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CAGED OR CURED: CLASSIFICATION AND TREATMENT OF CALIFORNIA FELONS AT THE CALIFORNIA MEDICAL FACILITY

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This paper was prepared while the author was a senior at the University of California School of Law, in partial fulfillment of the requirements of a seminar on the administration of criminal justice. Mrs. Stahl received her LL.B. degree from the University of California in 1964.—EDITOR.

INTRODUCTION

Between the poles of opinion on what a prison should be, or rather whether there should be prisons or not, a *de facto* position must be taken by the legislature in the administration of the state penal system.¹ The position taken by the California legislature since the Prison Reorganization Act of 1944 represents perhaps the most satisfactory compromise of conflicting ideas in the administration of criminal justice after the door closes upon the sentenced felon.²

It is the purpose of this paper to describe and evaluate the operation of a unique institution within the California Department of Corrections—the California Medical Facility. Many of the programs conducted by the Staff are, of course, similar to those carried on at other institutions; however, by reason of the peculiar orientation of the staff and over-all purposes of the institution, apparent similarities often are fundamentally different.

No exposé of prison scandal and prisoner abuse is as dramatic as the revelation of the aims and methods of the new penology whereby the rehabilitation of society and the convicted felon is pursued by dedicated individuals within a frame-

work of treatment designed to effect a social cure from "within and without" the asocial member of society. The extent to which this philosophy of criminal law is applied to the correction of adult offenders at the California Medical Facility depends on the Staff, both medical and custodial, as well as the institutional facilities provided by the legislature. That such a significant beginning has been possible is an encouraging prospect for the future role of the behavioral sciences in the care and treatment of the convicted felon.

LOCATION AND INSTITUTIONAL BACKGROUND

Today, the California Medical Facility occupies approximately 908 acres of land just off Highway 40 midway between San Francisco and the State Capitol, about three miles from the City of Vacaville. Located within commuting distance of two major cities, the institution enjoys the benefits of communication with nearby universities and colleges for training and educational purposes as well as more attractive employment inducements and exchange of consultant services.³ At the same time, the relative remoteness of the location from heavily populated areas serves the purpose of avoiding public reaction to the proximity of an institution housing press-depicted "sex maniacs" and "mad dog killers."⁴

The institutional background may be conveniently traced to 1941⁵ when San Quentin was designated as a reception depot for men sentenced to imprisonment. A medical examination was made, and a series of intelligence, aptitude, and interest tests were conducted. Only if the prisoner appeared to be mentally ill was he examined by the prison psychiatrist. A brief social evaluation was

* The writer wishes to express her appreciation for the invaluable introduction by Dr. Winslow Rouse, Associate Superintendent, Reception-Guidance Center, California Medical Facility, to both the Reception-Guidance Center and the California Medical Facility as well as for his patient tutoring in the fundamentals of the behavioral science, applicable to the unique situation of a psychiatric prison hospital. The materials of this paper are the result of one semester's study as a Student Professional Assistant of the California Department of Corrections.

¹ According to Tannenbaum, "the less imprisonment, the better." Tannenbaum, *Foreword* to BARNES & TEETERS, *NEW HORIZONS IN CRIMINOLOGY*, at V (rev. ed. 1945). Or, the only possible future for the prisons is as a place for diagnosis and for beginning treatment." BARNES & TEETERS, *supra*, at 672. "Imprisonment . . . furthers rather than combats crime." REIWALD SOCIETY AND ITS CRIMINALS (1949).

² Cal. Stat. 3d Extra Sess. 1944, ch. 2, at 13.

³ Keating, *The California Medical Facility* 1 (undated, unnumbered mimeograph at California Medical Facility, Vacaville, California).

