.

Role

Further consideration needs to relate the psychotherapeutic role to total institutional function. The role of mental health professionals is to bring mental health concepts, tasks and personnel into increasing cooperation with security personnel so that division of labor becomes more defined in areas of success as well as areas of stress. The goal is to increase the mental health dimension in its application to correctional work in order to help corrections move toward its rehabilitative goal. This necessitates taking into account those which promote or limit growth. Crucial to this goal is the pursuit of increased communication at all levels between and within both mental health and correctional agencies. Four prior publications present experience with this in the Massachusetts system.[12] The first dealt with the role problems of the psychotherapist in establishing a meaningful therapeutic contact with the inmate patient. The second described the role performance of a mental health administrator toward developing an environment in which therapists can successfully operate. The third related the problems

12. Haughey, D., Neiberg, N., Smith, B., Gilbert, R.; Proceedings of the American Correctional Association, Philadelphia, Pa., 1962, pp. 187-216

of a superintendent in providing support and reassurance to both the treatment unit and other vested interests in the institution. The fourth discussed from the Commissioner of Correction's office the problems as a large system moves from a more custodial toward a more habilitative orientation.

Role functions in their specific stem from the traditional professional interests in research, service, and teaching. These include the tasks of evaluating, treating, teaching, advising, studying and getting to know each other in a variety of social and professional ways. Most important in this is long term commitment, perserverance and stability in the development of relationships. "Hit-and-run" contacts have been a large part of corrections' prior experience with the mental health professions. In terms of corrections' perceptions and wishes for and from mental health personnel, some characteristics have been observed. First is the polar concept of stay out or take over. Either of these fosters continued isolation of corrections and the venting of hostility against the mental health professional. Second is the attitude that mental health professionals should deal with inmates only. The analogue of this is the impossibility of effective work with the child in a child guidance agency without the involvement of the parent caretakers. Third is the attitude of companionship without work. The work avoidance is based on the equation of job difficulty with personal failure and the companionship expresses the wish for substitute gratification to bear the tensions and hopeless feeling. Corrections is basically a chronic care service and is in continuing danger of identifying with the recidivists and of ignoring the successes who are seen no more. This identification with the failures leads to a self-critical attitude which is projected upon mental health professionals who are viewed as critical and judging until the attitude is worked through. The problem is the same as that of the physician working on a terminal cancer ward. He either can be devoted to his task, do the best he can and continue to look for more effective methods of care or he can identify with the failure when his techniques do not alter a downhill course.

The variations in the tradition and geography of the institutions themselves have lent their own influence to our role functions. In some places the mental health unit has been centrally located within the walls, in some places dispersed throughout the institution; and in some places, it was effectively isolated for some time from the on-going life of the institution.

The actual role functions as they have evolved have varied depending on the relative strength of the above factors, namely, the wishes and actions of the mental health personnel and of the correctional people as these people have come into contact in their institutions and met with success and pleasure and/or frustration and pain together.

THE PUBLIC, CUSTODY AND TREATMENT

By Howard Leach

New Mexico Council on Crime and Delinquency

The remarks I am about to make reflect my experience in working with the public in New Mexico on many of the same treatment and custody problems we have discussed during these Institute sessions. Since 1962 I have been the staff person directing the New Mexico NCCD Citizen's Action Program. In New Mexico this is known as the New Mexico Council on Crime and Delinquency . . . the Council being some thirty people selected from throughout the state, and working in all walks of life. The New Mexico Council program has been to review our state's correctional problems, to measure these against national practice, and to promote solutions that apply the principles of good practice to the practicalities of New Mexico.

Working with the Council over the past five years has meant trying to mediate custodial and treatment differences in a way understandable and acceptable to the public. This public to which I am referring, is represented by our Council and the state at large . . . the latter being reached through speeches and mass media. Accordingly, I will be presenting at this time one point of view as to how these differences can be interpreted to the public, and our experience with the public's response. Since we here are interested in changing our program, and since such change ultimately depends upon what the public will support, I feel that review of an operating citizen-action program directed at securing changed correctional practice may be of interest to you. Where possible, I will also relate my comments to points made by earlier speakers, so that perhaps in part they may serve as a partial summary to our discussions.

