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AUTHOR Haskins, Jimmy R.; Friel, Charles M.
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ABSTRACT

Surveyed were the correctional systems of 45 states and the District of Columbia to assess the levels of diagnosis and treatment of mentally retarded (MR) offenders in correctional institutions as part of Project CAMIO (Correctional Administration and the Mentally Incompetent Offender), a Texas study to determine the incidence of criminal incarceration of the MR and to identify laws, procedures, and practices which affect the prosecution and imprisonment of the MR offender. Findings indicated that approximately 90% of correctional systems employed psychometric means to determine the intelligence level of prisoners, that approximately 4% of prisoners were identified as MR persons, and that 10% of state systems did not provide any form of special treatment of MR offenders. Findings showed improved treatment for MR offenders over the last ten years and suggested that a court decision ordering state correctional systems to either provide appropriate treatment or release the MR offender would have less impact than in years past. (DB)

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A National Survey of the Diagnosis and Treatment of Mentally Retarded Offenders in Correctional Institutions

PROJECT CAMIO

Volume 8

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PROJECT CAMIO

CORRECTIONAL ADMINISTRATION AND THE MENTALLY INCOMPETENT OFFENDER

Jimmy R. Haskins, Ed.D.
Project Director
Superintendent
Brenham State School
Texas Department of Mental
Health and Mental Retardation

Charles M. Friel, Ph.D.
Associate Project Director
Director of Research
Institute of Contemporary Corrections
Sam Houston State University
Huntsville, Texas

Don E. Kirkpatrick, Ph.D.
Project Coordinator

Frank G. Willey, M.A.
Principal Researcher

December 1973

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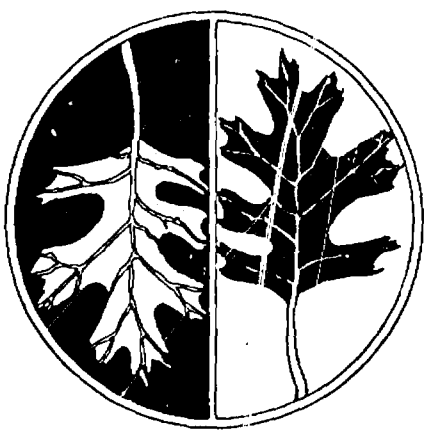

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ACKNOWLEDGEMENTS

The present study involved a national survey of state adult correctional institutions persuant to determining the procedures used in the diagnosis and treatment of mentally retarded offenders. Considering the diversity of correctional institutions in this country, the study was a complicated undertaking and its successful completion is primarily a credit to the interest and enthusiasm manifested by the directors of the nation's correctional institutions. To these individuals and their dedicated staffs the authors wish to extend their sincere appreciation.

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1.0 INTRODUCTION

> The correctional philosophy is now clearly predominate in the American institutional field...[1] Penologists in the United States today are generally agreed that the prison serves most effectively for the protection of society against crime when its major emphasis is on rehabilitation [correction or treatment].[2]

Prevailing philosophy in the field of contemporary corrections would thus appear, by pronouncement and through observation, to be moving toward an ultimate goal of treating the criminal offender for the causes or at least symptoms of the causes of his socially unacceptable behavior, be it asocial or anti-social in nature. This tact is vastly different from past practices of retributive imprisonment as a form of punishment based solely upon either the commission of the offender's deviant acts or the effect of these acts upon others.

Unfortunately, this transition appears to result from a long standing tendency in American corrections to reform rather than form correctional philosophy, policies and procedures.

> ...Commonly generated by crisis, they [correctional innovators] seldom go beyond readjustment of the existing system... The adaptive innovation is a reaction to a situation rather than a response to a need, and it is almost always adapted to the system rather than the other way around. "Planned innovation, on the other hand, presupposes a system which

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[1]The American Correctional Association, Manual of Correctional Standards (3d ed.; Washington, D.C.: The American Correctional Association, 1966), p. 13.

[2]Ibid., p. 10.

> is in a state of constant readiness to adapt as the need for change becomes apparent, and to do so in advance of the situation which actively (and often negatively) demonstrates the need. It is planned innovation which will be required in the development of advanced correctional programs of the future...[3]

Changes in correctional philosophy and the associated programs may therefore be viewed as stemming from three motivational sources which fall into a frame of either internal or external reference.

The first internal source is composed of the professional personnel of the correctional field ranging from the researcher or administrator in any correctional system in the country to such nationally known and emminent authorities as Sanford Bates, Normal Carlson, and Austin McCormack who have led the way in what planned innovations can be found in contemporary correctional history. Their actions, largely piecemeal and subject to the fluctuating financial whims of society, have spread slowly but have, to a large extent, consistently been the primeim mobile factors in the growth of corrections between sporadic periods of social concern and legal reform movements.

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[3]Harold B. Bradley, "Designing for Change: Problems of Planned Innovation in Correction," The Annals of the Academy of Political and Social Science, ed. by Richard D. Lambert; this edition - "The Future of Corrections," ed. by John P. Conrad (Philadelphia: The American Academy of Policital and Social Science, 381, January, 1969), 90.

A principal proponent of the professional or internal reform movement, the American Correctional Association, proclaims in the preface of its 1966 edition of the Manual for Correctional Standards that:

> For over 20 years we [ACA] have been at work in the development of criteria and standards for the central purpose of public protection through improved correctional practice in order to share in the trying task of law enforcement.[4]

A second source of internal innovation, be it planned or adaptive, is the governmental-legislative method. Prior to the past decade, action or even interest in corrections was confined largely to exposes and investigations of prison conditions and programs sparked either by widely publicized riots or by political motives at election time. With the rise in national concern for the rights of the individual, whether he be a free man or a convicted criminal, increased interest has been focused upon the legal rights of the institutionalized individual. Illustrations of this concern and its results can be found in the reports of the President's Commission on Law Enforcement and Administration of Justice[5] and the two Presidential

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[4]A.C.A, Manual of Correctional Standards, p. xv.

[5]President's Commission on Law Enforcement and the Administration of Justice (Washington, D.C.: U.S. Government Printing Office, 1968), passim.

Committees on Mental Retardation.[6] Twenty-two recommendations of the former[7] dealt with actions in the corrections field directly affecting incarcerated offenders. Goals of the Mental Retardation Committees included guarantees of protection of the rights of the mentally retarded individual whether he be found in the community, the judicial process or institutionalized in a correctional, mental health or mental retardation facility.[8]

Both of the aforementioned reports have served as the primary instruments of internal change since their major source of motivation comes from within "the establishment" or particular professional fields concerned. Each allows, to a large extent, the application of planned innovations and careful preparation by the respective institution for changes in correctional programs.

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[6] A National Plan to Combat Mental Retardation: Report of the President's Panel on Mental Retardation (Washington, D.C.: U.S. Government Printing Office, 1963); The President's Panel on Mental Retardation, Report of the Task Force on Law (Washington, D.C.: U.S. Department of Health, Education and Welfare, 1963); and The President's Committee on Mental Retardation, MR 71: Entering the Era of Human Ecology (Washington, D.C.: U.S. Government Printing Office, 1972).

[7] President's Commission on Law Enforcement and the Administration of Justice, The Challenge of Crime in a Free Society (Washington, D.C.: U.S. Government Printing Office, 1967), pp. 297-298; and Task Force Report: on Corrections (Washington, D.C.: U.S. Government Printing Office, 1967), passim.

[8] MR 71: Entering the Era of Human Ecology, pp. 16-17.

The third source of impetus for change, which has come into increasingly frequent usage involves motivations originating externally. While change originating outside the correctional system may take many forms, from riots and demonstrations to letter-writing campaigns, the method with the most immediately felt impact today is the development of test cases in order to force judicial decisions in contested areas. A general example is provided by case decisions resulting from the so-called criminal law revolution series of Supreme Court cases of 1961 through 1971.[9] The resultant decisions have, for the most part, required adaptive innovations in the criminal justice system. Direct judicial inroads toward changes in the correctional process have been, and currently continue to be, attempted through the filing of court cases designed to test the legal strength of correctional procedures involved in sexual psychopath laws,[10] Maryland's defective delinquent statutes, and associated indeterminate sentence provisions.[11]

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[9] Mapp v. Ohio, 367 US 643, 1961; Gideon v. Wainwright, 372 US 335, 1963; Escobedo v. Illinois, 378 US 478, 1964; Miranda v. Arizona, 384 US 436, 1966; U.S. v. Wade, 388 US 218, 1967; Chimel v. California, 395 US 752, 1969; and Harris v. New York, 382 US 162, 1971.

[10] Millard v. Cameron, 125 U.S. App. D.C. 383, 373 F. 2d 486 (1969); Commonwealth v. Page, 339 Mass. 313, 159 N.E. 2d 82 (1959); People ex rel. Kaganovitch v. Wilkins, 23 App. Div. 2d 178, 259 N.Y.S. 2d 462 (1965); People v. Levy, 151 Cal. App. 2d 460, 311 P. 2d 897 (1st Dist. Ct. App. 1957).

[11] Sas v. Maryland 334 F. 2d 506 (4th Cir. 1964); Barnes v. Director of Patuxent Institution 240 Md. 32, 212 A. 2d 465 (1965); Director of Patuxent v. Daniels, 243 Md. 16, 221 A. 2d 379 (1966).

A historical examination of judicial decisions adverse to current correctional laws and penal practices reveals a dilemma resulting in reactive reasoning which has repeatedly produced ineffective and unrelated solutions to the problems brought before the court. These contested court decisions have forced the correctional system to act; but these actions, in themselves, have not adequately nor successfully resolved the basic problems.

The courts face increasing numbers of prisoner rights cases, some of which eventually must be heard. The resulting decisions have a positive force in that the individual rights of the prisoner are broadened and lagging prison administrators are compelled to react (reform) instead of being allowed to act (form). However, the implication of programs designed simply to comply with court decisions does not automatically resolve the problem. Impetuous and unplanned programs seldom employ the scientific methods of research and experimentation necessary for success largely because of time limitations imposed by the judicial system. Speedy arrangements must also be made to sustain the additional financial burden of new facilities and personnel, since such resources are not usually provided for by the court.

The choice is a dichotomous one however, for correctional change may be compared to water backed up in a pipeline. If professionals in the field of corrections and concerned legislatures and elected officials do not insure that the control

valve of planned changes and improvements does not stay open to a sufficient degree to insure a smooth flow of change, the courts may be forced into opening the valve to deluge proportions.

1.1 Formulation of the Problem

According to statistics compiled by Brown and Courtless in their 1966 study,[12] the mentally retarded offender constitutes a relative minority in American correctional systems. "The significance of the problem [however] far outweighs the small number of people involved..."[13] Based on 1963 national prison population figures, approximately 20,000 of the 189,202 prisoners in the entire system were considered retarded.[14] This figure represents 9.5 percent of the 90,477 inmate comparative sample of all prison facilities in the United States.[15] This figure of nearly ten percent takes on added significance

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[12] Bertram S. Brown and Thomas F. Courtless, The Mentally Retarded Offender (Washington, D.C.: U.S. Government Printing Office, 1967), p. 1.

[13] Bertram S. Brown and Thomas F. Courtless, "The Mentally Retarded in Penal and Correctional Institutions," American Journal of Psychiatry, 124:9 (March 1968), 1164.

[14] Brown and Courtless operationally defined mental retardation as measured intelligence falling below IQ 70.

[15] Brown and Courtless, The Mentally Retarded Offender, p. 30.

when compared to the statistically projected three percent mental retardation figure for the entire country.[16] These numbers include only those individuals with IQ test results of less than 70, and when the data of those scoring less than 85 IQ (the upper limit for qualification for special education in many states) is added, the percentage jumps to 40 which translates to approximately 76,000 inmates. Suddenly that "relative minority" begins to acquire alarming numerical significance. Using 1966 estimates of U. S. prison population (estimated to approach 230,000 by 1975)[17] the same figures would now have risen to at least 22,000 under IQ 70 and more than 92,000 with IQ scores of less than 85.

In their study, Brown and Courtless further revealed that only a few of the nation's more enlightened correctional institutions systematically sought to determine the size of their mentally retarded population and that even fewer provide specific treatment programs designed to satisfy the educational, vocational, and/or psychological needs of these individuals.

Since that study was completed, national interest has been focused on the problem, and efforts have been increased to

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[16] Richard C. Allen, "The Retarded Offender, Unrecognized in Court and Untreated in Prison," Federal Probation, 32(3), (1968), 23.