⁴ *Ibid.*

⁵ Cal. Stat. 1941, ch. 22, at 436.

prepared by an inmate clerk.⁶ By the Prison Reorganization Act of 1944,⁷ the legislature authorized the nascent Department of Corrections to provide facilities and personnel for "a scientific study of each prisoner, his career and life history, the cause of his criminal acts, and recommendations for his care, training, and employment with a view to his reformation and to the protection of society."⁸ The result was the first professionally staffed *diagnostic clinic* for prisoners at San Quentin. A clinical psychologist with a staff of trained case workers, vocational counselors, and clinical psychologists recruited through civil service examinations began operation.⁹ Such was the background of the Reception-Guidance Center which was re-located at Vacaville in 1957 in connection with the California Medical Facility.¹⁰

The California Medical Facility was authorized in 1945¹¹ to meet the need for specialized medical and psychiatric services which existing facilities of the Department of Corrections were unable to provide.¹² From its initial and inadequate quarters leased to the State by the Federal Government at Terminal Island, San Pedro, the Medical Facility was re-located in 1955 at Vacaville, California.¹³

PHYSICAL DESCRIPTION

Unlike the "fortress type" architecture at San Quentin and Folsom which reflects the penology of another era,¹⁴ the California Medical Facility has been built on the "telephone pole" plan, with living and working areas opening on a long, central corridor leading to a centrally located administration building.¹⁵ The Medical Facility utilizes seven three-story wings; the Reception-Guidance Center, the remaining three wings. A common administration building separates the two institutions, illustrating the duality of functions under the supervision of the Superintendent of the California Medical Facility. The advantages of this

design include: control of large numbers of inmates by a minimum number of custody officials, facility of communication between wings and administrative offices, avoidance of building to building travel with decreasing "yard" problems, and reduction of construction and maintenance costs. More significant, however, are the psychological advantages gained from the substitution of parallel fences surrounding the institution, thus permitting a greater feeling of freedom, yet still maintaining necessary security.¹⁶ Together with its wells, water tanks, sewage plant, rifle range, superintendent's residence, guest house, ball park and orchard, the California Medical Facility represents a \$20,000,000 investment for plant and equipment and a \$5,500,000 yearly budget, of which \$3,500,000 is payroll.¹⁷

The normal capacity of the hospital section is fourteen hundred.¹⁸ One unit contains three hundred beds for inmates assigned to assist in the maintenance of the institution. The remaining units in the hospital section are occupied by inmates transferred to the California Medical Facility for psychiatric observation, examination or treatment.¹⁹

Special facilities are provided for psychotics in "S" wing²⁰ and a segregation unit for prisoners requiring isolation from the general hospital population.

The general hospital population resides in "treatment units," each consisting of two or three housing units. A staff composed of a psychiatrist or physician, a psychologist, a social worker and selected custodial personnel, operates

⁶ Rouse, *The Problem of Adult Corrections: A Case Study of the State Penal Administration in California*, at 136, April, 1961 (unpublished doctoral thesis in Claremont Graduate School Library).

⁷ Cal. Stat. 3d Extra Sess. 1944, ch. 2, at 13.

⁸ CAL. PENAL CODE §5079.

⁹ Rouse, *op. cit. supra* note 6, at 139.

¹⁰ King, *Psychiatric Program of the California Medical Facility*, 2 JOURNAL OF SOCIAL THERAPY 245 (1956).

¹¹ CAL. PENAL CODE §6100.

¹² Showstack, *Preliminary Report on the Psychiatric Treatment of Prisoners at the California Medical Facility*, 1956 AM. J. PSYCH. 821.

¹³ King, *supra* note 10, at 245.

¹⁴ Rouse, *op. cit. supra* note 6, at 201.

¹⁵ *Id.* at 162.

¹⁶ Interview with Associate Superintendent, Reception-Guidance Center, at California Medical Facility, Vacaville, California, Nov. 22, 1963.

¹⁷ Interview with Business Manager, California Medical Facility, at California Medical Facility, Vacaville, California, Nov. 18, 1963. The estimated average cost per prisoner is \$2,000 per year.

¹⁸ Keating, *California Medical Facility*, 1, May, 1960 (unnumbered mimeograph at California Medical Facility, Vacaville, California).