To begin with, it seems apparent to me that the public expects correctional programs to offer more than custody . . . and secondly, that the public expects us to provide leadership in determining what this "something more" should be. In my opinion much of the resistance to change resides not so much with the public . . . which seems to feel in generalities only that "something should be done" . . . but rather from resistance coming from within correctional agencies themselves. It is all too easy for an agency comfortable in old ways of doing things to sit back and claim that "we" would like to change but "public pressures just won't allow it." In this way such agencies justify continuing in their present sense of comfort by making the public the scapegoat, and wrongfully so.

The people on our Council include newspaper publishers, attorneys, public utility executives, a banker, an investments executive, real estate broker, mining executive, public relations executive and several housewives with substantial experience in civic activities. In short, our people

represent a generally conservative outlook; are opinion leaders in their own right, and almost without exception before joining the Council had no knowledge or particular contact with correctional programs or treatment points of view. Therefore, as substantial representatives of the public at large, it has been of interest to me to see that once such people were given a rationale for changing traditional correctional approaches which they could test with their own experience, they have often been ahead of agency administrators in willingness to move into so-called increased "risk" areas.

As an example, a typical principal fear of juvenile institution administrators is public reaction to escape. Often this picture of public expectations is that custody is the major responsibility of his institution, and that escapes, therefore, will be viewed as a prime indicator of a weak program. In fact, however, as has been pointed out earlier by Dr. Satten and others, only by giving trainees the chance to handle responsibilities can increased ability to handle them be learned. And giving a real responsibility means a chance to do something on one's own rather than out of conformity. Accordingly, giving trainees a real responsibility may open up increased possibilities for escape. However, in terms noted previously, here we have "nothing ventured, nothing gained." In other words, if trainee change is the school's purpose there is no plausible alternative to providing opportunities for handling real responsibilities as part of its program.

At the time of our organization, our people as much as anyone else in New Mexico tended to be aroused and indignant at escapes from our training schools. However, with explanation of the problem of escape from the above point of view, plus meetings with the superintendents of our two training schools, much of the indignance of our members at "escape" has shifted from the superintendent involved, to a sense of irritation at the mass media that they don't understand the issues involved. I might add, incidentally, that newspaper handling of training school incidents has improved with the onset of professional direction of our two training school programs.

What I am saying here is not that our Council people would condone escape resulting from sloppy security in an institution program with no particular operating rationale. Rather I am saying, that given assurance of the presence of a treatment rationale which makes sense in terms they understand, and which includes consideration of "escape" within that rationale, that the tolerance of our people of escape incidents has risen markedly. For example, it now generally includes acceptance of the true fact that a certain number of "incidents" are part of the price paid for a treatment program.

The important implications I see in the foregoing are twofold:

First, if a treatment rationale does make sense it can be interpreted to the public in a way that is understandable, and to that extent largely can be made acceptable.

Secondly, this approach calls for a considerable amount of honest soul searching on the part of corrections administrators. This is so because it is frankly easier to run a program whose principal reference point is conformity to the needs of the institution . . . than a program serving the inmate's development to the degree made possible by the situation involved.

In the above regard, we have to recognize that progress in our field has largely come from people who have accepted as possible what was previously felt to be impossible. Thus, comfort and belief in taking a new approach is a first step to bringing it into being. Accordingly, our personal views and sense of comfort as administrators become painfully central to the undertaking of new approaches. I say painful because the question here always becomes . . . "are the limitations I see to a new approach part of reality, or do they represent primarily a threat to what I am comfortable with?"