[17] President's Commission, Task Force Report on Corrections, p. 45, 213-215.

relieve the plight of the mentally retarded offender by both the criminal justice and mental health-mental retardation system.

1.2 Purpose

The purpose of this study was to provide information regarding earlier studies and the effect resulting programs have had on the correctional systems in the United States, including ascertaining the prevalence of the mentally retarded offender within adult, male correctional facilities. Toward this objective the following questions were specifically addressed:

a. How prevalent or extensive is intelligence testing (the most basic diagnostic practice) of offenders in state correctional systems today?

b. What portion of the prisoners entering correctional systems are mentally retarded?

c. To what degree are correctional systems providing treatment specifically aimed at the mentally retarded offender?

d. What would be the overall relative impact on existing correctional and mental retardation institutions of a high court decision that offenders must be provided some form of treatment, effective for their mental abilities, or be released?

There were two basic assumptions which must be considered in this study. First, a majority of mentally retarded offenders in correctional institutions suffer from so-called functional retardation rather than retardation of genetic origin. Secondly, functional retardation must be considered as a treatable condition and therefore generally responsive to special education programs

or as a minimum to special training activities. Without these assumptions, there could be but one viable solution to the problem of the mentally retarded offender, that of preventive detention or "warehousing." However, the term treatable cannot be equated with cureable since the latter connotes the improvement of the condition to a level of complete elimination of retardation--a situation not yet achieved.

1.3 Methods and Procedures

A variety of methods and procedures were employed in the preparation of this study. Library resources relevant to contemporary literature in the area of the mentally retarded offender and the question of an incarcerated person's right to be provided some form of institutional treatment were reviewed. Personnel of the Diagnostic, Research and Education divisions of the Texas Department of Corrections, and the Texas Department of Mental Health and Mental Retardation were utilized through interviews and correspondence. Testing practices and treatment programs, including the number of current admissions, in the fifty state correctional systems and the District of Columbia were then determined by a written survey. This study includes a brief examination of court cases and decisions regarding the sexual psychopath, defective delinquent and the practice of indeterminate sentencing which may, in the future, affect the responsibilities and policies of correctional administrators toward the retarded offender.

1.4 Limitations and Controls

This study was limited to data regarding the mentally retarded and borderline retarded adult, male offender in state and district correctional systems. As such, no attempt was made to report on retarded offenders within mental health and/or mental retardation facilities nor was any research conducted into the nature of the offenses committed, the questions of etiology of the retardation, or the relative degree of effectiveness of the current treatment programs.

The basic research instrument[18] consisted of a ten item, single or multiple answer questionnaire designed to survey the (1) prevalence of the mentally retarded offender among admissions to the fifty-one principal correctional systems in the United States; (2) the frequency and nature of psychometric probes administered to adult males within these correctional institutions; (3) the existence, frequency and categoric scope of specialized treatment and/or training programs available to and for the mentally retarded adult, male offender; and (4) the overall relative impact on existing correctional and mental retardation institutions of a high federal or Supreme Court decision that offenders must be provided some form of treatment, effective for their mental abilities, or be released from their confinement.

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[18] See Appendix A.

1.5 Definitions

Since vast differences of opinion exist in the definition of two of the most basic terms related to this study, operational definitions of each are essential to the development of this report.

Mental Retardation. The basic definition by the American Association of Mental Deficiency appears to be the most widely accepted and will serve as reference throughout this report.

> Mental retardation refers to sub-average intellectual functioning which originates during the [individual's] developmental period [birth to sixteen chronological years of age] and is associated with impairment in adaptive behavior.[19]

Sub-average intellectual functioning includes those individuals whose performance on valid objective tests of general intelligence ability is in excess of one standard deviation below the population mean.[20] Commonly accepted levels of measured intelligence are illustrated in Table 1. Principle indicators of adaptive behavior are (1) maturation during pre-school years, (2) learning during school years, and (3) social adjustment in the adult.[21] Social adjustment is determined in an abstract or subjective sense by:

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[19] R. F. Heber, "Modifications in the Manual on Terminology and Classification in Mental Retardation," American Journal of Mental Deficiency, 65 (Supplement, 1961), 499-500.

[20] David W. Brison, "Definition, Diagnosis, and Classification," in Mental Retardation: Appraisal, Education, and Rehabilitation, ed. by Alfred A. Baumeister (Chicago: Aldine Publishing Company, 1967), pp. 1-2.

[21] Brison, Mental Retardation, p. 2.

TABLE 1

LEVELS OF MEASURED INTELLIGENCE*

Word Description of Retardation in Measured Intelligence	Level of Deviation in Measured Intelligence	Range in Standard Deviation Value	Corresponding IQ Range:	
			Stanford-Binet SD-16	WAIS SD-15
Borderline	-1	-1.01 to -2.00	68-83	70-84
Mild	-2	-2.01 to -3.00	52-67	55-69
Moderate	-3	-3.01 to -4.00	36-51	40-54
Severe	-4	-4.01 to -5.00	20-35	25-39
Profound	-5	-5.00	<20	<25

*David W. Brison, "Definition, Diagnosis, and Classification," in Mental Retardation: Appraisal, Education and Rehabilitation, ed. by Alfred A. Baumeister (Chicago: Aldine Publishing Company, 1967), p. 10.

> the degree to which the individual is able to maintain himself independently in the community and in gainful employment as well as by his ability to meet and to conform to other personal and social responsibilities and standards set by the community.[22]

Although this would seem to raise a basic question of how reliable such a non-objective appraisal can be made regarding the majority of adults, the fact that the mentally retarded offender has failed to meet and conform to such "responsibilities and standards" is a moot point in view of the fact that he has (in this instance) been convicted of a crime of such consequence as to be sanctioned by imprisonment. A more objective appraisal

[22] R. F. Heber, "A Manual on Terminology and Classification in Mental Retardation," American Journal of Mental Deficiency, 64 (Monograph Supplement, 1959), 4.

may however be obtained in lower levels of adult retardation through the use of the Vineland Social Maturity Scale.[23] The Vineland provides a means of evaluating adaptive behavior and describing it in terms of levels of retardation comparable to those used in the measured intelligence scheme.

Although the term mental deficiency, as coined by Doll, is often used interchangeably with mental retardation in much of today's literature; it will not be so used in this report. The principal reason for this decision is the implication of irreversability or untreatability included in Doll's definition and concept.[24]

A further distinction is also necessary regarding an operational definition of mental retardation. Two basic categories of retardation are recognized based on the general etiology of the condition. Genetic retardation refers to a condition of organic or pathological origin.[25] Heber refers

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[23]Brison, Mental Retardation, pp. 9-10.

[24]E. E. Doll, "A Historical Survey of Research and Management of Mental Retardation in the United States," in Readings on the Exceptional Child, ed. by E. P. Trapp and P. Hilestein (New York: Appleton-Century-Crofts, 1962), p. 22.

[25]Conditions associated with American Association on Mental Deficiency Clinical Subcategories of Mental Retardation .0 through .7. The Committee on Nomenclature and Statistics of the American Psychiatric Association, Diagnostic and Statistical Manual of Mental Disorders, 3d ed. (DSM-II), (Washington, D.C.: American Psychiatric Association, 1968), pp. 14-21.

to this category as impairments of sensory-motor skills as opposed to an impairment of personal-social factors characteristic of the second category of functional retardation.[26] The latter involves elements of psycho-social or environmental deprivation and is often found under the archaic heading of pseudo-feeblemindedness. The pseudo in this instance represents adaptive innovation by those social scientists who maintained mental retardation to be incureable and then found themselves in need of an explanation for those mentally retarded individuals who were seemingly "cured" or improved. This distinction between functional and genetic retardation is extremely important since many forms of functional retardation have been found to be responsive to special forms of education, vocational training and psychological assistance. Unfortunately the state of the art in these same areas is not such that any degree of improvement has been realized when they are applied to the genetic retardate. In general, therefore, genetic retardation is not considered as being responsive to correctional treatment, whereas the reverse is true of the functional form. While not universally accepted by any means, this definition serves the purpose throughout the report.

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[26] Ibid., Clinical subcategory .8; also referred to as sociological retardation and/or emotional deprivation.

Correctional Treatment. A wide variety of professional opinions again reflect disagreement as to the meaning of the term. While rehabilitation and/or resocialization may be the ultimate goal of a correctional system, treatment programs are the tools for achieving that goal. It may be argued that simply being in a prison is a form of treatment; however, for the purpose of this report, correctional treatment will be defined as all those planned and programmed educational, vocational training and psychological efforts of the correctional community employed for the purpose of rehabilitating or resocializing the imprisoned offender.

Thus, in summary, the ultimate goal of this report is to provide information which will be useful in analyzing what "planned innovations" have taken place in the field of diagnosis and treatment of the mentally retarded offender during the last decade and support plans and efforts for future innovative change in the field of corrections.

2.0 THE MENTALLY RETARDED OFFENDER

Literature related to the mentally retarded offender is marked by little general agreement and vast differences of opinion as to definitions, research methodology, interpretations of findings, and courses of action to be taken in coping with the problem.[1]

To a considerable extent, society's recognition of the mentally retarded offender as an individual is limited to a period of time beginning in the late nineteenth century and extending, at various levels of intensity, through the present. For the major portion of society, the philosophy concurrent with this recognition has, however, remained one of "out of sight, out of mind."[2]

Brown and Courtless view professional interest and society's response as developing within three relatively distinct time frames.[3] While the inclusive dates of the three indicated periods are open to extensive debate, the labels placed on each do much to portray the prevailing philosophy of the times concerning the subnormal offender.

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[1]Brown and Courtless, Mentally Retarded Offender, pp. 1-27.

[2]Stephen M. Goodman, "Right to Treatment: The Responsibility of the Courts," Georgetown Law Journal, 57(4)(March, 1969), 683.

[3]Brown and Courtless, Mentally Retarded Offender, p. 1.

The period 1890 through 1920 is labeled one of early enthusiasm in which a number of studies were conducted involving the mentally defective prison inmate; the majority of which sought to determine the relationship, if any, between tested intelligence and criminality. Indeed, a significant number purported to show that all criminals were to some extent "feebleminded."

Prior to the introduction of the intelligence test into the United States shortly before World War I, mental retardation was included under the then popular and all-encompassing group of abnormalities referred to as deviancy. Included in this same category were insanity (mental illness) and various other forms of physical and moral degeneracy, all of which were considered as being linked to all crime. Since studies or research activities in the field prior to 1908 were based largely on subjective judgments,[4] they will not be further considered herein.

During this early period and extending into the second or Denial and Neglect period (1921 through 1960), basic theories were rather sharply divided into three distinct schools of thought. The numerically superior force, which included Goddard,[5] Hill,[6]

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[4]Brown and Courtless, Mentally Retarded Offender, p. 2.

[5]H. H. Goddard and Helen Hill, "Delinquent Girls Tested by the Binet Scale," Training School Bulletin, IX (1911), 50-56.

[6]Ibid.

Morrow,[7] Bridgeman,[8] Enyon,[9] Williams,[10] Glueck,[11] Haines,[12] Knollin,[13] Herrick,[14] Anderson,[15] Kelley,[16] Hickman,[17] Gregory,[18]

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[7]Louise Morrow and Olga Bridgeman, "Delinquent Girls Tested by the Binet Scale," Training School Bulletin, IX (1912), 33-36.

[8]Ibid.

[9]W. A. Enyon, "Mental Measurement of Four Hundred Juvenile Delinquents by the Binet Simon System," New York Medical Journal, XCVII (1913), 175-178.

[10]J. H. Williams, The Intelligence of the Delinquent Boy (California: Whittier State School, 1916).

[11]Bernard Glueck, "Concerning Prisoners," Mental Hygiene, II (1918), 177-218.

[12]Thomas Haines, "Feeble-mindedness Among Adult Delinquents," Journal of Criminal Law and Criminology, VII (1917), 700-721.

[13]H. E. Knollin and L. W. Terman, "A Partial Psychological Survey of the Prison Population of San Quentin, California," Surveys in Mental Deviation (California: State Printing Office, 1918).

[14]Jessie Herrick, Report of the Mental Examination of 194 Inmates of the Western Home of Refuge for Women, at Albany, New York, No. 10 (New York: State Board of Charities, 1917).

[15]V. V. Anderson, "Mental Defect in a Southern State," Mental Hygiene, III (1919), 527-565.

[16]T. L. Kelley, "The Mental Aspects of Delinquency," University of Texas Bulletin, No. 1713 (1917).

[17]H, B. Hickman, "The Defective Delinquent," Training School Bulletin, XIV (1917), 9-11.