¹⁹ *Ibid.*

²⁰ Eighteen "strip" cells, with Japanese toilet facilities, house psychotic patients who are fed on paper plates served through opening in the wall and exercised for one hour daily. On the lower floor, there are thirty-eight cells for less severe patients who engage in two hours of occupational therapy and two hours of exercises. These men have cots, outside windows, radio phones, and dine with inmates on the first floor. Greatest freedom is granted thirty-seven inmates confined on the first floor, including contacts with the general population. Transfers are made from floor to floor depending on patient's status. Interview and Tour with Custody Officer, California Medical Facility, Vacaville, California, Nov. 1, 1963.

as a treatment team and is responsible for observation and treatment of the unit's inmates. Closer cooperation between lay and professional personnel as well as more intimate contact with inmates has resulted from this decentralized, closely-knit team program, thus forming a therapeutic milieu in which treatment can be more effective.²¹

Medical, surgical, dental, and nursing services are provided by two units of the hospital section under the supervision of the Chief of Medical Services. These medical units contain operating and examining rooms and an electroencephalographic and neurological section, as well as facilities for continuous medical and nursing services for acutely ill, convalescent and chronic patients.²² The Chief of Medical Services is also responsible for a small Medical Clinic in the Guidance Center.²³ In 1959, the California Medical Facility was accredited by the Joint Commission on Accreditation of Hospitals.²⁴

As stated above, the hospital section is separate from the Reception-Guidance Center both by physical design and institutional function. The normal capacity of the Guidance Center is six hundred beds. Until classified, incoming prisoners are housed in a maximum security wing of the Guidance Center. Although connected to the hospital section by the central administrative building and served by common facilities such as the central kitchen, chapels, library, canteen, gymnasium and auditorium, maintenance shops and medical facilities, the inmates of the two institutions are normally kept separate.²⁵

In both the hospital section and Guidance Center the typical cell²⁶ contains one bed, desk and chair, shelf for toilet articles, clothing hooks, wash basin and toilet, and earphones for listening to the radio. Outside windows of thick glass have replaced the traditional bars, and steel doors with glass observation windows have displaced the "cage" gratings. Placement of pipes and heating apparatus between the walls renders these inaccessible to inmates as well as provides some aesthetic quality to the painted interior of the cell.

Each unit is served by its own cafeteria and inmates eat at four-man tables. This arrange-

ment is followed even in the maximum security area.²⁷

THE STAFF

The California Medical Facility is under the administrative supervision of the Superintendent who is appointed by the Director of Corrections and subject to civil service.²⁸ The present Superintendent, William C. Keating, Jr., M.D., is a graduate of the Menninger Foundation School of Psychiatric Hospital Administration and was formerly Associate Superintendent at California's Sonoma State Hospital for eleven years prior to his present appointment.²⁹

The Superintendent is assisted by the Associate Superintendent, Psychiatric Services, a psychiatrist, who is responsible for the psychiatric treatment program, including the recruitment and training of psychiatrists and psychotherapists, occupational therapy and other psychiatric services. The Chief Medical Officer, a physician, is responsible for the organization and operation of medical, surgical, dental, laboratory, pharmaceutical and nursing services. An Associate Superintendent, Correctional Institution, administers the custodial program as well as supervises educational and vocational training programs, inmate recreation and craft programs, religious services and other ancillary services. The Business Manager is responsible for the business services of both institutions, including personnel, purchasing, budgeting, accounting, maintenance, and records concerned with institutional operation.³⁰

The Associate Superintendent, Reception-Guidance Center, is responsible to the Superintendent for the administration and supervision of the Northern Reception-Guidance Center, including the reception, diagnostic classification, and assignment of sentenced felons³¹ to other institutions within the Department of Corrections, and the recruitment, training, and supervision of the clinical and clerical staff of the Center as

²⁷ *Ibid.*

²⁸ CAL. PENAL CODE §6105.

²⁹ Dr. Keating's experience in the Department of Mental Hygiene has no doubt produced a notable influence in the administration of the California Medical Facility, particularly in the emphasis given treatment programs over the more rigid custodial orientation characteristic of other penal institutions.