The preceding comments also raise a related question which has been of concern here, and which it is important that the public understand in familiar terms. This concerns understanding why individualized treatment is important to securing results for correctional efforts . . . the principles underlying such efforts, and how they are directed at producing more responsible behavior rather than "excuses" for its evasion. In particular I find it important to make clear the relationship between the psychological principles stated by previous speakers, and the problem of encouraging "personally responsible behavior." In doing so I find that referring to an individual's observation of his own experience in changing the opinions of others to be worthwhile. In brief, such observations show clearly that trying to change others through appeals lacking in personal meaning, fail to meet a basic factor working against all such change. In ordinary terms, this factor concerns the operation of self-justification . . . or "defensiveness" in psychological terms . . . as a block to new points of view. From this view it can be pointed out that like most people, offenders caught in the "wrong" usually find it more comfortable to justify themselves as "right," than to acknowledge responsibility for being wrong and seeking to change. This means that to himself, the offender does not act out of "evil" but out of a "good" that feels right to him . . . and which, therefore, he is willing to justify. Accordingly, if handling is to produce lasting change, it must touch upon the sense of self-justification personal to the individual involved. Treatment cannot be merely a mass program serving the institution's sense of "good" . . . but applied in such a way that the inmate feels no connection with what he sees as important.

The foregoing also says in effect, that the reference point an action is really intended to serve . . . is the principal determiner of where its value will come home to roost. Again, personal experience, this time as a parent, can be used to bring home the significance of this idea. For example, any parent honest in his observations is unlikely to deny the difference in

results between discipline directed primarily at making him feel better when his child has made him "mad" . . . and discipline really directed at his child's own good. The "doing" may be identical but its effect will vary according to the reference point it serves.

In short, we are elaborating here upon the remarks of Dr.'s Satten, Clannon and others, concerning the importance of inner motivation and self-understanding. The implications are important and worthy of further examination from several sides. If basic attitude "shines through" words and action, and determines their form and impact, as has been pointed out, then just as it behooves parents to question their real reference points in taking action . . . so again we as correctional administrators must be as honest as possible about whose "good," conscious or unconscious, is being served by our programs. The implications noted here are not simply deductions based on pure theory but again can be found in practical experience. For example, my own experience in doing institutional studies has shown that a program administered out of an inner sense of fear and antagonism produces a compatible institutional climate. From the point of view which has been mentioned, this is because "things" done in the program, even though "officially" relaxed and approved, all serve this negative attitudinal reference point which determines their net impact. Administrators with fearful and antagonistic attitudes can no more successfully use "relaxed" techniques, than can a fearful parent raise a relaxed child by merely borrowing techniques from a parents' magazine or "Ann Landers" column.

Thus the point under discussion also provides a theoretical base for understanding a fact previously noted and common to the experience of all of us. This is, that an administrator cannot make a program go until he and his staff are personally comfortable with the change. It shows why real change cannot be successfully "pretended" . . . through "lip service" which varies from inner intent. In addition, in terms of what to do, it casts a very practical light on the need to "know thyself" . . . a fact long recognized in analytical circles. Analytical Psychiatry has insisted for some time that the psychiatrist who is not aware of his own problems may well unconsciously work these out on the very people he is trying to help. And, thus, they serve his purposes instead of vice versa.

In summary, a first point is that the psychological method which has been espoused here as underlying "treatment," operates according to principles governing human nature generally. It is not merely a theoretical nicety whose practical application is confined to narrow clinical situations. A central point we have considered here is the relationship between personal meaning and personal responsibility, and its implications for programming. As one girl put it during an institutional study . . . "This program's no good because it is only important to the school. The other girls will go along with it while they are here, but they don't see any connection between

what the school thinks is important and their own lives. So when they get out they are going to continue doing what makes sense to them."

Secondly, a number of speakers have pointed out that loyalty to the idea of change means first being "true to oneself." This has been examined from several sides with the conclusion reached that "techniques" not supported by the force of inner conviction are likely to be self-defeating. A practical implication is that, therefore, we in corrections must more seriously follow the lead established by psychiatry in training techniques which focus on self-understanding and self-motivation.

