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

57403

NCJRS

MAY 14 1979

ACQUISITIONS

STATE OF IOWA

Robert D. Ray, Governor

Victor Preisser
Commissioner, Department of Social Services

Harry Woods
Director, Division of Adult Corrections

Douglas Miller
Chief, Bureau of Admin. Support Services

PRINTED BY THE PRISONER EMPLOYMENT PROJECT (P.E.P.)

CONTENTS

		Page
	Abstract	v
	Conclusions and Recommendations	vi
I.	Introduction	1
II.	Extent of the Problem	3
III.	Legal Issues	4
IV.	Goals and Conflicts	6
V.	Diagnoses	8
VI.	Mental Health Services and Treatment	17
	References	28
	Appendix A. Discussion Questions	30
	Appendix B. Iowa Code	31
	Appendix C. Standards	34

ACKNOWLEDGEMENTS

I wish to thank the administrators and professional staff of the four mental health institutes and the seven correctional institutions of Iowa for taking the time to discuss these issues with me. I hope I have not done them an injustice through my errors of commission or omission. I would like to thank Senator Charles Miller, Dr. K. V. Shah and Mrs. Eva Parsons for making certain publications available for me.

ABSTRACT

In response to a request for a greater understanding of the interrelationships between the four mental health institutes and the seven adult correctional institutions of Iowa, discussions were held with administrators and professional staff at these facilities. In order to place their concerns in a more general theoretical framework, some of the relevant literature is summarized. It appears that the same issues are being raised in England and in other correctional systems, as in Iowa.

It appears that there has been little interfacing of mental health and correctional institutions, not only in Iowa but throughout the nation. This is a subject that is gaining a new interest and awareness.

Some of the issues that relate to the conflicts between the "medical" model and the "social system" model of deviance are presented. By addressing these issues, the problems that need to be faced are related to both models. There is first a need for diagnosis and classification, and secondly, a need to adjust the social system to determine where to receive and what to do with which inmates.

CONCLUSIONS AND RECOMMENDATIONS

At present, a committee of mental health and correctional professionals is being formed in Iowa that will be able to examine these issues in greater depth. One of the concerns frequently mentioned by psychiatrists is that our society has in the past been the victim of the "over-selling" of psychiatry. I would be remiss if I did not pass along their caution to the reader.

1. There is a need for an empirical assessment of the extent of the problem of mental illness in the correctional institutions of Iowa. This study has only presented some information obtained from various sources, but psychiatric evaluations of the correctional institutional population (or a sample thereof) is needed in order to accurately determine if persons requiring psychiatric treatment are being missed.

2. The services that could be provided at the MHI's or at the correctional institutions with the assistance of MHI psychiatric and mental health professionals is dependent, basically, on the availability of such staff. The discussions at the MHI's frequently cautioned that there is a shortage of psychiatric staff and resources.

3. Greater communication is needed between the MHI professionals and the corrections professionals. My discussions with these persons was one of the few occasions on which their mental health concerns had been discussed.

4. Training and staff development should be introduced for both mental health and correctional personnel, at all levels. MHI psychiatrists would probably benefit from a greater exposure to the types of psychiatric problems encountered at the Iowa Security Medical Facility, and at the six correctional institutions. The correctional officers could benefit from training in the

identification of psychiatric symptoms and how they could be handled.

5. Group therapy appears to be a treatment modality that can have positive results for some correctional clients, and this would provide a means for training both MHI staff and correctional paraprofessionals among the inmates.

6. Utilization of the facilities at the Iowa Security Medical Facility at Oakdale needs to be evaluated. Particularly at Fort Madison, there appear to be a considerable number of violent and disruptive inmates who might be treated at Oakdale. The suggestion was made that some of the less disruptive cases at Oakdale, such as the court evaluations, might be better accommodated at the MHI's.

7. The most promising group of inmates who might be treated at the MHI's are the substance abusers. This group might be transferred from the correctional institutions to the MHI's as part of their pre-parole plan.

8. The sociopathic, psychopatic, or disruptive prisoners are described by the correctional personnel as the most troublesome and by the MHI psychiatrists as the patients that "traditional" psychiatric methods are least sucessful with. My response to this was to ask if there were new horizons in psychiatry that might be applied to such inmates, and although the replies were not encouraging, behavior modification and operant conditioning have been mentioned in my discussions and in the literature (Clinard, 1974, Chapter 6) as showing promise. However, behavior modification has certain legal and ethical issues (as in the Clockwork Orange) that may be unresolvable.

9. Some of the correctional institutions in Iowa are currently in the initial stages of "unitization", a management tool designed to improve both the control and rehabilitation of the criminal offender. This would appear to be an opportune time for these units to attempt to apply what mental health care is indicated and to encourage a greater interaction between the MHI's and these institutions.

10. The medical schools of Iowa might consider the exposure of their students to the mentally disturbed offender as a necessary part of their training. The utilization of the psychiatric hospital at the University of Iowa at Iowa City for the psychiatric care of correctional inmates should be evaluated.

I. INTRODUCTION

Today, because of declining populations in the mental health institutes and overcrowding in correctional institutions, there has been renewed interest in how mental health interfaces and interrelates with corrections.

The Director of the National Association of State Mental Health Directors informed me that in February, 1979, the first meeting of a new Task Force on Mental Health and Corrections was held in order to begin to study these interrelationships.[1]

When I was asked to study the issues and concerns, Mr. Harry Woods, Director of Iowa's Division of Adult Corrections, restricted the topic to the four mental health institutes and the seven correctional institutions in Iowa. The specific questions that I explored are included at the end of this report, but the discussions were not confined to these questions. They were used as starting points into a very complex and interesting topic. This report is a product of these eleven brainstorming sessions, and a sampling of an extensive literature.

While my intention has been to focus only on the institutional interface, unavoidably, this report touches upon other components of the criminal justice system, including court-ordered evaluations, probation and parole.

There have been various efforts in Iowa in the past when there was greater interaction between the mental health and correctional institutions than appears to exist today. Around the time of World War II, correctional inmates were employed at the mental health institutes for maintenance, operation of the power plant, and other duties.[2] They were housed in a separate building from the mental patients and were treated as minimum security risks. There were up to 50 inmates

---

[1] Harry Schnibbe, personal communication.

[2] This information was obtained mostly from Mr. Nolan Ellandson, former Director of the Division of Adult Corrections.

at each Mental Health Institute, and they were supervised by one correctional officer.

There probably was no psychiatric treatment involved. This program was discontinued as technological change resulted in the selling of the dairy herds, the discontinuance of the preparation of canned goods, and the automation of the heating and power plants.

In the 1960's the mental health institutes were used for the treatment of substance-abusing inmates, and as pre-parole facilities.

In 1958, a psychiatric unit was established at the Men's Reformatory at Anamosa. By 1962, the unit at Anamosa housed 114 patients. Of these, 15 were transfers from the mental health institutes as security problems, 36 were committed on criminal charges, but were ruled incompetent to stand trial, and 63 inmates had been transferred there from the general prison population at Anamosa and Ft. Madison after being diagnosed mentally ill. The conditions at this unit have been described as a "snake pit," at that time.