³⁰ Keating, *op. cit. supra* note 3, at 2.

³¹ The Reception-Guidance Center, pursuant to CAL. PENAL CODE §1203.03, also provides diagnostic services to California Superior Courts prior to the sentencing and final disposition of felony cases.

²¹ Keating, *op. cit. supra* note 3, at 3.

²² *Ibid.*

²³ *Ibid.*

²⁴ *Id.* at 1.

²⁵ Keating, *op. cit. supra* note 18, at 1.

²⁶ Rouse, *op. cit. supra* note 6, 148.

well as of the custodial, maintenance, record-keeping and budgeting activities directly concerned with that operation.³²

The total staff of both units, including treatment, administrative, and custody personnel, exceeds four hundred civil servants.³³ Members of the treatment staff include psychiatrists, psychologists, physicians, clinical psychologists, and case workers. Individuals frequently perform services in both institutions, e.g., members of the Clinical Staff of the Reception-Guidance Center conduct psychotherapy in the hospital section,³⁴ and medical, surgical, dental, and nursing personnel assist in the operation of the Guidance Center. Full time Protestant and Catholic Chaplains, and a part-time Jewish Rabbi provide religious services.³⁵ It is notable that all personnel attached to the institution, with minor exceptions, are civil service and receive instruction in the In-Service Training Program.³⁶

RECEPTION-GUIDANCE CENTER

The importance of the functions performed by the Reception-Guidance Center becomes evident from the following considerations: (1) the Guidance Center may be the prisoner's first contact with State penal institutions, and the orientation adopted by him determines in a significant measure whether his participation in rehabilitative programs will be constructive or otherwise;³⁷ (2) the classification by the Center on the basis of the Cumulative Case Summary initiated by its staff provides the principle source of information for the correctional program pursued by the Department of Corrections while the individual is within its jurisdiction;³⁸ and (3) court decisions as to the propriety of imprisonment or some other form of sentence in cases of convicted but unsentenced felons referred to the Guidance Center are signifi-

cantly influenced by the Center's reports and recommendations.³⁹

The Northern Reception-Guidance Center is the largest reception center for male prisoners and is the only one attached to a psychiatric hospital.⁴⁰ It "receives and processes all adult male prisoners from the forty-seven northern counties of the State and all parole violators returned to prison from anywhere in California, or elsewhere."⁴¹ In addition, the Center provides diagnostic studies for certain wards of the Youth Authority, Department of Mental Hygiene cases transferred to the Department of Corrections for care, and Federal prisoners or prisoners from other states committed under agreement with the State of California.⁴²

Intake for new arrivals in the Guidance Center ends on each Thursday at noon. Initially, all arrivals are processed in the Receiving and Release Room as follows: (1) Receiving Sergeant's Speech, (2) Preliminary Physical Examination, (3) Body Search, (4) Taking of Height, Weight, and Clothing Sizes, (5) Processing of Personal Property, (6) Completion of Personal History Form, (7) Fingerprinting, (8) Showers, Shaves, and Haircuts, (9) Dressing Out, (10) Photographs, and (11) Housing Assignment.⁴³ On the following day, the Intake Supervisor orients the new arrivals to the Center specifically and the Department of Corrections in general.⁴⁴ The initial psychological testing is completed during orientation, and forms are completed preparatory to interviews with sociologists.⁴⁵

Well equipped recreational facilities exist for softball, basketball, handball, weight lifting, horseshoes, and shuffleboard. Professionally trained civil service directors supervise these activities. Each housing unit contains television sets and facilities for reading and playing table games. Under the supervision of the institution librarian, inmates are provided with books, papers, and magazines. A small legal library is available for inmate use. Each cell has headphones which

³² Keating, *op. cit. supra* note 3, at 2. It should be pointed out, however, that the assignments to other institutions are based upon a review by the Director of Corrections through a delegated staff representative.