[18]C. A. Gregory, Public Health Bulletin No. 112, University of Oregon, 1920.

Kuhlman,[19] Root,[20] and Erickson,[21] supported the view that a significant relationship existed between low intelligence and criminality. On the opposite extreme of the spectrum stood Stone,[22] Weber,[23] Guilford,[24] and Murchison[25] favoring the position that a significant relationship between high intelligence and criminal behavior existed. A third position held that no significant relationship existed whatsoever. Advocates of this school included Bronner,[26] Healy,[27] Adler,[28] Doll,[29]

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[19]Frederick Kuhlman, Report of the Director, Division of Research, Minnesota State Board of Control, 1926.

[20]W. T. Root, Psychological and Educational Survey of 1916. Prisoners in the Western Penitentiary of Pennsylvania, 1927.

[21]M. H. Erickson, "A Study of the Relationship Between Intelligence and Crime," Journal of Criminal Law and Criminology, XIX (1929), 592-625.

[22]Calvin P. Stone, "A Comparative Study of the Intelligence of Three Hundred Fifty Three Men of the United States Army," Journal of Criminal Law and Criminology, XII (1921), 238-257.

[23]C. O. Weber and J. P. Guilford, "Character Trends of Mental Deficiency in the Problem of Delinquency," Journal of Criminal Law and Criminology, XVI (1926), 610-672.

[24]Ibid.

[25]Carl Murchison, Criminal Intelligence (Worcester: Clark University Press, 1926), Chapter IV.

[26]Augusta Bronner, "A Research on the Proportion of Mental Defectives Among Delinquents," Journal of Criminal Law and Criminology, V. (1914), 561-568.

[27]William Healy, "The Diagnosis of Feeblemindedness in Relation to Delinquency," Journal of Psycho-Asthenics, XXIV (1919), 69-72.

[28]Herman Adler, "Prisoners versus Men Generally," Survey, XLV (1920), 147-148.

[29]E. A. Doll, "The Comparative Intelligence of Prisoners," Journal of Criminal Law and Criminology, XI (1920), 191-197.

Curti,[30] and as a result of his 1933 survey of these three schools, also Zeleny.[31]

Zeleny pointed out that much of the disagreement was due to a wide range of variabilities both in the definition of feeble-mindedness and in the estimated frequency of retarded individuals in the non-criminal population.[32]

The major portion of the denial and neglect period was also appropriately characterized since there were few studies which added significant knowledge until the publication of Abrahamsen's book Crime and the Human Mind in 1944.[33] Prior to this work and generally throughout the second and third decades of the century, most studies relating to the mentally retarded offender were aimed at questioning the methods, validity and reliability of earlier studies with an implied or stated aim of discounting the causal relationship findings of previous studies. Since early methodology, to include controls, sampling techniques, and operational definitions, was extremely

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[30] Margaret Curti, "The Intelligence of Deliquents in the Light of Recent Research," Scientific Monthly, XXII (1926), 131-138.

[31] L. D. Zeleny, "Feeble-Mindedness and Criminal Conduct," American Journal of Sociology, 38 (1933), 564-576.

[32] Zeleny, "Feeble-Mindedness and Criminal Conduct," p. 564.

[33] David Abrahamsen, Crime and the Human Mind (New York: Columbia University Press, 1944).

shoddy, generalizations as to such a causal relationship became suspect and, on occasions, the target of severe attack.[34] As a result of these reactive studies and attacks, the practice of considering intelligence as a causal factor in explaining criminal or extreme anti-social behavior fell into widespread disfavor.

Discourse and research into the question of causation in regard to intelligence and crime did not, however, end with the chronological end of the second cited period of concern, but continued in the form of works by Abrahamsen,[35] Vold,[36] Cooper,[37] Taft,[38] England,[39] and Schur[40] supporting the null hypothesis and Mannheim,[41] warning against acceptance of such a theory.

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[34]C. Murchison, "American White Criminal Intelligence," Journal of Criminal Law and Criminology, (August 1924), 239-312.

[35]Abrahamsen, Crime and the Human Mind, passim.

[36]George B. Vold, Theoretical Criminology (New York: The Oxford University Press, 1958).

[37]Clara C. Cooper, A Comprehensive Study of Delinquents and Non-Delinquents (Portsmouth, Ohio: The Psychological Service Center Press, 1960).

[38]Donald R. Taft and Ralph W. England, Criminology (New York: The MacMillan Company, 1964).

[39]Ibid.

[40]Donald R. Schur, Our Criminal Society (New Jersey: Prentice-Hall, Inc., 1969).

[41]Herman Mannheim, Comparative Criminology (New York: Houghton Mifflin Company, 1965).

The contemporary scene begins in approximately 1960 and coincides with a period of increasing social concern throughout the United States. Contributions to a contemporary understanding of the problems posed by the mentally retarded offender have come from principal and collateral studies evolving from President Kennedy's 1961-1962 panel and President Nixon's continuing panel on mental retardation,[42] The American Bar Foundation's publication of The Mentally Disabled and the Law,[43] to a limited extent from the Task Force Report on Corrections of the President's Commission on Law Enforcement and the Administration of Justice,[44] and the National Institute of Mental Health supported study of The Mentally Retarded and the Law.[45]

Although a number of articles were published during the early stages of this modern period; little, if anything significantly new was added until the study by Brown and Courtless upon whose findings and data many subsequent studies are, at least in part, based. This nation-wide survey resulted from the 1963

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[42]See supra note 6, p. 3.

[43]Frank T. Lindman and Donald McIntyre, Jr. The Mentally Disabled and the Law (Chicago: The University of Chicago Press, 1961).

[44]See supra note 7, p. 3.

[45]A three year unpublished empirical study by the Institute of Law, Psychiatry and Criminology, George Washington University under the auspices of a planning grant from the National Association for Retarded Children and a project grant from the National Institute of Mental Health (MH-01947).

report of the Task Force on Law[46] and provided input for The Challenge of Crime in a Free Society.[47] Findings of the study are based on information received from 80 percent of the major penal and correctional institutions in the fifty states and the District of Columbia. These responding facilities housed, at the time of the survey, approximately 181,600 male offenders. Principal significant findings of the study are summarized as follows:

1. About 9.5 percent of prison inmates can be classified as mentally retarded, using [a measured] IQ [score of] 70 as the cutoff (it is estimated that about 3 percent of the general population is mentally retarded).

2. Although more than 70 percent of the reporting institutions routinely test the intelligence of inmates on admissions, a number of different tests are used, and testing procedures vary widely; and several reporting institutions make no effort to test the intelligence of their inmates.

3. Nearly 1,500 (1.6 percent) of the inmates had reported IQ scores below 55, ranging down to a low of 17 (well within the "profound" category, for whom full-time nursing care is usually required).

4. There is a general lack of mental health manpower resources within the institutions and consequently virtually no special programs for retarded inmates: 160 institutions with nearly 150,000 inmates are served by 14 full-time psychiatrists and 82 full-time psychologists; and more than half of the institutions reporting offer no program of any kind for their retarded inmates---not even a single special education class.[48]

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[46]See supra note 6, p. 3.

[47]See supra note 7, p. 3.

[48]Richard C. Allen, "The Retarded Offender: Unrecognized in Court and Untreated in Prison," Federal Probation, XXXII (3) (1968), 23.

The question of a causation and mental disability, however, still continues as a subject for debate.

> Although there is a paucity of factual information about mental retardation and crime, there has been no shortage of opinions about it through the years. About a half-century ago, it was pretty widely believed that every intellectually impaired person was likely to be delinquent, and that most criminal offenders were such because of impaired intellect. The polemicists have now come full circle and it is today just as stoutly maintained by some members of the scientific, legal and correctional communities that mental retardation bears no causal relationship to crime.[49]

While the trend of studies today again appears to reflect a resurgence of the causal debate, it is more significant that attempts are being made to establish programs and practices in the criminal justice system that will effectively accomodate the mentally retarded offender. Reflecting this latter trend, contemporary literature in the field of the mentally disabled in the criminal justice system is generally centered in the areas of equal protection under the law and innovative treatment programs in specialized facilities or institutions for the mentally retarded.

Principal proponent of guaranteed equal legal protection for the retarded offender is Richard C. Allen, Director of the Institute of Law, Psychiatry and Criminology at George Washington University. In his publications, Allen addresses such

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[49] Richard C. Allen, Legal Rights of the Disabled and Disadvantaged (Washington, D.C.: U.S. Department of Health, Education, and Welfare, 1969).

problems as the admissibility of confessions by retardates, their competency to stand trial and criminal responsibility, as well as such post-trial decisions as determination of an individual's potential for community based treatment weighed against the relative danger he might present to society. A specific subject of interest to Allen is the special handling of the retarded offender in the adjudication process beginning with identification of the retarded offender prior to trial followed by referral to a special "Exceptional Offender's Court."

> ...the individual offender whose intellectual capacity is grossly impaired requires special techniques and procedures to the end that "equality before the law" can become an operational reality in the administration of criminal justice.[50]

This court would, by design, be specifically equipped to deal with the unique problems of the mentally disabled and disadvantaged offender. He does not, however, advocate that the mentally retarded be excused from responsibility for his criminal acts, but that:

> ...adequate procedures be designed to enable the fact of mental deficiency to be disclosed at or prior to trial; and that if it be determined that the unlawful act is related to the mental condition of the accused, he receive treatment appropriate to his condition.[51]

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[50] Richard C. Allen, "Toward an Exeptional Offender's Court," Mental Retardation, IV (1) (February, 1966), 4.

[51] Allen, "The Retarded Offender," Federal Probation, p. 27.

"...the criminal trial process is not [now] equipped to identify..."[52] nor fairly administer justice to the mentally retarded offender. Significant attempts are being made to determine those deficiencies and ommissions in the law which affect the disabled (in this case, mentally retarded) offender and to develop improvements on a national scale to remedy these defects.[53]

An historical approach is necessary to fully understand the significance of the second prime area of related concern. In retrospect, it is readily apparent that the history of treatment and handling of such prisoners from the general prison population and their assignment to segregated facilities often in combination with mentally ill inmates. This philosophy of separation and special handling appears to reflect the most consistent philosophy to be found anywhere in a review of related literature. Since Clark's first advocacy of the segregation policy in 1894[54] supporters of this doctrine, with variations, have included Fernald,[55] Mulligan,[56] Goddard,[57]

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[52]Allen, Legal Rights of the Disabled, p. 31.

[53]Lindman and McIntyre, Mentally Disabled and the Law, passim; Allen, Legal Rights of the Disabled, passim.

[54]Martha Clark, "The Relation of Imbecility to Pauperism and Crime," Arena, 10 (November, 1894), 791.

[55]W. E. Fernald, "The Imbecile with Criminal Instincts," The American Journal of Insanity, 65 (April, 1909).

[56]J. W. Mulligan, "Mental Defectives Among Prisoners," Proceedings of the American Prison Association, (1912), 353-357.

[57]H. H. Goddard, "Feeblemindedness and Crime," Proceedings of the American Prison Association, (1912), 353-357.

Davies,[58] Dybwad,[59] Pense,[60] Laurie,[61] and Westwell.[62] However, inconsistency between theory and application is readily evidenced in the field, since 90 percent of all correctional institutions responding to a 1963 survey[63] indicated that separate facilities for mentally retarded offenders did not exist in their systems. Findings of the research noted in Chapter Four of this report will reveal that the number of such facilities or correctional units reported have increased, in the interim period, both in actual use and in planning or programming stages.

The trend in many correctional systems is currently to create a combined special handling category which includes certain sexual offenders, psycho or sociopaths, and borderline areas

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[58] S. P. Davies, Social Control of the Mentally Deficient, (New York: Thomas Y. Crowell Company, 1939).

[59] G. Dybwad, "The Problem of Institutional Placement for High-Grade Mentally Defective Delinquents," American Journal of Mental Deficiency, 45 (1941), 391-400.

[60] A. W. Pense, "Problem of the Male Defective Delinquent in the State School," American Journal of Mental Deficiency, 47 (1943), 467-472.

[61] L. A. Laurie et al., "The Defective Delinquent," American Journal of Orthopsychiatry, 14 (1944), 103.

[62] A. E. Westwell, "The Defective Delinquent," American Journal of Mental Deficiency, 56 (1951), 283-389.