From 1963 to 1965, a committee of professional lay people and legislators studied mental health care in Iowa (Iowa Mental Health Authority, 1965). A sub-committee focused on the adult offender and reported that 10 - 15% of the inmates in Iowa's correctional institutions were "blatantly psychotic" (IMHA,p.73). The majority of the offenders were assumed to suffer from some "psychological disorders". The report's recommendations were directed at a psychiatric or medical model of treatment of the offender, and the recommendation was made to establish the Iowa Security Medical Facility. At about the same time, the 61st General Assembly appropriated $5,610,000 for the building of the Iowa Security Medical Facility at Oakdale.

Although the report considers the problem of providing mental health care for correctional clients, there is very little attempt to examine what relationships

might be developed between the mental health institutes and the correctional institutions. This is the focus of the present report.

II. EXTENT OF THE PROBLEM

Discussions were held at Iowa's four mental health institutions (MHI's) and the seven correctional institutions[1] during November, 1978, to February, 1979. Meetings were held with the Superintendents, Wardens, Psychiatrists, Psychologists, and other key professionals of the institutions. This report focuses on these discussions, but an attempt was made to assemble any relevant, available data. Unfortunately, not very much exists.

The data system of the Division of Mental Health Resources indicates that in the second half of FY 1977 there were five admissions from the adult correctional institutions to the MHI's (not specified). During FY 1978, there were four admissions to the MHI at Cherokee from correctional institutions. The most recent data available show three admissions to Cherokee from correctional institutions. On the basis of the interviews, these figures probably refer to admissions from the Women's Reformatory at Rockwell City.

Figures obtained from the Iowa Security Medical Facility at Oakdale show an average of about 10 admissions a year from the four MHI's and the two state hospital schools for the mentally retarded. The period for which data were available was from September, 1969 to October 1978, and during this time, there were 39 admissions from the State Hospital Schools and 67 admissions from the MHI's to the Iowa Security Medical Facility.

A doctoral dissertation at the University of Iowa by Edward Rockoff (1973, 1978) found that in 1965, about 13% of the residents at Fort Madison and Anamosa

---

[1] Iowa State Penitentiary at Fort Madison, John Bennett Facility, Men's Reformatory at Anamosa, Riverview Release Center at Newton, Mt. Pleasant Medium Security Unit, Women's Reformatory at Rockwell City, and the Iowa Security Medical Facility at Oakdale.

were retarded. By 1972, only 2% of the inmates were classified mentally retarded. Recently, statistics compiled at the Iowa Security Medical Facility and for all correctional institutions from the Offender Based State Correctional Information System show that about 2.5% of the inmates are retarded.

Rockoff suggested that the decline in mentally retarded offenders in Iowa's correctional institutions was due to two possible influences. One possibility was that with changing court attitudes and policies, and the greater use of community corrections, the mentally retarded offender was being placed on probation or being paroled more often.

Another factor identified by Rockoff was a report by the Iowa Department of Public Instruction in 1968 which evaluated educational and rehabilitative programs at Anamosa. This evaluation may have exerted some pressure to parole the retarded offenders.

The discussions for the present report dealt with which inmates may be in need of mental health services and this information will be summarized below in the section concerned with diagnoses. There is a need for an objective, empirical assessment by qualified professionals of the degree of mental illness, mental retardation and behavior disorders among inmates in Iowa's correctional institutions.

III. LEGAL ISSUES

Appendix B of this report refers to and quotes from the Iowa Code on the main areas of concern in this report. These topics include the admissions, transfer and treatment of mentally ill offenders within the institutions of the state.

A discussion of the civil rights of correctional clients and mental patients is beyond the scope of the present report, but certainly needs to be examined.[1]

---

[1] A memo to Legal Services of the Dept. of Social Services requesting input on these issues was sent on Feb. 15, 1979, but a response has not yet been received.

There has been an increased interest in this area in recent years and various court cases are relevant.

The appendix of an LEAA publication (1977) summarizes some of the legal issues regarding medical care in correctional settings, but most of the cases cited deal with medical needs rather than psychiatric treatment. Three cases are cited which refer to the right to rehabilitative treatment. These are: 1) dangerously violent or suicidal prisoners must be examined and removed to mental hospitals if so advised by a physician (Jones v. Wittenberg, 330 F Supp. 707 (1971)); 2) the treatment of alcoholics and drug addicts during withdrawal should be directed away from jails (Alberti v. Sheriff of Harris County, 406 F Supp. 649 (1975)); and 3) "Psychological or psychiatric treatment is required if prisoner's symptoms evidence disease, disease is curable, or may be substantially alleviated and delay in providing treatment would cause substantial harm," (Browning v. Godwin, ___ F. 2d ___, 21 Crl 2040 (1977)).

In the discussions at the institutions a number of legal questions were raised. The 14th Amendment would probably prohibit a mental patient from being placed in a correctional facility without due process, but disruptive or dangerous patients are routinely transferred to the Iowa Security Medical Facility. Institutional transfers are authorized by the sections of the Iowa Code that are referred to in the Appendix.

Correctional clients are occasionally confined in the mental health institutes for various lengths of time, but this is done with the "voluntary consent" of the prisoner. The legal issue of "voluntary consent" also has been raised in various court cases.

Whether persons are competent to stand trial and whether convicted offenders are civilly commitable are other legal issues that frequently are confronted by the mental health professionals.

In 1976, a court suit brought by the Iowa Mental Health Authority against the Department of Social Services focused on the problems of converting part of the Mental Health Institute at Mt. Pleasant to a Medium Security Unit. This conversion has taken place and the community opposition that was so vigorous at the time has subsided.

At that time, the concerns were that inmates would overpower the mentally ill patients, and that the therapeutic milieu of the MHI would be destroyed. Consequently, there has been no attempt to combine the programs and no inmates are employed on the MHI grounds. The Medium Security Unit is surrounded by double fences and razor sharp barriers. The psychiatric staff of the MHI are not utilized at the MSU next door. Some of the support services from the MHI are, however, available to the Medium Security Unit, such as, the business office and managers, maintenance support, storeroom and purchasing, food purchasing, the same canteen, and the same pharmacy.

The paradox remains that community sentiments and professional interests are such that mental illness and criminality are viewed as separate and distinct entities. Although this report attempts to explore ways in which their treatment may be interrelated, any attempts to more closely link the mental health services at the Mental Health Institute at Mt. Pleasant to the Medium Security Unit, adjacent to it, might be opposed by another court suit.

IV. GOALS AND CONFLICTS

The problems of correctional systems have often been linked to the lack of a clear cut philosophy and goals. Within correctional institutions this is most often seen as a conflict between custody and rehabilitation, or security versus treatment.

One of the major concerns of both the mental health and corrections professionals is security. The open-door policy at the MHI's is frequently mentioned as one reason for not treating the incarcerated offender at these institutions.

J.H. Orr has written a paper describing the problem of overcrowded prisons in England housing hundreds of mentally disordered offenders who could benefit from treatment in psychiatric hospitals (1978). He relates the inability to find places in psychiatric hospitals for these offenders to several factors. He suggests that the introduction of the "open-door policy" in mental hospitals produced a shortage of places for people (whether criminal offenders or not) who needed to be kept in conditions of at least some security some of the time. The open-door policy also meant that hospital staff lost the skills needed to care for difficult and disturbed patients. He suggests that prison staff and these kind of prisoners are paying the price of the open-door policy. Orr writes that the paradox is that "developments such as the open-door policy which are seen as progressive are cancelled out by retrogressive consequences".