³³ Keating, *op. cit. supra* note 18, at 2. It is also notable that women are employed in positions consonant with security. Such represents a significant innovation in employment within penal institutions in view of the attempts to keep inmates in a reality situation.

³⁴ Keating, *op. cit. supra* note 3, at 5.

³⁵ Keating, *op. cit. supra* note 18, at 7.

³⁶ *Id.* at 2.

³⁷ TAPPAN, CONTEMPORARY CORRECTION 94 (1951).

³⁸ CALIFORNIA DEPARTMENT OF CORRECTIONS, MANUAL OF CLINICAL PROCESSING PROCEDURES OF THE RECEPTION-GUIDANCE CENTER NORTHERN BRANCH ¶100.03 (April, 1959).

³⁹ CAL. PENAL CODE §1203.03; Braithwaite & Rouse, *The Use of Department of Corrections Reception-Guidance Center Diagnostic Services By California Superior Courts Under Section 1203.03 P.C. From January 1957 to January 1, 1963* (undated, unnumbered mimeograph at California Medical Facility, Vacaville, California).

⁴⁰ Keating, *op. cit. supra* note 3, at 4.

⁴¹ Rouse, *op. cit. supra* note 6, at 140.

⁴² Keating, *op. cit. supra* note 3, at 4.

⁴³ CALIFORNIA DEPARTMENT OF CORRECTIONS, *op. cit. supra* note 38, ¶300.01.

⁴⁴ *Id.* at ¶300.02.

⁴⁵ *Id.* at ¶300.021.

carry two radio programs.⁴⁶ Religious counseling services are also provided. Mail censorship occurs where deemed necessary.⁴⁷

During the period inmates are undergoing clinical study, they participate in group counseling sessions.⁴⁸ In view of the fact that "most inmates enter the institution with fears, resentment, misconceptions, and frustrations,"⁴⁹ resulting from feelings that they were "treated unfairly by police, prosecuting attorneys, or the courts,"⁵⁰ it is not surprising that "persons who are preoccupied . . . are not in a frame of mind to enter upon a program of self-improvement."⁵¹ To meet this situation, the Guidance Center has utilized group sessions in which new inmates are encouraged to discuss their problems.

Other activities are carried on during the ninety-day period⁵² which bear an informational relationship to the clinical studies conducted and to the preparation of the Admission Summary which forms a major part of the Cumulative Case Summary. The Cumulative Case Summary, required by Penal Code §5079, contains the clinical data and evaluation made by the Guidance Center Staff⁵³ and forms a repository for subsequent information relative to the individual's progress within the Department of Corrections, including parole.⁵⁴

This summary is utilized by the Guidance Center in determining the institution to which the individual is to be transferred,⁵⁵ by the Classification Committee at the institution where the individual will serve his term,⁵⁶ by the Adult Authority when the individual comes up for parole,⁵⁷ by the Division of Adult Paroles in helping the individual to make a successful adjustment to the general community,⁵⁸ and by the Director of the Department of Corrections and his staff as a source of information when inquiries are re-

ceived from social agencies, prison and parole agencies outside of California, and for research purposes.⁵⁹

The Admission Summary is an individual case study prepared by the Guidance Center Staff and partly consists of a description of the offense, legal data relating to it, the arrest record, personal history, and brief diagnostic evaluations by members of the clinical staff which are based on personal interviews and examinations.⁶⁰ Further evaluations are included: (1) social evaluation, (2) vocational evaluation, (3) vocational shop evaluation, (4) psychological evaluation, (5) psychiatric evaluation, (6) group adjustment evaluation, (7) medical and dental examinations and evaluation, (8) recreation evaluation, and (9) custodial evaluation.