[63] Brown and Courtless, Mentally Retarded Offender, p. 34.

of mental illness in addition to the mentally retarded offender. This grouping is commonly referred to by some variation of the term defective delinquent.[64] Offenders falling into this category are, in most instances, subjected to a civil hearing and psychiatric examination following criminal conviction to determine eligibility for commitment to a defective facility.[65] While special category treatment today still centers largely on the concept of separate facilities and programs, the basic purpose of this action is distinctly different, in theory, from those of previous eras. Ostensibly, the prime difference lies in the fact that earlier separation was based on convenience of handling by correctional administrators, on protection of of the non-defective members of the prison population from the supposedly harmful effects of close association with the defectives, and in some instances, prevention of hereditary passage

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[64]The most widely referred to definition of the defective delinquent is found in the Code of the State of Maryland as follows: "an individual who, by the demonstration of persistent, aggravated, antisocial or criminal behavior, evidences a propensity toward criminal activity, and who is found to have either such intellectual deficiency [mental retardation] or emotional unbalance, or both, as to clearly demonstrate an actual danger to society so as to require such confinement and treatment, when appropriate, as may make it reasonably safe for society to terminate the confinement and treatment." Harold M. Boslow et al., "Methods and Experiences in Group Treatment of Defective Delinquents in Maryland." The Journal of Social Therapy, VII (2) (April-June, 1961), no page. Included in this category are "defective" offenders regardless of chronological age and the designation should not be confused with that of the juvenile delinquent.

[65]Defective Delinquent Statute, Article 31B, Section 6 (a), Annotated Code of the Public General Laws of Maryland, 1971 Cumulative Supplement, (Maryland: Patuxent Institution, 1971), 5.

of the mental deficiency by means of sterilization or "colonization and segregation" to preclude the possibility of sexual relations by one or more of the defective offenders.[66] The proclaimed purpose of segregation, as practiced today, is to provide an opportunity for individualized, specialized and effective treatment for the retarded offender. Those publishing works in support of this approach to the problem of the defective delinquent or retarded prisoners include Boslow,[67] Kandel,[68] and Manne.[69]

The theory of treatment for the mentally retarded offender would thus appear to be reaching the same point on the spectrum of correctional philosophies as the non-retarded offender--treatment based on the needs of an individual rather than on the nature of his crime or the convenience of the correctional system.

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[66] H. H. Goddard, "Feeblemindedness and Crime," Proceedings of the American Prison Association, (1912), 353-357.

[67] Harold M. Boslow and Arthur Kandel, "Administrative Structure and Therapeutic Climate," The Prison Journal, XLVI (1) (Spring-Summer, 1966), 23-31.

[68] Harold M. Boslow, "The Team Approach in a Psychiatrically Oriented Correctional Institution," The Prison Journal, XLVI (2) (Autumn, 1964), 37-42.

[69] Harold M. Boslow and Sigmund H. Manne, "Mental Health in Action: Treating Adult Offenders at Patuxent Institution," Crime and Delinquency (January, 1966), 22-28.

3.0 A RIGHT TO TREATMENT

> Recognition of the idea that rehabilitation is the central purpose of a sentence by a criminal court is now found in many of the statutes throughout the country; and a few states, like Oregon, have even inserted language in their constitutions such as "Reformation [is] the basis of criminal law. Laws for the punishment of crime shall be founded on the principles of reformation, and not of vindictive justice."[1]

Based both on a recognition of this rehabilitative philosophy[2] and on the need for providing special care and treatment facilities for a mentally disabled or defective segment of its prison population, the State of Maryland, in 1951, enacted its Defective Delinquent law.[3] This unique law was based on three key features:

1. It established a procedure for the determination of a class of criminals known as "defective delinquents" who

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[1]Richard A. McGee, "What's Past is Prologue," The Annals of the American Academy of Political and Social Science, 381, (January, 1969), p. 7.

[2]"It is the feeling of the [Maryland] Commission [to study Medico-Legal Psychiatry] that the function of the modern penal institution is no longer purely punitive. The function rather is to remove the offending individual from society for the protection of society and to provide a means for his eventual psychological rehabilitation, if possible." A statement of the Maryland Commission to Study Medico-Legal Psychiatry [December 28, 1948], as cited by the Honorable Jerome Robinson, House of Delegates of Maryland, in an address on "Defective Delinquency" (presented at the General Assembly of the States' Council of State Governments, Sheraton Hotel, Chicago, Illinois, December 5, 1958), p. 3.

[3]See supra note 6, p. 27.

are diagnosed and treated by psychiatrists and other health professionals. [Certain mentally retarded offenders are, by definition,[4] included in this category.]

2. It established the Patuxent Institution where defective delinquents are housed in a setting that combines the security of a prison with the therapeutic milieu of a mental hospital.

3. It provided that a defective delinquent is committed for as long as he is deemed a danger to society. This is called an indeterminate sentence and in function is rather analogous to the indefinite commitment of the mentally ill.[5]

While the entire law has since become the repeated target of "third source" or external reform attempts in the form of court tests of its constitutionality,[6] the numerical preponderance of judicial "writs" were aimed at the provisions for an indeterminate sentence.[7]

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[4]Cited as "intellectually deficient," ibid.

[5]Emory F. Hodges, "Crime Prevention by the Indeterminate Sentence Law" (paper presented at the American Psychiatric Association Annual Meeting, Washington, D.C., May, 1970), p. 1.

[6]As illustrated by Sas v. Maryland, 334 F. 2d 506 (4th Cir. 1964), 513.

[7]Barnes v. Director of Patuxent Institution, 240 Md. 32, 212 A 2d 465 (1965); and Tippett et al. v. Maryland (no citation available - decided: January 4, 1971) as cited in a review of "Consolidated Petitions: Eppitt et al. vs. State of Maryland," by the U.S. Court of Appeals for the Fourth Circuit.

> The primary purpose of [this] ... legislation is to protect society from [a] ... segment of the criminal population who will probably again commit crimes if released on the expiration of a fixed sentence; and thus they should be detained and specially treated unless and until cured.[8]

These two points of attack are closely associated, however, since the U.S. Court of Appeals for the Fourth Circuit held that "provisions for treatment were a predicate to this law's constitutionality."[9] In reviewing related court decisions throughout the United States, Stephen M. Goodman indicates that:

> The most straightforward manifestation of judicial scrutiny of the conditions of confinement appears in those cases holding that involuntarily confined tuberculars, sexual psychopaths, mentally ill persons, juveniles, alcoholics, "defective delinquents," and others have a right to care and treatment or release. The rationale underlaying these decisions generally reflects the legislative promise of treatment as a basis for the given confinement.[10]

Although many of the cases cited in the above discussions are related to the mentally ill and their "civil" commitment (as opposed to criminal commitment) to mental care facilities, a significant number are directly related to defective delinquents and, specifically, the mentally retarded offender, thus making the cases relevant to this study.

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[8]Hodges, "Indeterminate Sentence Law," p. 2.

[9]Stephen M. Goodman, "Right to Treatment: The Responsibility of the Courts," Georgetown Law Journal, 57 (4) (March, 1969), 682.

[10]Ibid., p. 683.

Arguments and judicial responses and opinions presented in connection with the stated conditions and purposes of the indeterminate sentence, i.e., the existence and provision of rehabilitative treatment, have led to the development of the concept of a guaranteed right to treatment for certain classes of offenders.

> The [R]ight to [T]reatment is shorthand for a radically new jurisprudential concept of unquestionable social importance ... Where deprivations of liberty are concerned, we will no longer justify these divestments ... by referring to glib, but unfulfilled, legislative promises...[11]

The majority of decisions pertaining to an involuntarily institutionalized individual's "Right to Treatment" have to date been made in the area of civil commitments based principally on the condition of the individual, with the question of any crime involved being a secondary issue. In the statement of their decisions, however, an increasing number of judges have begun to address their rationale in a form of somewhat parallel to conditions and promises found in criminal cases.

> [The] ostrich-like attitude [of "out of sight, out of mind"] toward the criminal and the "sick" has only recently been subject to re-evaluation. Courts and legislatures have begun, still in nascent fashion, to re-examine the appropriateness of punishment both for the criminal and for those persons who have been in some manner removed from the criminal system and institutionalized ... Rather than allowing "treatment" or "rehabilitation" to be a Draconian process ... these bodies are taking steps to ensure that a "right to treatment" will exist.[12]

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[11] Goodman, "Right to Treatment," p. 680.

[12] Introduction to "A Symposium: The Right to Treatment," Georgetown Law Journal, 57 (4) (March, 1969), 673.

Presently the responsibility of society for furnishing treatment is at least an implied one in sentences to imprisonment. However, where the basis of confinement has, in such instances as the case of the defective delinquent, been specifically stated as the necessity for treatment or rehabilitation, the courts have generally held that a failure to provide meaningful treatment may warrant a judicial decision to treat or release.

In his foreword to "A Symposium: The Right to Treatment," Judge David L. Bazelon[13] expresses strong support for the rights of institutionalized persons to care and treatment.[14] Therein he also addresses a number of criticisms both as to the overall concept as well as to the implications of such guarantees. The first of these criticisms is that such a correctional philosophy would vastly increase the size of appropriations or resources necessary to support the expanded treatment programs required. Bazelon's answer to these complaints is:

> By basing deprivation of liberty at least partially upon a promise of treatment, legislatures have already committed the community's resources to adequate facilities. They must [now] complete the circle started. If the legislature's promise of treatment is dishonored, involuntary and indefinite "hospitalization" amounts to no more than preventive detention ["warehousing"].[15]

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[13]Chief Judge, United States Court of Appeals for the District of Columbia Circuit.

[14]David L. Bazelon, foreword to "A Symposium: The Right to Treatment," Georgetown Law Journal, 57 (4) (March, 1969), 676-679.

[15]Ibid., p. 676-677.

In view of this near "contractural agreement" the courts, when confronted with associated questions, need not examine the constitutionality of the law under which the individual was committed, but need only ask the question, "Is the complainant receiving the treatment promised?"[16]

A second major question which emerges from juristic inquiry is that of the adequacy or effectiveness of correctional treatment (primarily in the specialized institution). Judge Bazelon here again provides an answer by noting that although psychologists and correctional authorities do not agree on what constitutes adequate treatment; this is not a major decision point. At this juncture in the judicial proceedings, it is not necessary for the court to actually make a decision for which it is basically unqualified as to the exact effectiveness of the various treatment programs. Not withstanding any disagreement by psychiatrists in general:

> ...it is nevertheless [only] essential to ensure that the patient [inmate] confined for treatment receives some form of therapy that a respectable sector of the psychiatric profession regards as appropriate--and received enough of that therapy to make his confinement more than a mockery.[17]

The question of effective treatment for mentally deficient (retarded) offenders is but one element of a far larger controversy which involves the philosophy of individualized or differential treatment of inmates--treatment based on the psychological

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[16] Ibid., p. 677.

[17] Bazelon, "The Right to Treatment," p. 677.

educational and vocational needs of each offender; not on the type or seriousness of his crime or on his conduct within the prison setting. If an institution truly provides individualized treatment, in all probability, it provides effective treatment for all inmates regardless of their intellectual capacity, learning ability or emotional stability.

> To provide adequate treatment [in the eyes of the court], the critical requirement is that the hospital [institution] pay individual attention to each patient [inmate] and make an individualized effort to help him. ...If there is an individualized treatment plan created at the inception of treatment and modified as treatment progresses, a reviewing court can hope to assist whether a bona fide effort to provide a meaningful amount of some appropriate form of treatment has been made.[18]

Although related "treat or release" court cases are almost exclusively based on laws which involved indefinite commitment or indeterminate sentences, it is entirely possible that at some future point in time a similar question might be asked in relation to the non-defective inmate. Parallels are easy to draw between the stated and/or implied basis for parole, termination of indeterminate sentences and other forms of early release. The prime criterion in considering an individual for release in each instance is based on his relative degree of response to the sentence of confinement. Regardless of how such a response may be evaluated, i.e., scores on objective psychometric probes of his adaptive behavior levels, or psychiatric and/or correctional administrators' subjective evaluations; the basic measurement remains the same in either system--rehabilitation, resocialization or "cure."

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[18] Ibid., p. 676.

Since much of American jurisprudence is based upon the judicial concept of stare decisis, it is not inconceivable that at some point in the not too distant future, the current "Right to Treatment"--"Treat or Release" case decisions would be applied to the non-mentally disabled or non-intellectually impaired prisoner who claims he is not receiving effective assistance in modifying his behavior into socially acceptable patterns. With a greater portion of anti-social or criminal behavior being considered as a form of "sickness,"[19] it would appear easy for the courts to use analogous reasoning in their future findings. If the promise of correctional treatment is made or even implied, it may not be too long until the courts are forced into a position of making society honor that promise.