Thirdly, since the laws of human behavior operate generally, and not only in treatment settings, they are as close to the general public as to professionals, although the familiar form of their application may be different. Accordingly, we have noted that corrections can use application of these principles in situations familiar to the public to interpret the logic of their application in treatment settings. Practically speaking, the idea that no one can change is as illogical as the idea that everyone can change. Both equally make sense if applied to the right person, or are equally "naive" if applied to the wrong individual. Accordingly, "treatment" viewpoints have as solid a logical basis as do "custody" points of view, and need not be apologized for as being more naive to human nature. However, treatment is harder because in a sense, it is pushing human nature "up hill."

I think before finishing that we might also direct a few words toward "research." I know that many of us have been disappointed during these sessions at the failure of "statistics" to show the practicality of treatment methods we sense are valid. In considering this subject I think we need to look at the motivation which we bring to our use of research, and see if looking at this anew can't bring us some relief. In my opinion a major problem encountered here is the frequently encountered hope by administrators that research findings will be sort of a "permission-giving" indicator of "what to do." In other words, I frequently sense a hope from those approaching research abstracts, that a "good report" on a project will mean that the project in its entirety can be transplanted successfully into "our" particular setting. Then we will have been told "what to do" . . . and everybody will feel just an awful lot better. In fact, however, it is well to remember that regardless of a project's success in another place, there is an improbability of its working equally well for us, particularly if our approach to this project is at a level no deeper than "advice seeking." This is so for essentially the same reasons that "advice giving" usually does not work . . . in general, because the person giving advice brings a level of force and confidence to it which the receiver does not have. Thus, the force of a project transplanted to another setting through understanding no deeper than advice seeking, can seldom be expected to equal that of the original project.

Rather than research projects being looked upon as the source of program "answers," I believe they more reasonably should be used as guidelines for possible new approaches. We must resist the temptation to use research abstracts in the same way the public uses "Dear Abby" columns. Research findings should not be a substitute for the application of judgment and understanding geared to the individual situation faced by a program administrator. If this way of looking at research is more realistic, then it can help us by taking much of the edge off disappointment that research does not now provide all of "the" answers. I guess what I am recommending, is that at this stage we probably would do well to admit that in research "there ain't no jolly Old St. Nick," and no one is sorrier than I am.

A second observation suggests that part of what may be wrong with our present research approach is the too-narrow level of understanding out of which many research problems seem to be viewed. A narrowly conceived project logically will produce results which have narrow implications, if indeed implications are worth drawing at all. For example, one correctional abstract journal within the past year soberly reports upon a project which examines why graduates of a training school, trained exclusively for service in the Merchant Marine, have a low recidivist rate. Cautiously, the study concludes that "apparently" this is because there are fewer chances to commit crimes on a boat than in the community at large. I don't think you can quarrel with this conclusion but then again - why bother?

The point being made is certainly not that research is of no value. Rather, that in the same way mechanical research produces shallow results, narrow in their application . . . so research approached out of a depth of understanding can and has produced widely usable principles. And that, therefore, we perhaps need to do "deeper" research as opposed to simply "more." This in turn supports the comments made by Dr. Clannon that research should give increased attention to quality factors involved in correctional programs. In other words, there seems to be little argument but what people change people. If this is so then the quality of interpersonal contacts must be acknowledged by research if results are to be realistic. For example, is it really the number of people in a caseload, or the numbers of MSW's in a project that are responsible for essential differences in results . . . or are not prime factors also quality facets which bear on the force of understanding brought to the job by the people involved? Dr. Clannon has suggested that statistics concerning his Institution at Vacaville, California, looked at from this point of view, are beginning to become more significant and potentially more usable for management purposes. It seems clear that we need to look to this experience further if research is to be true to truth, and more helpful to corrections.

Thank you.