Each category requires some remarks as to its composition: "*Social Evaluation* included in the Admission Summary and written by the case worker contains significant information on the complex of social, cultural, and psychological factors in the prisoner's life which have contributed to his problems."⁶¹ The social worker also helps the inmate with any immediate social problems.⁶²

"*Vocational Evaluation* is also based on personal interviews and examination and is prepared by the case worker. It contains the inmate's work history, special interests, and preferences,"⁶³ as well as provides information on proficiency and skills.⁶⁴

Vocational Shop Evaluation: A trained civil service shop supervisor tests the inmate on projects in woodworking, metal working, electricity, etc., as well as manual dexterity tests.⁶⁵

Psychological Evaluation: Several days of group psychological testing is conducted by staff clinical psychologists and later evaluated in connection with a personal interview to provide a report of the prisoner's intellectual functioning and an analysis of significant symptoms of intellectual impairment, if any, as well as of the prisoner's general emotional adjustment or mental problems

⁴⁶ Rouse, *op. cit. supra* note 6, at 147.

⁴⁷ CALIFORNIA DEPARTMENT OF CORRECTIONS, *op. cit. supra* note 38, at ¶420.12.

⁴⁸ Keating, *op. cit. supra* note 18, at 3.

⁴⁹ TAPPAN, *op. cit. supra* note 37, at 94.

⁵⁰ *Ibid.*

⁵¹ *Ibid.*

⁵² Keating, *The California Medical Facility* 4 (undated, unnumbered mimeograph at California Medical Facility, Vacaville, California).

⁵³ CALIFORNIA DEPARTMENT OF CORRECTIONS, *op. cit. supra* note 38, ¶100.08.

⁵⁴ *Id.* ¶100.03.

⁵⁵ *Id.* ¶100.02.

⁵⁶ *Id.* ¶100.04.

⁵⁷ *Id.* ¶100.05.

⁵⁸ *Id.* ¶100.06.

⁵⁹ *Id.* ¶100.07.

⁶⁰ *Id.* ¶120.02.

⁶¹ *Id.* ¶120.03.

⁶² Rouse, *The Problem of Adult Corrections: A Case Study of State Penal Administration in California*, 141 April, 1961 (unpublished doctoral thesis in Claremont Graduate School Library).

⁶³ *Id.* at 142.

⁶⁴ CALIFORNIA DEPARTMENT OF CORRECTIONS, *op. cit. supra* note 38, ¶120.04.

⁶⁵ *Id.* ¶120.05.

and a prognosis, including comments on treatment potential and motivation.⁶⁶

*Psychiatric Evaluation.*⁶⁷ Where prisoners have been committed for crimes involving aggression or violence, unusual sexual behavior or arson, as well as when a prisoner is found to have a history of mental illness, written psychiatric evaluations are required and include "formal diagnosis, discussion of pertinent dynamics, and recommendations for psychiatric care, management, and treatment."⁶⁸

*Group Adjustment Evaluation.*⁶⁹ Group counseling (not group therapy, which will be discussed *infra*) sessions conducted twice weekly for one hour are commented on by the group leader, usually a case worker, with reference to the individual's understanding of the diagnostic process and insight into his problems, and included in the summary.⁷⁰

*Medical and Dental Examination and Evaluation.*⁷¹ Within the first week, each man is examined and tested by the medical and dental staff. Medical histories are obtained to assist in present and subsequent medical problems as well as provide information relative to proper institutional assignment.⁷²

*Recreation Evaluation.*⁷³ Where the inmate participates in the Center's recreational program, pertinent information as to physical fitness and personal and social adjustment are reported by the Supervisor of Recreation.⁷⁴

Custodial Evaluation. Factual reports as to personal habits, attitude, associations, etc., by Wing Custodial Officials are summarized by Watch Lieutenants and approved by the Custodial Captain.⁷⁵

"The Reception-Guidance Center Staff recommendation . . . completes the initial case summary."⁷⁶ Its purpose is to centralize and synthesize staff recommendations. "On completion of

the case study, each inmate is transferred to an appropriate institution in the Department. Transfer recommendations are made by the Reception-Guidance Center Staff on the basis of the history and problem of the inmate and Departmental policies."⁷⁷

Classification has been completed, at least, in its early phase; however, "the treatment program must be kept current with inmate's changing needs. The major objectives of classification are the development of an integrated and realistic program for the individual, arrived at through the coordination of diagnostic, planning, and treatment activities; and an informed continuity in these activities from the time of commitment until release."⁷⁸

"Another feature (of the Reception-Guidance Center) is psychiatric and medical diagnosis of convicted felons from the various counties prior to sentencing."⁷⁹ Under Penal Code §1203.03, these men are received for ninety days' study and evaluation, then returned to the courts with recommendations as to disposition.