American psychiatrists (including Karl Menninger and Francis Tyce) have also argued that persons in correctional institutions are in the same situation as were chronic mental patients a quarter of a century ago.

However, one might argue that as the mental hospitals have moved toward an open-door policy, the correctional system has moved toward a greater reliance on community corrections. The problem remains, as Orr has defined it: Where do you treat the mentally disturbed person who needs a secure setting?

More will be said on this subject in the following sections dealing with diagnosis and treatment. Within criminology, this has been referred to as the controversy over whether criminals are "mad" or "bad".

In many states, the provision of mental health services for offenders has

suffered because of conflicts between separate Departments of Corrections and Mental Health. In Iowa, where the Divisions of Adult Corrections and Mental Health Resources are part of the same Department of Social Services, any conflicts are not administrative or structural, but are probably remediable through more discussion and greater communication regarding mutual concerns. As one mental health administrator put it, there may probably not be a greater "integration" of the mental health institutes and the correctional institutions, but there could be more "mutual assistance".

V. DIAGNOSES

One concern expressed by both correctional and mental health administrators dealt with inconsistencies or disagreements in diagnoses among psychiatrists. When psychiatric evaluations are conducted throughout the state, in the four MHI's and at the Iowa Security Medical Facility, there may be different prognoses and recommended treatments. Inconsistencies in whether a person is "competent", or "mentally ill", or "psychopathic" are plentifully documented in the literature.

This general subject is summarized by a British forensic psychiatrist, John Gunn (1977), as follows:

> "The main problem in discussing any relationship between criminal behavior and mental disorder is that the two concepts are largely unrelated. We are all aware that the very existence of mental illness has been challenged (Szasz, 1961) and that definitions are extremely difficult to promote... yet most of us believe that somewhere in the confusion there is a biological reality of mental disorders, and that this reality is a complex mixture of diverse conditions, some organic, some functional, some inherited, some learned, some acquired, some curable, others unremitting. It would be surprising if such a milange had a clear-cut relationship with any social parameter, specifically one which is arbitrarily determined by legislation". (p. 317)

The literature on this subject is extensive. The subject of mental disorders and homicide has probably been of greatest concern to a community, but my own research on 43 years of homicides in Detroit has shown that the abnormal offender

was responsible for 0.0% up to about 13% of the homicides in Detroit, in any particular year. Usually, this figure was about 5-7% (Boudouris, 1974). Homicide, it should be pointed out, constitutes a relatively small part of all crimes committed.

A study by Cocozza, Melick, and Steadman (1978) tests the assertion that "a core belief of the American public is that the mentally ill are dangerous". On the contrary, these authors cite the lack of empirical data showing a relationship between mental illness and crime. Their study of the arrest rates of former mental patients compares their criminal behavior with the general population at three points of time, in 1947, 1968, and 1975.

Their data show that there has been a "very substantial increase" in the proportion of male residents in (New York) state mental hospitals who have prior arrests. In 1975, 40% of the residents had a prior arrest. This article discusses the debate on how the "mental health and criminal justice systems have been shifting the same clientele from one to another..." In California, legislation has been blamed for the arrest and incarceration of mentally disordered persons in place of mental hospitalization. In New York, the opposite trend is noted. Persons formerly in jails or prisons are now sent to the state mental hospitals. "As prisons have become overcrowded, other alternatives for detention have been sought with the state mental hospitals apparently being one solution", (loc cit, P.331).

The psychiatrist, Thomas Szasz, has taken the radical position that mental illness is "a convenient myth" which obscures certain difficulties in human relations which are inherent in social intercourse, but which need not be unmodifiable. Instead "of calling attention to human needs, aspirations and value, the notion of mental illness provides an amoral and impersonal thing (an illness) as an explanation for problems in living", (Szasz, 1960, 1961). According to

this writer, the concept of mental illness is "an immoral ideology of intolerance", like the earlier persecution of witches and heretics (Szasz, 1970).... to take this a step further, one might add, (at some times or in some states), the homosexual, the marijuana smoker, the abortionist, the adult consenting sodomists, the fornicators, and the drinkers of alcohol.

But, in the present context, taking a less radical view and accepting that diagnoses of psychiatrists and sentences by the courts, while fallible, are a part of our social reality, we should distinguish between the "medical model" of deviance and a "social system model".

Most textbooks on deviant behavior deal separately with mental illness and criminality, but the definition or labeling of the deviance is approached, generally, by referring to these alternative ways of defining the behavior. If one uses the "social system" model, the mental illness or criminal behavior can be seen as a definition or label imposed by certain persons or social institutions with the power to do so. In the case of mental illness, the persons with this power are the deviant's family, neighbors, psychiatrist, employer, and others. In the case of the criminal offender, it is sometimes these same persons who are the complainants to the police or courts who make decisions with considerable discretion. The deviant behavior, whether psychiatric or criminal, is viewed (or diagnosed) in relation to certain social and cultural norms or values. This view is basic to Szasz's arguments and has been discussed by others, most notably by the sociologist, Erving Goffman (1961, 1963).

On the other hand, the "medical model" of deviant behavior has been summarized by Clinard (Ch. 6, 1974) as follows:

1. All deviant behavior is a product of something in the "sick" individual.
2. All persons at birth have certain inherent basic needs.
3. Childhood experiences lead to certain personality types.
4. A child's family experiences determine later behavior.
5. Certain personality traits distinguish the deviant from the nondeviant.

The "medical model" is implicit in the view that criminal offenders can be rehabilitated in either mental hospitals or prisons, that psychiatrists can provide the answers to criminal behavior and recidivism, and that correctional institutions should be modeled after the therapeutic community of the mental hospital.

Peter Lejins (1977) traces the rising influence of the psychiatric approach to criminality to the 1930's when European dictatorships resulted in the migration to the United States of psychiatrists, psychoanalysts, and psychologists. They were then involved in the diagnosis and treatment of criminality among military personnel during World War II, so that by the late 1940's, criminals were seen as "mentally abnormal" persons.

The experiment in indeterminate sentencing at the Patuxent (Maryland) Institute is an example of an intensive correctional treatment program for mentally abnormal criminal offenders (Lejins, 1977). It was begun in 1955 and was viewed as a logical development of the belief in the control of crime through cause removal, and of medical and psychoanalytical theories of criminal behavior. The initial confinement was for two years, and the treatment program included "individual depth therapy, group therapy, the use of certain drugs, and a progressive tier system" for classifying inmates in reference to progress toward release.[1] No thorough evaluation of the program was performed, but recidivism rates differed little from releases from other prisons. The experiment contributed nothing to the methodology of treating mentally abnormal dangerous offenders. It did serve to confine dangerous offenders, although the problems with predicting "dangerousness" are noted.

---

[1]Lejins points out that the "graded tier system" was invented by Crofton in the 1850's under the name of the Irish Prison System...(p. 128).