> The continued neglect of this task [the rights of the prisoner] by corrections may, as it has in the case of police procedures, make it difficult for [the] courts to do anything but write their own rules.[20]

While such decision might have an immense effect on the mentally retarded and defective delinquent offenders, the effect on the general correctional population is staggering to imagine. Planned innovations in the treatment of the mentally disabled offender along with expanded individualized treatment programs, would appear to be the only means of precluding the necessity for the courts to open the "flood gates" and thereby drowning corrections in forced changes for which they are not equipped or deluging society with a segment of the population for which it is not otherwise prepared to handle.

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[19] See supra note 43, p. 22.

[20] President's Commission, Task Force Report: Corrections, p. 16.

4.0 SURVEY FINDINGS

The primary source of this report consisted of a ten question, single or multiple answer, survey. This survey was conducted primarily by mail with supplementary coverage through telephone conversations and personal contact, in the case of the Texas Department of Corrections. Forms were directed to the fifty states and the District of Columbia utilizing addresses obtained from the American Correctional Association Directory of Correctional Institutions.[1] Where possible, questionnaires were directed to listed diagnostic, classification, in-processing, or reception centers. When no such facility was included in the directory, correspondence was addressed to the principal officer of the corrections division (or comparable level agency), with an attention line indicating the Adult Diagnostic/ Classification Division or Branch.

Forty direct mail responses were obtained in a period of 47 days and an additional three questionnaires were completed through supplementary telephone discussions. Correctional systems responding represent 81.2 percent of the total U.S. state prison population as reported in the 1967 National Prison Statistics bulletin[2] and 84.3 percent of the original 51 correctional systems in the sample. A geographical representation

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[1] Directory: Correctional Institutions and Agencies of the United States of America, Canada and Great Britain, compiled and published by the American Correctional Association, 1971 edition (College Park, Maryland: ACA, 1971).

[2] "Prisoners in State and Federal Institutions for Adult Felons," National Prisoner Statistics, U.S. Department of Justice, No. 44, (July, 1969), 30-31.

of the area encompassed by the responses is illustrated in Figure 1. A degree of area bias was noted in the absence of four significant states in the north central portion of the country. Attempts to correct this bias by telephone survey met with negative results.

A limited amount of additional data regarding two states, not responding to the questionnaire, was obtained by a review of their annual reports and from unused information gathered as a part of a previous study of testing practices in eighteen selected state correctional systems.[3] These additional states are not included in the summary contained in the previously cited percentages.

4.1 Inventory Survey

The inventory survey was generally oriented to four specific areas of interest, (1) intelligence testing, (2) use of test scores, (3) treatment programs available for the mentally retarded offender, and (4) prisoner statistics and the prevalence of the mentally retarded currently entering the correctional setting.

Throughout this Chapter the terms "meaningful" and "useful" data from responding agencies refers to "hard" numbers and excludes estimates and approximations. Partial answers to

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[3] Donald J. Starr, "Intelligence Testing in Correctional Institutions: A Study," (unpublished Master's Thesis, Sam Houston State University, 1971).

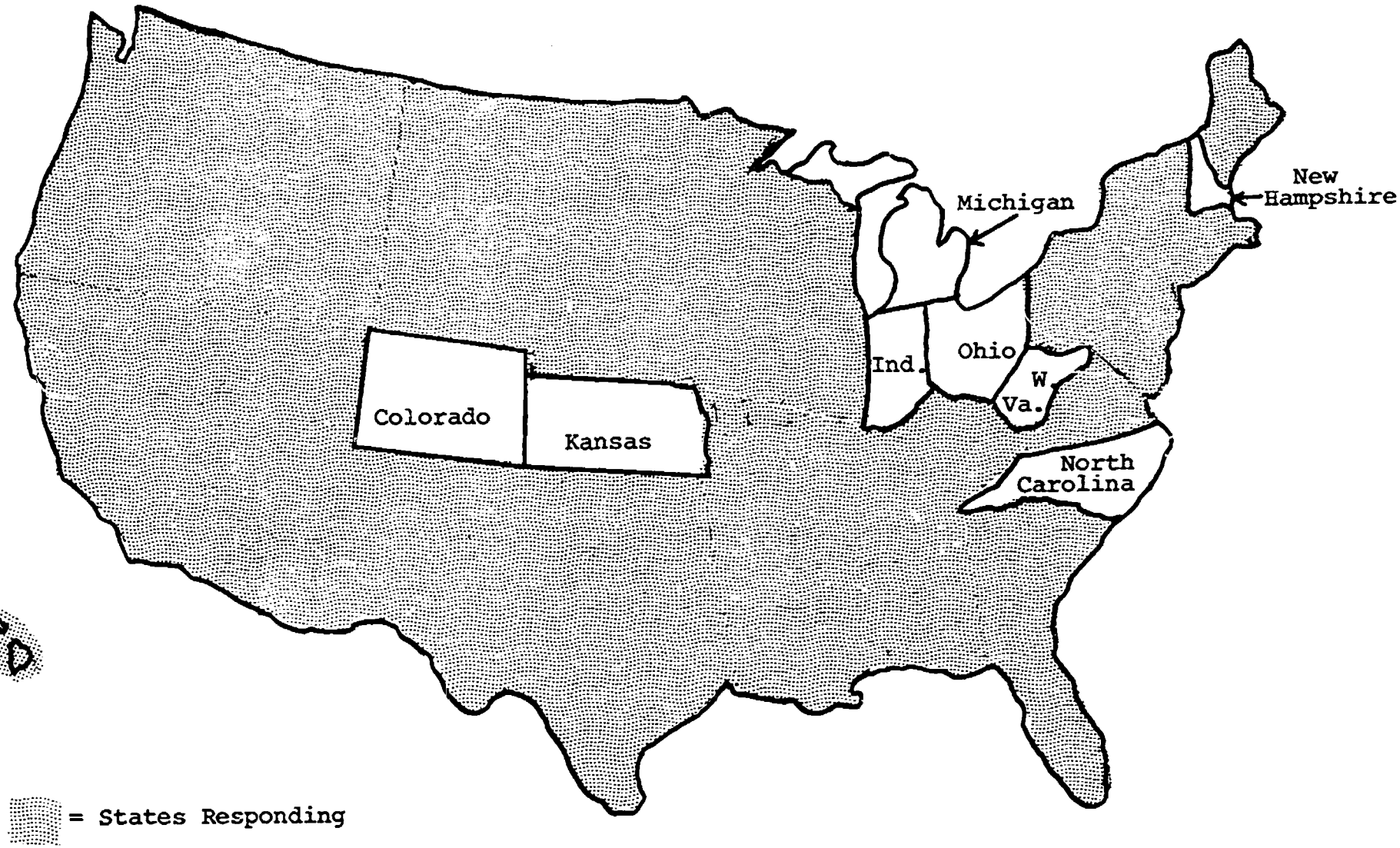

Figure 1
Geographic Representation of State Level Systems Responding to the Survey Inventory

many of the questions also rendered their relative value unacceptable for statistical computation. It should be further noted that the basic frame of reference for comparison of mentally retarded individuals in the prison setting was established as the current admissions since variations resulting from innovative changes are more readily apparent in admissions than in total population figures which are diluted by earlier admissions and past problems.

4.2 Initial Processing

The first question inquires about the manner in which adult male prisoners enter the correctional process and about where such initial processing is accomplished in relation to the general prison population.

Rationale. This first question was included for two purposes. First, it provides an indication of the atmosphere and surroundings in which prisoner reception and testing are accomplished. Secondly, it was deemed useful to establish a point of reference in the reception process at which it might be logically assumed that any significant degree of mental retardation might initially be observed. Specifically, the question was designed to determine to what degree, if any, the retarded offender is exposed to direct contact with more "seasoned" prisoners before his deficiency might be assumed to be discovered.

Empirical Response. Eighty-eight percent (n=45) of the surveyed states provided input for this questionnaire. This sample represented 88.7 percent of the total 1967 male prisoner population.

Separate facilities were reported as being provided in 51.1 percent (n=23) of the systems; isolation wings or similar elements within the correctional facilities or units were reported in 33.3 percent (n=15); while 15.6 percent (n=7) indicated that separate reception or diagnostic facilities were not utilized. Two of the latter did, however, indicate that separate units or facilities were either in the planning stages or actually under construction for their system.

Interpretation. Findings of this question indicate that 84.4 percent of the reporting systems value isolating newly arrived prisoners, at least in part, until their various needs and deficiences can be determined. Of the remainder, nearly one-third also apparently realize the necessity for such a procedure and facilities and have initiated action to obtain isolated diagnostic type units.

4.3 Incidence of Testing

The second question queried the various sample systems regarding the routine employment of tests of intellectual capacity or general intelligence levels during the in-processing, reception or diagnostic phase. A negative answer to the question

made responses to the following two questions regarding test administration unnecessary. An affirmative answer also required an indication of the title(s) of the test(s) used and included a choice of twelve common test scales in addition to spaces for examination forms not previously included. Listed tests were chosen from those contained in Anne Anastasi's Psychological Testing[4] and from responses to Starr's earlier work.[5]

Rationale. The basic purpose of this question was to determine those systems utilizing psychometric intelligence probes as a part of their initial diagnostic process. Inquiry into the number, type and frequency of probe use was also a principal goal of this question.

Empirical Response. Responses were obtained from 84.3 percent (n=43) of the major survey sample and represented 81.2 percent of the total previously referenced prison population. Only two systems indicated that they did not conduct any form of intelligence testing as a routine part of their initial processing step; two other states conducted testing, but did not utilize any test of intelligence as defined by Anastasi or Burros.[6]

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[4]Anne Anastasi, Psychological Testing, 3d ed. (London: The MacMillan Company, Collier-MacMillan Limited, 1968), p. 638-641, and passim.

[5]Starr, "Intelligence Testing."

[6]Oscar K. Burros, The Sixth Mental Measurements Yearbook, (New Jersey: The Gryphon Press, 1965), passim.

The latter employed general aptitude or personality inventory type probes. Frequency of use of principal cited instruments or instrument groups are as indicated in Figure 2. Tests, other than those listed in the basic questionnaire, which were employed by not more than one state and those not categorized as intelligence tests have been omitted.

Psychometric probes of intelligence or intellectual capacity were reported as being employed in 90.7 percent (n=39) of the responding systems. A single test form was utilized in 43.6 percent (n=17) of the systems; 28.2 percent (n=11) employed two probes; 30.8 percent (n=12) used three and 2.6 percent (n=1) reported using four examinations on a routine basis.

Interpretation. The Revised Beta Examination appeared as the most frequent group testing instrument being employed in 51 percent of the diagnostic procedures, followed closely by the Wechsler Adult Intelligence Scale (WAIS) in 49 percent of the systems. It was noted, however, by several states that the WAIS was used most often as a secondary or back-up examination for individual retest of offenders scoring outside the common institutional norms on primary test instruments. The Peabody and Wide Range Picture Vocabulary tests were likewise used when inadequate or questioned results were obtained by the main test form.