Although the legislature acted in 1957, "the first case was not received until April 30, 1959 and from that time to December 31, 1962, a total of only 62 men have been received and returned to court for disposition."⁸⁰ These men were processed by the Reception-Guidance Center in the manner previously outlined. It was found that the "characteristics of (the) men referred for diagnosis by the court were essentially the same as those of the general prison population,"⁸¹ however, "the percentage of offenders with organic brain damage, mental deficiency, and intellectual deterioration was higher than that of the average prison population."⁸² The fact that a complete neurological study was done in every case, including an electroencephalographic examination, skull X-rays and pneumoencephalograms and arteriograms where indicated⁸³ probably accounts for such a finding and indicates that the incidence

⁶⁶ *Id.* ¶120.06; Rouse, *op. cit. supra* note 62, at 143.

⁶⁷ CALIFORNIA DEPARTMENT OF CORRECTIONS, *op. cit. supra* note 38, ¶120.07.

⁶⁸ Rouse, *op. cit. supra* note 62, at 144.

⁶⁹ CALIFORNIA DEPARTMENT OF CORRECTIONS, *op. cit. supra* note 38, ¶120.08.

⁷⁰ Rouse, *op. cit. supra* note 62, at 144.

⁷¹ CALIFORNIA DEPARTMENT OF CORRECTIONS, *op. cit. supra* note 38, ¶210.02, 210.03.

⁷² Rouse, *op. cit. supra* note 62, at 145.

⁷³ CALIFORNIA DEPARTMENT OF CORRECTIONS, *op. cit. supra* note 38, ¶120.09.

⁷⁴ Rouse, *op. cit. supra* note 62, at 145.

⁷⁵ CALIFORNIA DEPARTMENT OF CORRECTIONS, *op. cit. supra* note 38, ¶120.10.

⁷⁶ *Id.* ¶120.11.

⁷⁷ Keating, *op. cit. supra* note 18, at 3.

⁷⁸ TAPPAN, *op. cit. supra* note 37, at 92.

⁷⁹ [1959-1960] CAL. DEPT. OF CORRECTIONS BIENNIAL REP. 47.

⁸⁰ Braithwaite & Rouse, *The Use of Department of Corrections Reception-Guidance Center Diagnostic Services By California Superior Courts Under Section 1203.03 P.C. From 1957 to January 1, 1963* at 2 (undated, unnumbered mimeograph at California Medical Facility, Vacaville, California).

⁸¹ *Id.* at 3.

⁸² *Ibid.*

⁸³ *Ibid.*

of organic brain damage in the general prison population is higher than has been noted.⁸⁴ "While only one man was found to be overtly psychotic, several were considered to be borderline psychotics."⁸⁵

Of the thirty-one cases where probation was recommended, twenty-eight were granted probation by the courts.⁸⁶ Where probation was not recommended by the Guidance Center, this recommendation was followed in twenty-three cases while eight were granted probation. Of those eight, one was still serving a conditional jail sentence at the end of the period covered by the study and another absconded. The remaining six were apparently making a satisfactory adjustment.⁸⁷ As to those granted probation, at the end of the study, three had successfully completed probation, while three men had violated probation by committing additional misdemeanors but were still under probationary supervision, and four men (11% of the total granted probation) had their probation revoked. "This revocation rate is significantly lower than that of other adults who failed on probation in California during the same period (26.5%)."⁸⁸