The repeal of the Indeterminate Sentencing Law by the Maryland legislature in 1977, meant that Patuxent would remain a treatment facility for mentally abnormal and dangerous criminal offenders, a facility provided "with professional staff capabilities far superior to most programs of this nature in this country and which can continue its use, experimentation and refinement of the multiple methodology treatment model that it developed", (Lejins, p. 116). Lejins argues that the experiment was terminated not because of inherent faults, but because of a change in public attitudes toward the correctional treatment of offenders. This includes "a disenchantment with the correctional model or medical model for handling crime problems, a disillusionment with psychiatric models, and a developing emphasis on the rights of individuals, including convicted offenders".

According to Lejins, Patuxent was "created in line with the then prevalent 'fads' regarding the etiology of criminal behavior and its treatment, and the program was terminated similarly in response to a different set of popular beliefs which had replaced those of 20 years ago", (pp. 116 - 117). Both the rise and the demise of Patuxent were based not on hard research data, but on "unwarranted assumptions".

If deviance and normal behavior are viewed as ends of a continuum, as has been proposed for mental illness and mental health, and criminal behavior and non-criminal behavior, then it may be possible to conceptualize a model of deviant behavior that has elements of both the medical and social system models (as suggested in the above quote from Dr. Gunn). The diagnostic and screening problem then becomes even more crucial in determining what should be done to or for an offender, if anything.

Even the psychiatrist, however, has in recent years become more behaviorally oriented, and in contrast to the Freudian psychoanalyst of the past, the modern psychiatrist has become more aware of social and cultural factors affecting behavior.

In a study of the records on 1154 men incarcerated in the Federal Penitentiary at Lewisburg, Pennsylvania, Roth and Ervin (1971) found that 56% had had a prior psychiatric contact, and 18% had been in a psychiatric hospital. The diagnoses included the following: alcoholism, 29%; drug abuse, 25%; mentally retarded, 3%, plus another 5% who were borderline; psychoses, 8%; and personality disorders, 31%.

A psychiatrist, Antonio Dy, has described various critical psychological phases that an incarcerated offender goes through and this work will be summarized in the section of this report dealing with treatment. It is important to note that this work does not rely on a medical model which would see the inmate as a sick person, but rather stresses the social and situational changes that the inmate goes through and with which he needs some assistance in coping.

Halleck states that "the prison environment is almost diabolically conceived to force the offender to experience the pangs of what many psychiatrists would describe as mental illness. A brief look at the prison environment will indicate that it contains the most pernicious factors that are listed as causes of mental illness in our psychiatric textbooks", (1967, p.286). He then goes on to summarize the following stresses:

1. Absence of close interpersonal relationships and discouraged from forming close relationships with other inmates or custodial officers.

2. Since socially acceptable sexual outlets are denied, only autoerotism and homosexuality are allowed, and the latter can lead to serious psychological disturbance.

3. "Prisoners are more isolated and more idle than is generally felt to be conducive to emotional health. Loneliness and inactivity lead to narcissistic withdrawal and over-reliance on autistic fantasy".

4. Solitary confinement (and sensory deprivation) may permanently scar inmates.

5. Prisoners are deprived of the opportunity to do socially useful work.

6. They are deprived of a sense of autonomy and encouraged to be dependent. This is unlikely to lead to the development of a meaningful sense of social responsibility.

7. "Repetitive attempts are made to break down the inmate's self-esteem and identity".

8. "The prison squashes all manifestations of useful aggression. Adequate mental health is dependent upon honest recognition of feelings of resentment and anger. The prisoner who shows evidence of anger or even verbalizes his feelings is in danger of being labeled a rebel, a troublemaker or a paranoid. He also faces the threat of additional punishment".

9. "In addition to all the above stressful experiences, the prisoner is subjected to an insidious series of paradoxical messages. Every message he receives which states, 'You are being treated for your own good and we are here to help you' is deceptive. Even the most primitive institution has some need to pretend that it is treating and reforming criminals. A jargon of helpfulness (which is often based on medical clich'es is sometimes inflicted upon even the most abused prisoner. Since the prisoner is dependent upon his captors and is hopeful that they will be good to him, he may accept such statements and ignore the reality of what is being done to him. To the extent that he is incapable of deciphering the dishonesty implied in paradoxical communication he will suffer the pangs of being oppressed, without even being able to ascertain who is hurting him", (1967, p. 288).

In addition, Halleck has overlooked the stresses felt by prisoners who fear or are threatened by other inmates.

The above may be interpreted as hypotheses by Halleck in the absence of more empirical evidence. This general subject was raised with psychologists at one of the correctional institutions, and their response was informative. In their view, most prisoners have had a long history of behavioral problems. In some cases they have been in mental hospitals and in juvenile institutions. The psychologists felt that the prisoners' lives were more hectic on the street, and that in most cases, they are psychologically healthier in prison than when on the outside.

If the above description is not sufficiently convincing from the social system point of view, one can turn to the more traditional psychiatric nosology, but additional problems are encountered.

In discussions with the psychiatrists and psychologists in Iowa, distinction has often been made between the psychotics and the inmates who were behavioral problems. The latter as the psychopaths, sociopaths, or prisoners with personality problems characterized by anti-social behavior.

The psychotics, including the schizophrenics and other mental illnesses, are considered treatable by the usual psychiatric skills and psychotropic drugs. However, once the psychotic episode has subsided, the offender is usually described as reverting to the sociopathic and anti-social behavior which is disruptive to the psychiatric hospital. It is at this stage that the psychiatrists tend to turn to the correctional institutions and say, "We can't handle him (or her) any more. You take him back." The MHI's with violent or disruptive patients use the Iowa Security Medical Facility for this purpose.

At the Men's Reformatory at Anamosa, it was estimated that there may be 50 - 80 inmates who are mildly retarded, but not enough to require hospitalization at the state hospital - schools. Anamosa has a special treatment unit where 5 psychotic inmates can be treated. It was estimated that there were a total of about 15 psychotics or sociopaths in the entire institution.

At the Iowa State Penitentiary at Fort Madison, the staff estimated that there were about 25 psychotics and between 50 - 100 behavioral problems or sociopaths. It was estimated that about 100 inmates who were psychotics or sociopaths and who were security problems might be suitable for the Iowa Security Medical Facility. In addition, there were 20 - 25 persons incarcerated for operating motor vehicles while under the influence of alcohol (OMVUI's) and about 10 sexual offenders who might be suitable for treatment at the MHI's.[1]

Attempts to define a "psychopath" have filled the literature since the term was introduced by Koch in the 19th century. Several authors have pointed out that the definition is faulty because it involves circular reasoning. A mental condition is inferred from anti-social behavior while anti-social behavior is explained by mental abnormality. Psychopathic disorder may be viewed as a failure of learning or socialization rather than a disease. Gunn writes, to use the

---

[1]These figures for Anamosa and Ft. Madison should be viewed only as "best estimates". One of the recommendations of this report is that a careful assessment by mental health professionals of the extent of the problem is needed.

terms "moral defective" or "psychopath" to explain "persistent criminality in medical terms has not only failed, but has been counterproductive", (1977, p. 326).