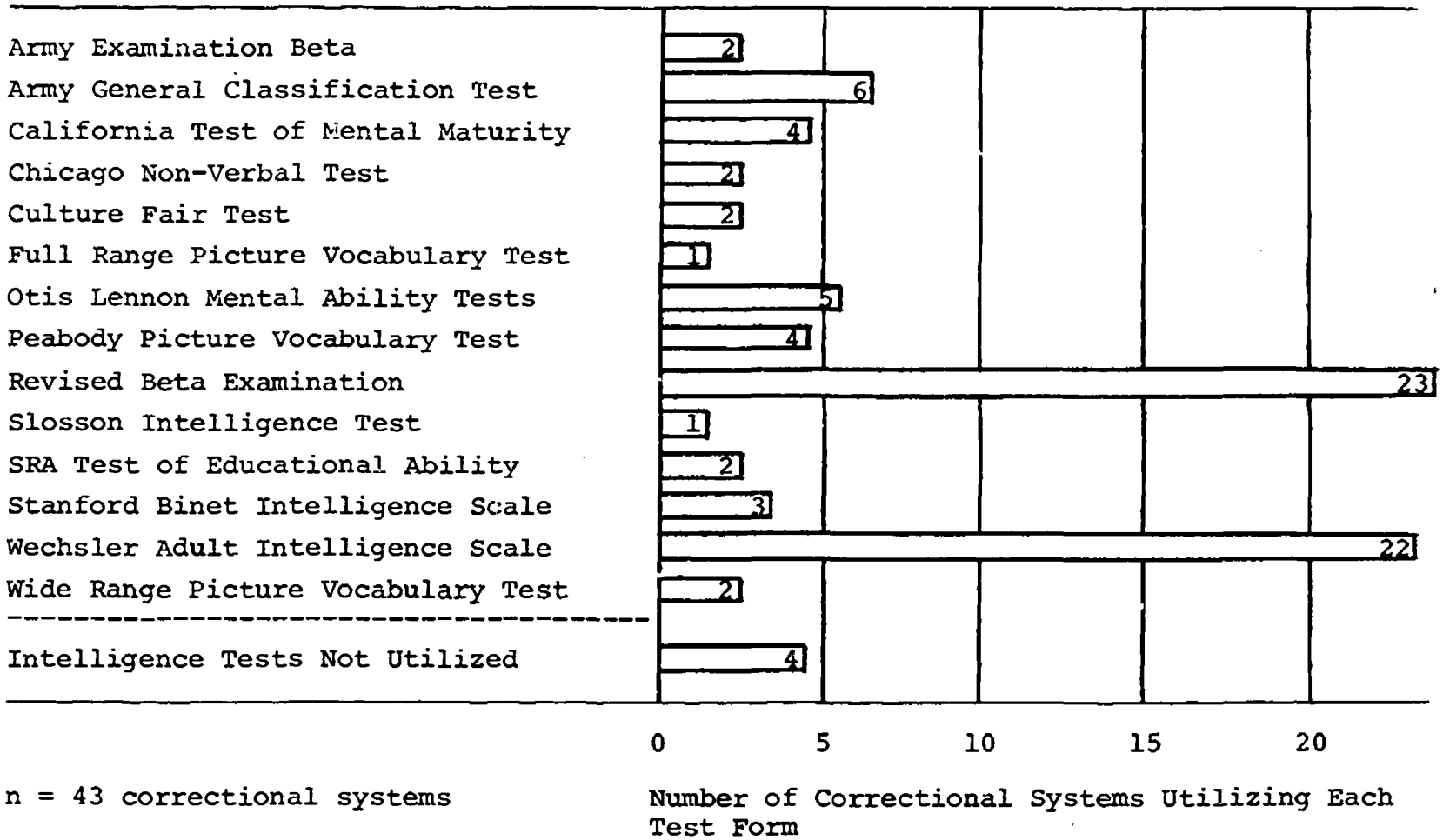

Figure 2

Frequency of Intelligence Test Usage

The two principal, non-intelligence type tests reported as being used were the Shipley-Hartford Institute of Living form (a non-projective, personality or character inventory; n=5) and the General Aptitude Test Battery (n=9). Eleven other psychological tests were reported as being used (by only a single state each) at some point in the diagnostic process.

The director of one of the two state systems not currently testing, remarked in a telephone conversation that his system was seriously considering adding the use of psychometric probes, as a diagnostic and evaluation phase of processing, in the near future. Response from the remaining state noted that although no formalized diagnostic testing was programmed at a system-wide level, individual counselors at each correctional facility had the option of using and did use intelligence test instruments on a selective basis or as deemed necessary. State-wide statistics were, however, not maintained regarding inmate intelligence levels and/or trends.

4.4 Test Administration

The third and fourth items in the survey inventory were designed to assess the manner in which intelligence tests were usually administered, scored and/or interpreted by employment of one of the following: (1) custodial or correctional officers, (2) professional staff members, (3) outside consultants, or (4) inmate assistants.

Rationale. Since the manner in which, and by whom, the diagnostic efforts are conducted could provide an indication of the relative importance assigned to them by correctional administrators, these two questions were included as an attempt at partially determining the degree of such importance.

Empirical Results. Responsive data was obtained regarding 78.4 percent (n=39) of the sample systems and represented 78.3 percent of the previously referenced 1967 prisoner population. Four of the 43 systems responding to the entire survey replied to this question as "not applicable" in as much as they did not use intelligence tests as noted in Question Number Two.

Custodial or correctional officers administered tests in 5.1 percent (n=2) of the states, but were not involved in the scoring/interpretation step in any one of them. Professionally trained staff members administered examinations in 76.8 percent (n=30) states and scored/interpreted the results in 97.4 percent or numerically 38 of the 39 systems. Outside consultants administered tests in 10.3 percent (n=4) and functioned in the scoring/interpretation role in 17.9 percent (n=7) of the systems. The latter were sole administrators in 2 states, interpreted in 1 and were utilized in computer scoring in 2 other facilities. Inmate assistants conducted examinations under direct professional staff supervision in 20.5 percent (n=8) diagnostic programs and in 15.4 percent (n=6)

states where they functioned without reported direct supervision. Inmates participated in test scoring and/or interpretation in seven states and were employed for administration and scoring of group tests only in 2 states.

Since professional staff members and/or trained outside consultant agencies are utilized in administering nearly 77 percent of all testing and in more than 97 percent of all scoring and analysis, the importance of accuracy, uniformity and professional administration of these psychometric instruments appears to be recognized by the majority of correctional systems.

4.5 Administrative Procedures - Mentally Retarded Offender

The fifth survey item was addressed as an inquiry into the manner in which prisoners, identified as mentally retarded, were handled once they leave the initial diagnostic, in-processing, or reception stage. Specific alternative responses to the question stem are as indicated in the response paragraph below.

Rationale. The primary purpose of this survey item was to ascertain whether identified retardates are provided any form of protection from the more aggressive or dominate members of the general prison population and if any provisions are made to remove the mentally disabled offender from the correctional system or to assign him to a protected special care facility within the system. The principal question is essentially one of determining what happens to the mentally retarded offender once he is identified in the correctional setting.

Empirical Response. Forty-three state level systems provided workable data in reply to this item, the combined total of which formed 81.2 percent of the total 1967 state prison population. Each responded by indicating one or more methods of handling the mentally retarded offender at this point in his correctional history. Retarded offenders were not segregated from the general prison population in 69.8 percent (n=29) of replies. Of these 29 systems, one indicated that a separate facility was under construction for the mentally retarded and mentally ill; a second replied that retarded individuals were normally identified prior to commitment to a correctional institution; a third indicated retardates were placed in "protected assignments to minimize abuse [by] other inmates;" and a fourth reported that a separate facility under construction would house both mentally retarded and physically handicapped offenders. In 11.6 (n=5) percent of the responding systems, retarded inmates were segregated from the general prisoner population for work assignments only. In 2.3 percent (n=1) of the systems the retarded offender was either segregated for work and housing but otherwise retained in the general population, transferred to state hospitals for the mentally ill which have facilities for "criminals," or transferred to state mental retardation schools if their IQ fell below 50 on the WAIS scale. Retarded offenders were transferred to special care facilities for the retarded or otherwise mentally defective offenders in only 7.0 percent (n=3) reporting states.

Interpretation. Although commitment of the defective delinquent to special facilities designed specifically to meet their needs is an operational procedure in several states, such does not appear to be the case with the retarded offender who does not meet the "habitual" offender clause of defective delinquent laws or who is not sufficiently fortunate enough to commit his offense in a state so "enlightened." An analysis of the reported procedures listed herein reveals that in only 7.0 percent of the correctional systems is the retardate afforded the "luxury" of a special care unit. In an additional 7.0 percent of the states he will find himself transferred to a school for the mentally retarded if he is extremely retarded. In one instance, he may be transferred to a hospital for the mentally ill since that is the only such element in the state's mental health/mental retardation program with facilities for criminal offenders. All in all, more than 79 percent of the reporting systems did not recognize any need for segregation of the retarded offender from the general prisoner population even in the assignment of housing.

4.6 Priority of Test Results

A sixth question was addressed toward assessing the level of importance that each of the responding correctional systems places on intelligence test results in their initial classification decisions. The four alternative responses provided range from not used to used in every decision.

Rationale. The question stem is essentially self explanatory with regard to rationale for its design. Starr's research[7] provided a degree of indication that although many correctional systems employed intelligence testing in their initial diagnostic setting, several did not use such results in any significant decision making process. The design of this question was aimed at resolving this implication of "non-use."

Empirical Response. Data was obtained regarding forty-five state systems, four of which were eliminated as not applicable since they did not employ intelligence testing procedures. The remaining 80.4 percent of the states surveyed constituted 83.6 percent of the total prison population. Intelligence quotients were reported as not used in any initial classification decision by 4.9 percent (n=2); used occasionally (in less than 50 percent of the decisions) by 41.5 percent (n=17); used in most (in more than 50 percent of the decisions) by 29.3 percent (n=12); and used in every decision by 24.4 percent (n=10) of the reporting systems.

Interpretation. With more than 95 percent of those responding indicating that IQ scores played at least a minimal role in initial decision making, the importance of such tests appears verified. It may be reasonably inferred from these findings

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[7]Starr, "Intelligence Testing," p. 64.

that even in the absence of objective test scores, the more subjective and easily recognized indications of mental retardation would, in themselves, have some bearing on the greater part of all initial classification decisions.

4.7 Impact of Testing on Classification

The seventh item in the questionnaire constituted a request for information concerning the type of decisions upon which an individual prisoner's measured IQ has some bearing.

Rationale. This inventory item is essentially a follow-up to earlier queries regarding the importance and use of intelligence test results. Rationale for its design is largely self-explanatory.

Empirical Results. Forty-three state level systems responded in some manner with thirty-nine of these providing meaningful data. The latter represented 75.1 percent of the total 1967 state prisoner population. Intelligence test results were reported as being utilized in the following decisions in the indicated number of state level systems; for work and job assignments in 92.3 percent (n=36); housing assignments in 5.1 percent (n=2); custody and/or security grade assignments in 23.1 percent (n=9); assignments to rehabilitative programs in 74.4 percent (n=29); and educational program assignments in 92.3 percent of the responding systems. Intelligence test results were further indicated as being used (in one state

each) to make assignments to group counseling, vocational training and work release programs, and, in one instance, in inmate disciplinary hearings.

Interpretation. Findings are essentially self-explanatory in this instance as they illustrate that in more than 74 percent of the states utilizing IQ scores, these scores are used in making major assignment decisions relating to (1) housing, (2) rehabilitative and educational programs, and/or job assignments.

4.8 Treatment Programs

An eight question dealt with the third major area of concern, that of treatment programs for the retarded. In this item, sample correctional systems were asked to indicate the availability of treatment programs in the three principal areas of vocational rehabilitation, education and psychological adjustment.

Rationale. A categoric list of major correctional programs was initially compiled from annual reports of approximately 25 percent of the principal correctional systems in the United States. Upon closer examination, the majority of these programs were found to fall into one of the following: individualized or group efforts in vocational rehabilitation, special or remedial education, or psychotherapy. The seven basic program

areas selected were discussed with and verified by Dr. Vearle McDaniel of the Division of Mental Retardation, Texas Department of Mental Health and Mental Retardation.[8] The basic purpose of this survey item was to determine the number of institutions offering correctional treatment programs which they considered reasonably available to the mentally retarded prisoner. Secondly, the question was aimed at determining the frequency of use of each of the seven cited program areas. No attempt was made, however, to evaluate either the content or relative effectiveness of the programs included therein.

Empirical Response. Of the forty-three responses received thirty-nine provided useable data representing 77.8 percent of the 1967 prisoner population. Group special education programs were provided in 69.2 percent (n=27); programmed instruction, individualized psychotherapy and special vocational rehabilitation in 28.2 percent each (n=11); individualized special education in 41.0 percent (n=16); group psychotherapy in 23.1 percent (n=9); and operant conditioning (involving behavior modification through reinforcement provided by a token economy arrangement) in 7.7 percent (n=3) of the reporting correctional systems. Slightly over 10 percent of four of the responding agencies indicated that they had no correctional treatment programs designed for or available to the mentally retarded offender. Each further commented that they felt no

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[8]Dr. Vearle McDaniel, interview held at the Texas Department of Mental Health and Mental Retardation, Austin, Texas, March 13, 1972.

effective treatment program for the retarded offender had been developed and, therefore, none could be made available within their department.

Interpretation. Slightly less than 90 percent of the sample systems reported the availability of treatment programs for the retarded offender. Thirty percent reported providing a combination of two such programs and forty-one percent indicated that their overall program provided treatment activities in three or more of the seven cited areas of treatment.

4.9 Treatment Programs - Borderline Retarded

The ninth survey item was addressed to determining the number of state level correctional systems extending their specialized treatment programs to the borderline retarded inmate.