On the other hand Restak, in describing research on "evoked brain potentials" thinks that "neurometrics" shows promise of distinguishing psychotics and neurotics and in diagnosing psychopathy. In a recent article, Restak (1979) writes:

> "Recent evoked - response work indicates that the diagnosis of psychopathy is undoubtedly legitimate: psychopaths are not just 'different' but, in fact, are a distinct group that can justifiably be classified as mentally ill. Their evoked response results, particularly in older psychopaths, show consistent failures of response to harsh or irritating stimuli".

In a Council of Europe publication on long-term prisoners (that is, incarcerated for five years or more), (1977), several reports discuss the psychiatric and psychological aspects of such imprisonment. Included under the diagnoses of "prison psychoses" or "acute psychic changes" are neurotic reactions (such as self-mutilation), depressive reactions (suicide), apathetic and sub-stuporose behavior disturbances (refusal to eat), schizophrenic reactions, and psychosomatic disturbances.

In this publication, W. Sluga describes a "functional psychosyndrome" among long-term Austrian prisoners which includes emotional disturbances, disturbance in comprehension and ability to think, infantile regressive changes, and difficulties in social contacts. The longer the imprisonment, the more neurotic defense mechanisms recede and personality characteristics bordering on psychotic deformation become frequent.

However, it is pointed out in this publication that deprivation of liberty doesn't always have the same effect. It depends on the inmate's personality, the measure of communication retained by prisoners, and the severity of the prison regime. In other words, as noted earlier, the "medical model" is tempered by the "social system" model.

VI. MENTAL HEALTH SERVICES AND TREATMENT

At the 1978 meeting of the American Society of Criminology, Seymour Halleck received the Sutherland Award and discussed what psychiatry is capable of providing in the criminal justice process (Boudouris, 1979). "He presented the following four possibilities regarding treatment: a) diminish the probability that an offender will commit crimes without regard to whether he is hurt or not, b) change the offender without harming him, c) make the offender a better person and more capable of functioning in society, or d) make the offender more comfortable and effective without worrying about whether he has not been rehabilitated. Dr. Halleck said rehabilitation can refer to the first three, but most psychiatrists are giving up on these and focusing on the fourth option".

The mood in corrections in recent years has been to turn away from the goal of rehabilitation. This is reflected, perhaps in a distorted way, in a controversial study by Lipton, Martinson, and Wilks (1975) and summarized in Martinson's article "What Works? - Questions and Answers About Prison Reform". In this article, Martinson (1974) concludes, "With few and isolated exceptions, the rehabilitative efforts that have been reported so far have had no appreciable effect on recidivism". Since then, Martinson and others have acknowledged that this judgement may be too harsh and that even in the Lipton et. al. work there were examples of programs that may have been partially successful for some persons at some times.

Psychiatrists themselves admit that their success rates with those kinds of persons that cause the greatest problems in correctional institutions, (the personality disorders, psychopaths, or sociopaths), have not been high.

Halleck raises the question, Why would any psychiatrist be asked to work or be willing to work in a prison? Correctional administrators say "the prison

psychiatrist is needed to maintain a climate of proper mental hygiene. This ridiculous statement represents only one of the many frustrating and inconsistent philosophies which arise when medical models are insensitively used to rationalize a punitive system", (1967, p. 228). What then can a psychiatrist do? Halleck suggests various rules and options for the psychiatrist. He can attempt to undo the bad effects of the prison itself. He can look after the short-term or long-term interests of the inmate by helping him deal with reactions to an oppressive system, or by helping him adjust to the situation.

Among the possibilities discussed by Halleck, including "doing nothing", is to send the inmate to a hospital for the criminally insane (although inmates will be reluctant to be labeled "insane"). The hospital "may resent having to deal with an aggressive and questionably psychotic inmate. Finally, the psychiatrist may feel dishonest in the knowledge that he is hospitalizing a man whom few of his colleagues would call mentally ill. Yet, there is often little choice. Sometimes transfer is the only way to break up a sadomasochistic relationship between guard and prisoners which is dangerous and harmful to both....Somewhere and somehow the psychiatrist must find a middle ground, a philosophy which allows him to survive and be useful in an environment that is peculiarly designed to defeat his purposes" (1967, p. 292).

Halleck does not mean his criticism of the prison to be an attack upon the motivations of the correctional officers who sometimes show "extraordinary concern" for prisoners. He thinks the psychiatrist is "in an excellent position to educate the custodial staff as to the meanings of certain types of behavior. Sometimes he can enlist the aid of custodial officers to provide specific types of attitude therapy. In a few enlightened institutions it is possible to train guards to do group counseling". He also states that institutions that provide outlets for work and recreation that are therapeutic are "characterized by an unusual degree of understanding between treatment and custodial staff", (1967, pp. 293 -4).

This extensive reference to Halleck's writings should be placed in the appropriate context of this report. The discussions with mental health and correctional personnel in Iowa frequently raised the same issues discussed by Halleck and others in the literature. Psychiatric staff at the MHI's tended to want to avoid dealing with some of these problems. My intention is to suggest ways in which behavior scientists and psychiatrists see these same issues. It was instructive to me that the same issues are raised in Great Britian, as in the United States or Iowa, although I did not attempt to survey the other states except through some of the literature.

For instance, Gunn (1977) suggests that criminal behavior is more likely to occur among patients with personality problems and social problems, are mentally handicapped, and are addicted to drugs or alcohol. "It would be non-sensical to try to separate off this vast lump of general psychiatry and call it forensic psychiatry, and yet there is a growing danger that this could happen". There is a danger that forensic psychiatry will be regarded as that part of psychiatry concerned with locking patients up. "There is also the danger that hard-pressed general psychiatrists will increasingly say that the difficult cases of personality disorders, alcoholism and the like are somebody else's problem", (p. 322).

Gunn goes on to quote British forensic psychiatrist, T.C.N. Gibbens, on the following: a) that forensic psychiatry should be a sub-speciality is debat-able; b) the "well-trained psychiatrist is as competent as anyone to deal with the majority of problems in forensic psychiatry, especially of the more serious kind..."; c) "any claim to specialization must lie in being able to cross.... social and administrative boundaries, as well as in the specialized studies of particular mental conditions"; and d) he stresses "the importance of all psychi-

atrists having the opportunity to learn about various penal institutions and methods of social control...."

In my discussions at Iowa's institutions, the question of treatability was often raised. If a disturbed, anti-social offender is always kept locked up, could a mental hospital do any more? Aside from prescribing medication, many psychiatrists feel there is little that could be done with such disruptive personalities.

This issue is discussed by Orr (1978) who writes that there has developed a tendency (although he is writing about England this sounds applicable to Iowa) for hospital doctors "to decline to admit a mentally disordered person on the ground that his disorder would not be amenable to treatment...If hospitals are to admit only those they can make better, this affectively excludes the possibility of a hospital disposal for quite a large number of 'inadequate' offenders who require long-term care within a sheltered environment", (1978, p. 196).

Orr quotes a prison medical officer writing, "to make it (admission) contingent upon a patient's likelihood of response to treatment is a cynical and recent innovation... Because there is still no - - repeat - - no - - certain cure for schizophrenea, chronic schizophrenics are or can be a demanding nuisance; but that, one was led to believe, is what mental hospitals are for: to look after mentally ill or disturbed patients", (1978, p. 197).

As well as the treatability of the correctional client, another issue raised by both psychiatrists and correctional professionals is the different personality traits and behavior patterns of inmates compared to mental patients. It was frequently mentioned that correctional clients are manipulative and aggressive, and would be a destructive influence on a treatment program if allowed to interact with the noncriminal mental patients. The typical noncriminal mental patient was portrayed as passive and unable to cope with stressful inter-

personal relations, and would be easily led by the criminal mental patient.

This manipulativeness of the offender was also seen as an ability to "con" the naive mental health institute psychiatrists and staff into meeting their needs. The need for extensive training of the MHI professionals in the treatment of the mentally disordered offender was frequently mentioned.

One of the possible types of inmates who might be treatable at the MHI's is the chemically dependent inmate. Many of the present residents on the chemically dependent units of the MHI's have been correctional clients. At the Mt. Pleasant MHI, about 36 of 212 patients are parolees, and most of these are on the chemically dependent unit. At the Cherokee MHI, most of the residents on the chemically dependent unit have had contact with the criminal justice system, and they include those sentenced to probation on OMVUI's.

It might be an interesting experiment in treatment methods to see what effects would result from a greater inter-mixing of probationers, inmates, and parolees with substance abuse problems on the same unit. It is conceivable that the exposure of probationers to the inmates and parolees might have positive effects on their rehabilitation as they observe and listen to the experiences of their peers who have had continued and prolonged contacts with the criminal justice system.

Wayne Wright, clinical psychologist and head of the Alcohol and Drug Abuse Unit, Independence MHI, has written a short paper on some of the problems in the treatment of the substance abuser. He writes, "the prospectus for success in the treatment of alcohol and drug abuse cases in a prison setting traditionally has been poor". He suggests this may be due to the impossibility of creating a therapeutic milieu in prison[1], or it may be due to the anti-social characteristics

---

[1]This statement has also been made by Halleck and others, but it should be seen as a hypothesis requiring testing rather than fact.

of the inmates, sometimes referred to as the "morality factor".

Wright cites the work of a Johns Hopkins psychologist, Robert Hogan, who has studied the development of morality. Comparing heroin addicts and neurotics, Hogan found that the addicts were not "sick" at all, but comparable to most people. He finds instead that they are "hedonists" - - just having a good time.[1] He suggests that heroin addiction is not a medical problem, but a "moral problem".

Wright writes, "The Hogan contentions would seriously question that logic underlies the development of moral reasoning or that moral conduct can be changed through education. It would further suggest that some of the kinds of programs conducted in security facilities are unlikely to have much impact. It is not a case of working with individuals who do not know the rules so much as it is a situation of not choosing to adhere to them. His theory would seemingly employ a need of imposing a sort of ideology, a self-help group, or peer group principle". This appears to be the treatment ideology at the Mt. Pleasant Medium Security Unit, and this is presently being evaluated by Dr. John Stratton of the University of Iowa.

Some of the suggestions made by Wright for the treatment of the substance abuser are as follows: a) the need for special training for persons operating a therapeutic community; b) the Board of Parole should not make decisions regarding release dates until certain treatment goals have been accomplished; c) transferring the residents to the chemically dependent units of the four MHI's prior to release for a final stage of treatment; d) a limited number of Mt. Pleasant residents should be transferred to a unit at an MHI, perhaps only 3 per 50 regular patients because of the danger that a greater number of inmates would create too big a "clique" which would preserve their inmate code and be

---

[1] My own research on the etiology of heroin addiction supports this conclusion. (Boudouris, 1977).

antithetical and disruptive of the treatment program at the MHI.

Wright concludes, "It would seem that parole ought to also consider the potential for some kind of extended care after release from the hospital, such as the halfway house approach. Since there is considerable difference in the manner in which various halfway houses in Iowa function, it might even be that some kind of criteria ought to be established which would figure in the approved halfway houses or other such release facilities", (p. 4).

Dy had identified certain critical psychological phases that a prisoner goes through and has suggested certain direct psychotherapeutic approaches for working with the offender (1974). He describes these "reactive phases:" 1) "initiation phase" consists of the time of arrest to the initial jail confinement; 2) "disorganization phase" is from pre-trial to sentencing; 3) the "short incarceration phase" consists of confinement of less than one year; 4) "long incarceration phase" is for a confinement of more than one year; 5) the "pre-parole phase" is just before consideration for parole; and 6) the "pre-release phase" is just before release.

Each of these phases is correlated with certain psychological symptoms and Dy offers suggestions on the appropriate treatment. In the present context, the "long incarceration phase" is most relevant and he suggests that during this time therapy groups are useful and inmates may become effective co-leaders of new groups. In these groups, Dy de-emphasized the sensitivity-type approaches (since inmates don't need encouragement to be "impulsive, violently expressive, and narcissistically hedonistic") and de-emphasized the history or psychopathogenesis which only serves as a rationalization for current unacceptable behavior.

The Director of Psychiatry for the New York City Prison System, Edward Kaufman, describes the comprehensive mental health care that has been developed for an average daily population (in September, 1972) of 13,000 inmates in New

York City, (1973). He discusses the problems of attempting to develop mental health care under overcrowded conditions and in the face of bureaucratic obstacles, such as delays in paying salaries, hiring, and spending allocated moneys; the resistance to establishing new positions; and budget freezes. All these influences lead to poor staff morale and high turnover.

Nevertheless, Kaufman describes the following mental health services that were established: 1) screening; 2) mental observation cell blocks; 3) a treatment team at each institution consisting of one psychiatrist, one psychologist, one social worker, and several paraprofessionals; 4) a Special Treatment Unit; 5) aftercare: 6) consultation to the correctional authorities; and 7) interfacing with other relevant agencies.

Kaufman concludes, mental health services can be provided "only if treatment principles are permitted ample priority over security considerations". He goes on to view these services only as part of the "social system" problems and the need to change the way society handles the crime of poverty, by pressures for court and bail reform, and, most directly, pressure for sweeping changes in our penal system. Regardless of the contribution of mental health, it is only through continued pressure for drastic reform that we will avoid a prison system which degrades and destroys human dignity", (op. it., p. 260).

The administration of psychiatric services for the mentally disordered offender by state agencies shows a large variety of alternatives. Based on information provided by the National Association of State Mental Health Program Directors (1977), the following state departments have organizational responsibility for these facilities:

Mental Health: 15 (33%)
Health and Social Services: 7 (16%)
Social Services or Human Resources: 6 (13%)
Institutions: 5 (11%)
Health (probably includes mental health): 4 (9%)

Social Rehabilitation Services: 2
Public Welfare: 2
Boards of Charities and Corrections (or Reform): 2
Health and Mental Health: 1
Mental Health and Corrections: 1

Finally, in a recent manual released by the U. S. Law Enforcement Assistance Administration, titled, "Health Care in Correctional Institutions" (1977), there is very little discussion of the need for mental health services. A chart summarizes what various organizations have so far developed in the way of standards for mental health care in jails and prisons.