Rationale. Since borderline retarded offenders, as cited earlier in this work, approached 40 percent of the 1963 national prison population, this question was included in order to ascertain whether or not these prisoners were receiving correctional treatment in a manner approaching that made available to the mild, moderate, severe or profound retardate.

Empirical Response. Useable data concerning this question was provided by thirty-four of the sample states representing 57.5 percent of the total referenced prison population. Specialized treatment programs were extended or made available (in at least

one unit or element of the agency) to the borderline retarded offender in 76.5 percent (n=26) of the responding systems. One of the eight states not now providing such services or programs included a comment that it would begin to do so in the near future.

Interpretation. Although the representative percentage of the final sample is only slightly over 50 percent of the total population the more than two to one majority of yes answers from the systems is readily apparent. It would thus appear that in excess of 76 percent of the correctional systems providing special treatment for the mentally retarded offender do recognize the borderline retarded offender as a definite portion of their population and do extend or make available special treatment programs for his participation.

4.10 Prevalence of the Mentally Retarded Offender

The final question consisted of a request for data regarding (1) 1971 year end, adult, male prisoner populations; (2) the number of adult, male admissions during each system's last yearly reporting period; and (3) the total number of inmates, identified as retarded or borderline retarded, that were admitted to the system during the cited yearly reporting period.

Rationale. The basic purpose of this question was to ascertain the size of the problem faced by the correctional administrator in dealing with the retarded offender. This final

question was, therefore, aimed at determining the frequency of retarded offenders entering the correctional system in relation to both the number of admissions for a like period and to the overall prisoner population.

Empirical Response. Forty-two state level correctional systems responded wholly or in part to this question. Twenty-six of these (51.0 percent of the total population of states) supplied useable data. Excluding estimated figures and approximations, the total 1971 year end, male, adult prisoner population for forty-two responding states was 120,485. The total adult, male admissions were reported at 81,749. Total admissions for those states including a frequency report of retarded offenders were 39,056; and for those reporting the frequency of borderline retarded offender admissions the total was 35,934. In other words, 4.1 percent (n=1,620) of these admissions were identified as mentally retarded and 13.9 percent (n=4,999) were identified as falling into the borderline retarded category. Frequency of retarded offenders being admitted ranged from 0.1 (n=1) to 28.0 percent (n=258), while borderline retardates ranged from 0.4 (n=4) to 65.0 percent (n=816). For a compilation of the data received refer to Appendix C.

Interpretation. Only 60.5 percent of the correctional systems responding to the survey provided the mentally retarded admissions data requested. Representative admissions data indicates

that 4.1 percent of the current adult, male offenders entering state correctional facilities were found to be mentally retarded while 18.0 percent of all those admitted scored less than 85 in measured intelligence. An interesting comparison may be drawn with the Brown and Courtless study of 1963 in which 10.0 percent of the total prison population was reported to have been identified as mentally retarded and 40.0 percent as possessing IQ's of 85 or less. The absence of complete responses by many state systems precludes any further suppositions from the accumulated statistical data.

5.0 SUMMARY

The purpose of this report was to examine the intelligence testing practices of U.S. correctional agencies, the treatment programs available for mentally retarded offenders, as well as the frequency with which such offenders are currently entering the fifty state and District of Columbia correctional systems. To this end, four basic questions were posed for investigation earlier in the study. This Chapter, therefore, will be principally addressed to a summary of the findings of the report in relation to those questions and the conclusions drawn from those findings.

5.1 Use of Intelligence Tests

The prevalence of intelligence testing, as examined by several of the survey questions, proved to be much higher than expected after a review of related literature and studies in the field of the retarded offender. At least 84 percent of the responding state correctional systems provided the surroundings and relatively formalized diagnostic setting necessary for obtaining reliable test results. Fully 90 percent of the correctional systems currently employ psychometric probes in order to determine the intelligence level or intellectual capacity of their prisoners as they are received. Over one-half of these use batteries of two or more tests in order to insure definitive identification.

Not withstanding arguments regarding the relative value of the IQ test in determining intelligence, the vast majority of correctional administrators demonstrate their desire to use such tests in order to identify those members of their populations with intellectual abnormalities. Additionally, the findings are utilized by more than 40 percent of these agencies in over one-half of their initial classification decisions.

5.2 The Prevalence of the Mentally Retarded Offender

The second area of inquiry was related to the frequency with which adult, male retarded and borderline retarded offenders are currently being admitted to state correctional facilities. This portion of the study was designed, essentially, to determine the size of the problem created by the retarded offender.

Of the approximately 39,000 adult, male prisoners admitted to the 26 responding states, 4.1 percent were reportedly identified as mentally retarded and 13.9 percent were identified as borderline retarded. A total of 6,519 offenders or 18.0 percent were listed as scoring less than 85 on the WAIS or equivalent scores on comparable examinations.

While a direct correlation cannot be drawn between these admissions and the population findings of Brown and Courtless, a reasonable comparison is in order. The overall 18 percent

admission rate would indicate a significant decrease if it can be assumed that the Brown and Courtless 40 percent residence figure was reflected in similar admissions during the same 1963 reporting period. Although not directly supportable in this study, several plausible rival hypotheses are available to explain the change. Primary among these are an increased recognition of the retarded offender's legal rights, and a reorientation of court thinking in the area of his degree of criminal responsibility. Either of these in combination with several others, developed as a result of the increased national awareness of the problem of mental retardation in the United States during the last decade, provide an explanation, and each would easily serve as the subject of a research study in themselves. The question of causation, however, was not addressed in this study.

5.3 Correctional Treatment

The degree to which special treatment efforts are afforded the retarded offender also demonstrated a significant downward movement from prior levels. While Brown and Courtless found that 56 percent (n=75) of all responding institutions did not provide any specialized programs in 1963, research revealed that only slightly over 10 percent (n=4) of the state systems responding to the current inquiry do not provide any form of such treatment today. These programs were found to be extended to the borderline retarded offender in more than three-fourths of the responding systems. The major areas of treatment emphasis remained in the field of education. This latter

finding is, in all probability, due to the fact that educational results are more readily demonstrated (by test scores or educational achievement) than those of psychological or vocational rehabilitation; and, therefore, education received more emphasis by correctional administrators.

In responding to questions regarding educational treatment programs, Mr. William Sweet, Special Education Supervisor for the Texas Department of Corrections' Windham School District,[1] voiced a significant explanatory comment which was echoed, at least in part, by the answers on several other questionnaires returned. His comment was, essentially, that although an educational [treatment] program may not be specifically labeled as being for the retarded offender, it may well be effective in educating him. If special education programs are well designed and based on a principal of individualized learning, they may well be effective across a broad spectrum of intelligenco level.

The manner in which treatment programs are administered, be it group or individual--"one to one"--activities, would thus appear to be of less importance than the degree to which the program is oriented towards or adaptable to the particular inmate's needs.

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[1]Mr. William Sweet, interview held at the offices of the Windham School District, Huntsville Unit, Texas Department of Corrections, Huntsville, Texas, (February, 1972).

Based on Judge Bazelon's earlier remarks that the major question should remain whether or not the inmate actually is afforded the opportunity for reasonably accepted forms of treatment, no further inquiry was made into the question of the effectiveness of any program. The primary aim of the question, thus, remained and was answered in the light of how many special programs were made available in how many systems.

5.4 Potential Impact of a Major "Treat or Release" Decision

A major portion of state correctional systems reportedly have taken at least minimal steps during the last nine years to insure that the retarded offender is provided acceptable treatment. The impact of a "treat or release" edict would thus appear significantly less than it would have been in the early 1960's. A "treat or release" decision regarding the mentally retarded offender would today affect the mentally disabled inmates of only four of the states responding to this survey question--an estimated 236 out of 39,056 individuals. A comparable projection, based on tentative and unpublished admission statistics obtained from the national Law Enforcement Assistance Administration for year 1970,[2] shows that such a decision would affect only one-tenth of a 4.1 percent slice of the 131,350 male, adult admissions to state level correctional systems or roughly 539 inmates throughout the entire

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[2]Mr. Paul White, Statistical Division, Law Enforcement Assistance Administration, Washington, D.C. telephone conversation, (April 19, 1972).

country. The impact of a decision that correctional systems must provide treatment for the mentally retarded offender, appropriate to his mental capabilities, or release him fron confinement would therefore appear to be negligible.

In summary, the mentally retarded offender is now, more than ever before in the history of corrections, recognized as a significant and important element of the prison population that must be identified and afforded effective treatment commensurate with his mental capacity and individual needs. Planned innovation, based on a need formally recognized in the mid-1970's has, in this instance, significantly reduced the probability of the need for adaptive innovation as a result of a forced judicial resolution of the question of retarded inmates' right to treatment.

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APPENDIX A

ERIC
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SURVEY INVENTORY - STATE OF _____ DATE: _____

1. Reception/In-processing/Classification of adult, male prisoners is accomplished: (please check one)

_____ in separate reception or diagnostic facilities/units.

_____ in isolation wings or similar elements at each correctional facility/unit.

_____ separate reception/diagnostic facilities/units/elements are not utilized.

Remarks: _____

_____

2. Does the reception/in-processing procedure include administration of tests to determine intellectual capacity or general intelligence level?

_____ No (please go to question five)

_____ Yes (please check scales/tests used)

_____ Armed Forces Qualification Test

_____ Army General Classification Test

_____ California Test of Mental Maturity

_____ Chicago Non-Verbal Test

_____ Full Range Picture Vocabulary Test

_____ Miller Analogies Test

_____ Otis-Lennon Mental Ability Test

_____ Peabody Picture Vocabulary Test

_____ Revised Beta Examination

_____ Slosson Intelligence Test

_____ Stanford-Binet Intelligence Test

_____ Wechsler Adult Intelligence Scale

_____ Other; please specify:

_____

3. Intelligence tests are usually administered by: (please check one or more)

_____ Custodial/Correctional Officers

_____ Professional Staff Members

_____ Outside Consultants

_____ Inmate Assistants

---

4. Intelligence tests are usually scored/interpreted by: (please check one or more)

_____ Custodial/Correctional Officers

_____ Professional Staff Members

_____ Outside Consultants

_____ Inmate Assistants

---

5. Prisoners classified as mentally retarded are: (please check)

_____ not segregated and remain in the general prison population.

_____ segregated for housing but retained in the general prison population.

_____ segregated for work but retained in the general prison population.

_____ transferred or assigned to special care units/ facilities within the correctional system.

_____ transferred to state mental retardation facilities/ schools.

Remarks: _____

---

6. Please indicate level of importance of intelligence test results in your initial classification decisions.

_____ Not used in decisions (go to question eight)

_____ Used in occasional decisions (less than 50%)

_____ Used in most decisions (more than 50%)

_____ Used in every decision

---

7. Indicate if results of intelligence testing are utilized in the following decisions:

_____ Work/Job Assignments

_____ Housing Assignments

_____ Custody/Security Grade

_____ Assignments to specific rehabilitation programs

_____ Assignments to specific education programs

_____ Other; please specify: _____

---

8. Please indicate the available treatment programs for mentally retarded adult male prisoners in your correctional system.

_____ Group special education (classes)

_____ Programmed instruction

_____ Individualized psychotherapy

_____ Special vocational rehabilitation training

_____ Individual special education

_____ Group psychotherapy

_____ Operant conditioning activity programs

_____ Other treatment programs; please specify: _____

---

9. Is participation in specialized treatment programs extended to borderline retarded inmates (WAIS IQ 70 to 84, or equivalent intelligence rating)?

_____ Yes _____ No

Remarks: _____

_____

_____

10. Population:

a. Total adult male prisoner population of this state correctional system as of 31 December 1971 = _____.

b. Total adult male prisoners admitted during last yearly reporting period was = _____. (Reporting period = _____ 19___ to _____ 19___).
(month) (month)

c. Number of adult male prisoners admitted during above reporting period determined to be mentally retarded (WAIS score less than 70, or equivalent intelligence rating) = _____.

d. Total adult male prisoners admitted during above reporting period determined to be borderline mental retardates (WAIS score 70 to 84, or equivalent intelligence rating) = _____.