The standards of the National Advisory Commission on Criminal Justice Standards and Goals (1973) are summarized as follows:

> "Includes fairly specific standards regarding the treatment of of the mentally ill in major correctional institutions. Among other things, the standards state treatment should be under the direction of a psychiatrist, that 'program policies and procedures should be clearly defined and specified in a plan,' that diagnostic tests should be conducted, that regular medical and lab work should be done, etc. (p. 374). Additional standards deal with transferring individuals to mental health facilities (p. 374) and the types of counseling service that should be provided (p. 385)".

Also, standards are summarized that have been proposed by the American Public Health Association (1976):

> "Includes a very extensive section on mental health services. Essentially, the APHA believes that such services should be made available at all institutions, that treatment should not be compelled except under extreme circumstances, that mental health personnel who participate in administrative decision-making processes that affect the inmate (e.g., parole or furloughs) should not be the ones providing therapeutic services and that all patient information should be kept confidential. In addition, the APHA lists nine different types of direct treatment services which should be provided, including crisis intervention, short and long term therapy and detoxification (pp. 27 - 33)".

The commentary by the author of this summary concludes, "Again, the groups agree that mental health care should be provided, but there is little agreement on the basic services that should be available and under what circumstances", (LEAA, 1977).[1]

---

[1]The LEAA manual also has a short paper in the Appendix which describes the mental health care that is being developed in the San Francisco Jails.

The State of Iowa corrections system is currently striving to meet the standards for accreditation that are quoted in Appendix C (Commission, 1977). These standards are explicit and specific regarding the diagnosis and treatment of emotionally disturbed inmates. These standards refer to many of the issues that have been discussed in this report and call for the treatment of the emotionally disturbed inmates in mental hospitals, in separate prison facilities, or in separate psychiatric facilities (such as the Iowa Security Medical Facility at Oakdale).

It may be that the greatest impediment to providing psychiatric services to the criminal offender is related to the conflicts between the "medical" model and the "social system" model of deviance, as defined earlier in this report. The psychiatric or medical model, when applied to inmates in correctional institutions, may exclude these persons with emotional or behavioral problems from treatment in psychiatric facilities, including the Iowa Security Medical Facility at Oakdale. These persons may not fit into the psychiatric categories amenable to traditional psychiatric treatment.

On the other hand, the inmate with behavioral problems in the correctional institution is not likely to receive any treatment or rehabilitation. From the medical model point of view, the behavior or symptoms are the same, but from the social system point of view the question is, In what institution is the person's behavior most likely to be improved? Or put in another way, What institution is best able to care for the mentally and behaviorally disordered offender? That which also needs to be explored is what changes in staffing and organizational structure may be needed to more adequately treat some inmates within the correctional institutions, others at the Iowa Security Medical Facility, and still others at the mental health institutes.

By addressing these issues, the problems that need to be faced are related both to the medical and the social system models. There is first a need for diagnosis and classification, and secondly, a need to adjust the social system to determine where to receive and what to do with which inmates.

REFERENCES

American Public Health Association, "Standards for Health Services in Correctional Institutions, " 1976.

Boudouris, James, "A classification of Homicides, " Criminology, Vol. 11, No. 4, pp. 525-540, February, 1974.

______________, "Attitudes of Former Drug Addicts", Offender Rehabilitation, Vol. 1 (2), pp. 181-191, Winter, 1976 - 1977.

______________, "Meeting of the American Society of Criminology, November 8 - 11, 1978." Feedback #3, Iowa Division of Adult Corrections, February 12, 1979.

Clinard, Marshall B., Sociology of Deviant Behavior, 4th Edition, Holt, Rinehart, $ Winston, Inc., 1974.

Cocozza, Joseph J., Mary Evans Melick, and Henry J. Steadman, "Trends in Violent Crime Among Ex-mental Patients." Criminology, Vol. 16, No. 3, pp. 317 - 334, November, 1978.

Commission on Accreditation for Corrections, Inc./American Correctional Assoc. Manual of Standards for Adult Correctional Institutions, August, 1977.

Council of Europe, European Committee on Crime Problems, Treatment of Long-Term Prisoners, 1977.

Dy, Antonio J., "Correctional Psychiatry & Phase Psychotherapy," American Journal of Psychiatry, 131;10, pp. 1150-1152, October, 1974.

Goffman, Erving, Asylums, Anchor Books, 1961.

______________, Stigma, Prentice-Hall, 1963.

Gunn, John, "Criminal Behavior and Mental Disorder," British Journal of Psychiatry, V. 130, pp. 317-29, 1977.

Halleck, Seymour L., Psychiatry and the Dilemmas of Crime, Harper & Row, 1967.

Iowa Mental Health Authority, Mental Health Planning In Iowa, December, 1965.

Kaufman, Edward, "Can Comprehensive Mental Health Care be Provided in an Over-Crowded Prison System?" Journal of Psychiatry and Law, pp. 243-262, Summer, 1963.

Law Enforcement Assistance Administration, Health Care in Correctional Institutions, Prepared by University Research Corporation for the National Institute of Law Enforcement & Criminal Justice, 1977.

Lejins, Peter, "Patuxent Experiment," Bull. of the American Academy of Psychiatry and Law, Symposium Issue, V. 5, No. 2, pp. 116-133, 1977.

Lipton, Douglas, Robert Martinson, and Judith Wilks. The Effectiveness of Correctional Treatment, Praeger, 1975.

Martinson, Robert, "What Works? - Questions & Answers About Prison Reform." Public Interest, 35:22 - 54, Spring, 1974.

National Advisory Commission on Criminal Justice Standards & Goals, Report on Corrections, Washington, D.C., 1973.

National Association of State Mental Health Program Directors, "Forensic Facilities, " Study No. 318, July, 1977.

Orr, J.H., "The Imprisonment of Mentally Disordered Offenders," British Journal of Psychiatry, V. 133, pp. 194-9, 1978.

Restak, Richard M., "Brain Potentials: Signaling Our Inner Thoughts,"Psychology Today, Vol 12, No. 10, pp. 42-54, 90, March, 1979.

Rockoff, Edward, "The Retarded Offender in Iowa Correctional Institutions," Unpublished Ph.D. dissertation, University of Iowa, 1973.

____________, "The Retarded Offender: Missing in Action," Corrective and Social Psychiatry and Journal of Behavior Technology, Methods and Therapy, V. 24, No. 3, July, 1978.

Roth, Loren H., and Frank R. Ervin, "Psychiatric Care of Federal Prisoners," American Journal of Psychiatry, 128:4, pp. 56-62, October, 1971.

Szasz, Thomas S., "The Myth of Mental Illness," The American Psychologist, Vol. 15, pp. 113 - 118, February, 1960.

____________, The Myth of Mental Illness, Paul B. Hoeber, Inc., 1961.

____________, The Manufacture of Madness,Harper and Row, 1970.

Tyce, Francis A., "P.O.R.T. Of Olmsted County, Minnesota, Community Rehabilitation of Legal Offenders," Congressional Record, pp. 11625-11627, April 22, 1971.

Wright, Wayne, "Commentary on the Development of More Effective Treatment for Prisoners in Iowa Security Facilities," unpublished paper, 1976.

APPENDIX A

DISCUSSION QUESTIONS

MHI's

1. What interrelationships exist between MHI's and Correctional Institutions?
2. What training would be needed for either evaluating or treating correctional clients at the MHI's?
3. What structure/physical changes would be needed?
4. What changes in job classifications would be needed?
5. What correctional clients could be accomodated?
6. What outpatient services could be provided for correctional clients?
7. Could MHI staff be utilized at correctional institutions in order to provide both evaluation and treatment functions?

CORRECTIONAL INSTITUTIONS

1. What concerns do correctional personnel have about sending inmates to MHI's?
2. What training do they need at the MHI's in order to accommodate correctional clients?
3. What security concerns do correctional personnel have?
4. What problems might be expected if a) part of an MHI is converted to a Mt. Pleasant-type medium security facility, and b) if inmates with psychiatric problems are included within the MHI population?
5. What correctional clients might be sent to MHI's?

APPENDIX B

IOWA CODE

Ch. 218.90: "Transfer of prisoners. The directors of the Divisions of the Department of Social Services in control of State Institutions may tranfer any prisoners under their jurisdiction from any institution supervised by them to any other institution under their control or under the control of another Director of a Division of the Department of Social Services with the consent and approval of such other director and they may likewise transfer any prisoner to any other institution for medical or physical examination or treatment retaining jurisdiction over such prisoners when so transferred".

Ch. 218.92: "Dangerous mental patients. Where a patient in any state hospital - school for the mentally retarded, any mental health institute, or any institute under the administration of the Director of the Division of Mental Health of the Department of Social Services, has become so mentally disturbed as to constitute a danger to self, to other patients in the institution or to the public, and the institution involved cannot provide adequate security, the director of such institution with the consent of the Director of Corrections of the Department of Social Services may order the patient to be transferred to the Iowa Security Medical Facility, provided that the executive of the institution involved with the support of a majority of his medical staff recommends the transfer in the interest of the patient, other patients or the public. The order of the Director of the Division of Mental Health shall have the same force and effect as a warrant of commitment for mental illness. The cost of the transfer shall be paid from the funds of the institution from which the transfer is made".

Ch. 229: deals with the commitment and discharge of mentally ill persons.

Ch. 245.12. "Transfer of mentally ill from (Rockwell City). The said state director (Director of the Division of Adult Corrections) may cause any woman commited to said reformatory and suspected of being mentally ill to be examined by one of the superintendents or his qualified designee of a state hospital for the mentally ill or transferred to the Iowa Security Medical Facility for examination. If the woman is found to be mentally ill, the department may order such woman transferred to or retained at a state hospital or the Iowa Security Medical Facility where she shall thereafter be maintained and treated at the expense of the state until such time as she regains her good mental health when she shall be returned to said reformatory. The cost of such transfer and return shall be paid as heretofore provided for other transfers".

Ch. 223. "Iowa Security Medical Facility".

Ch. 224. "Drug Addicts".

Ch. 225. "Psychopathic Hospital" (at the University of Iowa).

Ch. 225A. "Criminal Sexual Psychopaths".

Ch. 226.30. "Transfer of Dangerous Patients" (from MHI's to ISMF).

Ch. 229. "Commitment or Discharge of Mentally Ill Persons".

Ch. 246.16. "Transfer of Mentally Ill (From the Penitentiary at Fort Madison or Men's Reformatory at Anamosa). When the said state director (of the Division of Adult Corrections) has cause to believe that a prisoner in the penitentiary or reformatory is mentally ill, the department may cause such prisoners to be transferred to the Iowa Security Medical Facility for examination, diagnosis, or treatment. The prisoner shall be confined at such institution or a state hospital for the mentally ill until the expiration of his sentence or until he is pronounced in good mental health. If the prisoner is pronounced in good mental health before the expiration of his sentence, he shall be returned to the penitentiary or reformatory until the expiration of his sentence. The provisions of the Code applicable to an inmate at the correctional institution from which transferred shall be applicable during the inmate's stay at the Iowa Security Medical Facility. However, Sections 246.32 ("Enforcing Obedience to Orders") and 246.33 ("Insurrection") shall apply to the total inmate population, including both convicts and patients".

Ch. 246.17 "Discharge of Mentally Ill (From Ft. Madison or Anamosa). When the state director (of the Division of Adult Corrections) has reason to believe that a prisoner in the penitentiary or said reformatory, whose sentence has expired, is mentally ill, it shall cause examination to be made of such prisoners by competent physicians who shall certify to the state director whether such prisoner is in good mental health or mentally ill. The state director may make further investigation and if satisfied that he is mentally ill, he may cause him to be transferred to one of the hospitals for the mentally ill, or may order him to be confined in the Iowa Security Medical Facility".

APPENDIX C

Commission on Accreditation for Corrections, Inc., Manual of Standards for Adult Correctional Institutions, August, 1977, American Correctional Association.

4275 "Written policy and procedure govern the treatment of inmates with severe emotional disturbances". (Essential)

"DISCUSSION: Many emotionally disturbed inmates are prone to violent and destructive behavior and are oriented toward escape. While severely psychotic inmates should be transferred to state hospitals, less disturbed inmates should be retained in the general inmate population, where possible, and provided treatment programs that are supervised by competent mental health professionals and that utilize the least coercion necessary".

4276 "Where there are separate living units for inmates with severe emotional disturbances, an interdisciplinary team is assigned to these living units". (Essential)

"DISCUSSION: All staff members responsible for providing services in a living unit for emotionally disturbed inmates should be integrated into a multidisciplinary team and should be under the direction and supervision of a professionally trained staff member. Consistency in approach and treatment is essential for the emotionally disturbed inmate, and a team approach that includes regular meetings ensures that the treatment given these inmates is intensive, coordinated and direct".

4277 "Written policy specifies that appropriate facilities are available for inmates who are diagnosed by qualified psychiatrists or psychologists as severely psychotic".(Essential)

"DISCUSSION: Psychotic inmates should be transferred to mental health institutions. However, many state mental hospitals are becoming more open and are resisting the admission of disturbed inmates for whom secure housing is required. Partly in response to this, state correctional systems have begun to develop their own psychiatric facilities. Whatever system prevails, psychotic inmates should be transferred to a facility that can treat them effectively and assure public safety. These facilities must be under the supervision of mental health personnel and operated according to the standards and procedures of the psychiatric field".

4278 "Written policy and procedure specify that qualified psychological and psychiatric personnel provide services for inmates diagnosed as severely mentally retarded". (Essential)

"DISCUSSION: Severely mentally retarded inmates should be placed in facilities specially designed for their treatment. If they cannot be placed in such facilities outside the correctional institution, the institution should provide adequate services for their health, development and protection of their dignity. Where possible, programs should provide for their continued physical, intellectual, social and emotional growth and should encourage the development of skills, habits, and attitudes that are essential to adaptation to society".

4279 "Psychiatric consultation is available for the management and treatment of inmates with special needs". (Essential)

"DISCUSSION: A qualified psychiatrist should always be available to assist the trained mental health personnel who are responsible for the day-to-day management of inmates with special needs. Depending upon the size of the institution and the number and type of inmates classified as special needs inmates, the psychiatric services may range from one or more full-time staff psychiatrists to one part-time consulting psychiatrist. Whatever the arrangement, this service should be available 24 hours a day".

END