_____

General Remarks/Comments: _____

_____

_____

APPENDIX B

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CLINICAL SUBCATEGORIES OF MENTAL RETARDATION*

Genetic or Pathological Retardation:

Following infection and intoxication [subcategory .0] - included retardation as the result of residual cerebral damage from intracranial infections, serums, drugs, or toxic agents. Examples are:

Cytomegalic inclusion body disease, congenital
Rebella, congenital
Syphilis, congenital
Toxoplasmosis, congenital
Encephalopathy associated with other prenatal infections
Encephalopathy due to postnatal cerebral infections
Encephalopathy, congenital, associated with other maternal intoxications
Bilirubin encephalopathy (Kernicterus)
Post-immunization encephalopathy
Encephalopathy, other, due to intoxication

Following trauma or physical agent [subcategory .1] - includes:

Encephalopathy due to prenatal injury
Encephalopathy due to mechanical injury at birth
Encephalopathy due to asphyxia at birth
Encephalopathy due to postnatal injury

With disorders of metabolism, growth or nutrition [subcategory .2] - includes all conditions associated with retardation directly due to metabolic, nutriational, or growth dysfunction including disorders of lipid, carbohydrate and protein metabolism, and deficiencies of nutrition. Examples are:

Cerebral lipoidosis, infantile (Tay-Sach's disease)
Cerebral lipoidosis, late infantile (Bielschowsky's disease)

---

*The Committee on Nomenclature and Statistics of the American Psychiatric Association, Diagnostic and Statistical Manual of Mental Disorders, 3d ed. (DSM-II), (Washington, D.C.: American Psychiatric Association, 1968), p. 14-22.

Cerebral lipoidosis, juvenile (Spielmeyer-Vogt disease)
Cerebral lipoidosis, late juvenile (Kuf's disease)
Lipid histiocytosis of kerasin type (Gaucher's disease)
Lipid histiocytosis of phosphatide type (Niemann-Pick's disease)
Phenylketonuria
Hepatolenticular degeneration (Wilson's disease)
Porphyria
Galactosemia
Glucogenosis (Von Gierke's disease)
Hypoglycemosis

Associated with gross brain disease (postnatal) [subcategory .3] - includes all disease and conditions associated with neoplasms, but not growths that are secondary to trauma or infection; also includes a number of postnatal diseases and conditions in which the structural reaction is evident but the etiology is unknown or uncertain, though frequently presumed to be of hereditary of familial nature. Structural reactions may be degenerative, infiltrative, inflamatory, proliferative, sclerotic, or reparative. Examples are:

Neurofibromatosis (Neurofibrobiastomatosis, Von Rechlinghausen's disease)
Trigeminal cerebral angiomatosis (Sturge-Weber-Dimitri's disease)
Tuberous sclerosis (Epiloia, Bourneville's disease)
Intracranial neoplasm, other
Encephalopathy associated with diffuse sclerosis of the brain
Encephalopathy, other, due to unknown or uncertain cause with the structural reactions manifest

Associated with diseases and conditions due to unknown prenatal influence [subcategory .4] - used for classifying conditions known to have existed at the time of or prior to birth but for which no definite etiology can be established. Included are the primary cranial anomalies and congenital defects of undetermined origin as follows:

Anencephaly (including hemianencephaly)
Malformations of the gyri
Porencephaly, congenital
Multiple-congenital anomalies of the brain
Other cerebral defects, congenital
- Craniostenosis
- Hydrocephalus, congenital
- Hypertelorism (greig's disease)
- Macrocephaly (Megalencephaly)
- Microcephaly, primary
- Laurence-Moon-Biedi syndrome

With chromosomal abnormality [subcategory .5] - includes those associated with an abnormal number of chromosomes and those with abnormal chromosomal morphology. Examples are:

Autosomal trisomy of group G. (Trisomy 21, langdon-Down disease, Mongolism)
Autosomal trisomy of group E or D
Sex chromosome anomalies
Abnormal number of chromosomes, other
Short arm deletion of chromosome 5--group B (Cri du chat)
Short arm delition of chromosome 18--group E
Abnormal morphology of chromosomes, other

Associated with prematurity [subcategory .6] - includes retarded who had a birth weight of less than 2500 grams (5.5 pounds) and/or a gestational age of less than 38 weeks at birth, and who do not fall into any one of the preceding categories.

Following major psychiatric disorder [subcategory .7] - includes retardation following psychosis or other major psychiatric disorder in early childhood when there is no evidence of cerebral pathology; must be good evidence that the psychiatric disturbance was extremely severe.

Functional Retardation:

With psycho-social (environmental) deprivation [subcategory .8] - includes retardation with no clinical or historical evidence of organic disease or pathology but for which there is some history of psycho-social deprivation. Cases in this group are classified in terms of psycho-social factors which appear to bear some etiological relationship to the condition as follows:

Cultural-familial mental retardation--requires that evidence of retardation be found in at least one of the parents and in one or more siblings, presumably, because some degree of cultural deprivation results from familial retardation. The degree of retardation is usually mild.

Associated with environmental deprivation--an individual deprived of normal environmental stimulation in infancy and early childhood may prove unable to acquire the knowledge and skills required to function normally. This kind of deprivation tends to be more severe than that associated with familial mental retardation. This type of deprivation may result from severe sensory impairment even in an environment otherwise rich in stimulation. More rarely it may even result from severe environmental limitations or atypical cultural milieus. The degree of retardation is always borderline or mild.

APPENDIX C

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STATE CORRECTIONAL SYSTEM PRISONER POPULATIONS

State or Dist Correctional System	Percentage of Total U.S. Prison Population	NPS[a] Reported Adult Male Population 1967	Reported Adult Male Prisoner Population as of 31 December 71	Last Reporting Period (LRP)	Adult Male Admis-sions (LRP)	Percentage Admitted Adult Male Retarded (LRP)	Percentage Admitted Adult Male Borderline Retarded (LRP)
Alabama	2.2	3,750	4,274	01/01/71-12/31/71	[1,000]	Unk	Unk
Alaska	(b)	(b)	380	01/01/71-12/31/71	558	Unk	Unk
Arizona	0.9	1,549	1,284	01/01/71-12/31/71	691	28%	11%
Arkansas	0.9	1,609	1,500	07/01/70-06/30/71	1,560	13%	38%
California	15.8	22,904	15,734	07/01/70-06/30/71	4,678	.8%	3.4%
Colorado	1.4	2,460	NR	NR	NR	NR	NR
Connecticut	0.9	1,483	3,000	01/01/71-12/31/71	2,200	Unk	Unk
Delaware	0.2	287	605	07/01/70-06/30/71	5,441	Unk	Unk
Dist of Columbia	0.7	958	3,560	01/01/71-12/31/71	2,680	5.2%	15.8%
Florida	4.1	6,975	9,662	01/01/71-12/31/71	4,742	5%	7%
Georgia	3.0	5,125	7,713	07/01/70-06/30/71	5,689	Unk	Unk
Hawaii	0.2	364	251	07/01/70-06/30/71	65	5%	12%
Idaho	0.2	384	360	07/01/70-06/30/71	347	2%	Unk
Illinois	4.0	6,865	5,993	01/01/71-12/31/71	2,269	.1%	.4%
Indiana	2.2	3,816	NR	NR	NR	NR	NR
Iowa	1.0	1,786	502	07/01/70-06/30/71	531	6.2%	17.3%
Kansas	1.3	2,234	NR	NR	NR	NR	NR
Kentucky	1.6	2,289	2,970	07/01/70-06/30/71	1,721	15%	13%

State or Dist Correctional System	Percentage of Total U.S. Prison Population	NPS[a] Reported Adult Male Population 1967	Reported Adult Male Prisoner Population as of 31 December 71	Last Reporting Period (LRP)	Adult Male Admis-sions (LRP)	Percentage Admitted Adult Male Retarded (LRP)	Percentage Admitted Adult Male Borderline Retarded (LRP)
Louisiana	2.4	3,984	3,877	07/01/70-06/30/71	1,794	NA	Unk
Maine	0.3	546	338	01/01/71-12/31/71	283	Unk	Unk
Maryland	2.9	4,953	NR	01/01/71-12/31/71	3,957	NA	NA
Massachusetts	1.0	1,707	2,432	01/01/70-12/31/70	2,775	2.2%	Unk
Michigan	4.0	6,906	NR	NR	NR	NR	NR
Minnesota	0.9	1,599	1,025	07/01/70-06/30/71	800	2.5%	3.8%
Mississippi	1.0	1,609	1,850	01/01/71-12/31/71	750	15%	65%
Missouri	1.9	3,193	NR	01/01/71-12/31/71	2,078	2.5%	8.6%
Montana	0.3	512	251	01/01/70-12/31/70	292	1.3%	2.1%
Nebraska	0.6	928	991	01/01/71-12/31/71	549	.5%	10%
Nevada	0.4	592	630	01/01/71-12/31/71	264	8%	15.9%
New Hampshire	0.1	221	NR	NR	NR	NR	NR
New Jersey	2.6	4,320	5,397	07/01/70-06/30/71	3,745	4.6%	10.2% (c)
New Mexico	0.5	870	700	07/01/70-06/30/71	343	Unk	Unk
New York	8.0	13,274	NR	04/01/71-03/31/72	1,292	.3%	11%
North Carolina	3.2	5,357	NR	NR	NR	NR	NR
North Dakota	0.1	179	130	07/01/69-06/30/70	177	Unk	Unk
Ohio	5.9	9,988	NR	NR	NR	NR	NR
Oklahoma	1.6	2,698	2,197	01/01/71-12/31/71	1,113	4.2%	21%
Oregon	1.0	1,760	2,381	01/01/71-12/31/71	1,530	1.2%	8.3% (c)

State or Dist Correctional System	Percentage of Total U.S. Prison Population	NPS[a] Reported Adult Male Population 1967	Reported Adult Male Prisoner Population as of 31 December 71	Last Reporting Period (LRP)	Adult Male Admis-sions (LRP)	Percentage Admitted Adult Male Retarded (LRP)	Percentage Admitted Adult Male Borderline Retarded (LRP)
Pennsylvania	3.2	5,504	6,072	07/01/71-12/31/71 (d)	[3,212]	Unk	Unk
Rhode Island	0.2	345	525	01/01/71-12/31/71	4,500	[<5%]	[<5%]
South Carolina	1.3	2,138	2,989	01/01/71-12/31/71	2,262	Unk	Unk
South Dakota	0.3	477	378	01/01/71-12/31/71	306	.3%	1.3%
Tennessee	1.7	2,920	3,200	07/01/70-06/30/71	1,671	7.3%	17.5%
Texas	7.0	11,922	15,386	01/01/71-12/31/71	8,359	[7.4%]	[8.4%]
Utah	0.4	632	593	01/01/71-12/31/71	282	6.0%	30.5%
Vermont	0.1	218	NR	NR	NR	NR	NR
Virginia	2.3	3,912	4,981	01/01/71-12/31/71	2,195	2.8%	2.2%
Washington	1.6	2,667	3,740	07/01/70-06/30/71	1,537	Unk	Unk
West Virginia	0.7	1,174	NR	NR	NR	NR	NR
Wisconsin	1.5	2,477	2,384	07/01/70-06/30/71	1,381	Unk	Unk
Wyoming	0.1	246	250	01/01/71-12/31/71	130	3.1%	36.0%
	-	165,666	120,485	-	81,749	-	-

n_1 - 42 states responded to item number 10 of the questionnaire

n_2 - 26 states and District of Columbia provided useable data regarding retarded and borderline retarded admissions

[a] National Prisoner Population - Males in Adult, State Facilities as of 31 December 1967; as reported in and extracted from "Prisoners in State and Federal Institutions for Adult Felons," National Prisoner Statistics, U.S. Department of Justice, No. 44 (July,1969), 30-31.

[b] Alaska not reported separately on 1967 NPS Statistics; estimated at approximately 0.2%

[c] Borderline retardates in New Jersey and Oregon reported as those with IQs falling in the 70-79 range

[d] Pennsylvania reported for six month period only; estimated admissions obtained by doubling the reported admissions for the indicated period.

NR - State did not respond to questionnaire; or state did not respond to this item of questionnaire

NA - State reported that requested data was not available

Unk - State reported that requested data was unknown or not maintained in statistical records

[ ] - Data reported in estimate or approximation form

PROJECT CAMIO

Correctional Administration and the Mentally Incompetent Offender

Volume 1 Strategies for the Care and Treatment of the Mentally Retarded Offender

Volume 2 Theories on Criminality and Mental Retardation

Volume 3 The Mentally Retarded and the Law

Volume 4 The Mentally Retarded in an Adult Correctional Institution

Volume 5 The Mentally Retarded in a Juvenile Correctional Institution

Volume 6 The Delinquent in a State Residential Facility for the Mentally Retarded

Volume 7 The Mentally Retarded and the Juvenile Court

Volume 8 A National Survey of the Diagnosis and Treatment of Mentally Retarded Offenders in Correctional Institutions

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