The average annual cost for the supervision and care of a prisoner in a state penal institution is \$1,800. The median term is thirty months. Of the thirty-six men who were granted probation, four had their probation revoked. One was still serving a jail term. If the thirty-one others had served the median term, the cost to the State would have been \$138,500. The annual cost of probationary supervision is \$300 and would require an expenditure of \$23,250. The resultant saving to the taxpayers has been \$115,250. It is further pointed out that where probation was granted, the man was enabled to continue the support of his family and there was no necessity for them to be supported at public expense.⁸⁹

During the period covered by the study, the counties were charged \$79.90 for the diagnostic summary plus \$3.69 per day for institutional care. The total cost to the county for a ninety-day study would be \$414.00. The average time of processing was seventy-one days, thereby reducing the cost to \$341.89.⁹⁰ At the last session of the

legislature, a two year moratorium was declared so that the county no longer pays.⁹¹

Since January 1, 1963, until October 1, when the moratorium became effective, approximately eight cases per month were received. Since October 1st, the cases have increased to approximately twenty-five per month.⁹²

THE CALIFORNIA MEDICAL FACILITY

According to Penal Code §6102, the "primary purpose of the Medical Facility shall be the receiving, segregation, confinement, treatment, and care of males under the custody of the Department of Corrections." This includes those who are "either 1. Mentally ill, or 2. Mentally defective, or 3. Epileptic, or 4. Addicted to the use of narcotics, or 5. Otherwise physically or mentally abnormal, including, but not limited to psychotics and sex offenders, or 6. Suffering from any chronic disease or condition."⁹³ The transfer of mentally ill and seriously disturbed prisoners to state hospitals became undesirable in view of the decreasing security and custody features of the hospitals which had developed into "open institutions." To meet the need for a centrally located institution within the Department of Corrections, the Medical Facility was established.⁹⁴

Most of the patients are adult male prisoners; however, the institution "also provides treatment for a small number of male California Youth Authority wards, a few male wards of the Department of Mental Hygiene, and, on occasion, male prisoners placed at the institution for observation, diagnosis, or treatment by Federal courts or contracting states."⁹⁵ Tubercular males who have refused to accept treatment in their communities and therefore convicted of misdemeanors are also at the Medical Facility.⁹⁶

The transfer of tubercular cases and acutely disturbed mental cases to the California Medical Facility is immediately intelligible in view of the Penal Code provision; however, the transfer of other classes of prisoners requires some analysis of the policies⁹⁷ governing the Reception-Guidance

⁸⁴ *Ibid.*

⁸⁵ *Ibid.*

⁸⁶ *Id.* at 2.

⁸⁷ *Ibid.*

⁸⁸ *Ibid.*

⁸⁹ Braithwaite & Rouse, *op. cit. supra* note 80, at 5.

⁹⁰ *Id.* at 4.

⁹¹ CAL. PENAL CODE §1203.03 (h).

⁹² Interview with Associate Superintendent, Reception-Guidance Center, at California Medical Facility, Vacaville, California, on Dec. 30, 1963.

⁹³ CAL. PENAL CODE §6102.

⁹⁴ Keating, *op. cit. supra* note 62, at 1.

⁹⁵ *Id.* at 3.

⁹⁶ *Ibid.*

⁹⁷ CALIFORNIA DEPARTMENT OF CORRECTIONS, *Man-*

Center's transfer of individuals to the Medical Facility. All psychotic inmates diagnosed by the medical staff as psychotic and in need of in-patient care as well as inmates with a diagnosis of psychosis in remission are transferred to the Medical Facility; consideration being given to space available.⁹⁸ Further, those inmates requiring segregation because of pronounced feminine sexual behavior patterns, who are not psychotic but constitute serious institutional management problems, are also transferred to the Medical Facility, as well as inmates with histories of sex offenses and those whose offenses were characterized by disturbances involving sexual motivation.⁹⁹ And finally, those inmates, who, in the opinion of the Guidance Center staff, are especially good candidates for intensive psychiatric treatment, especially to include those with treatable emotional and personality trait disturbances, are transferred to the Medical Facility.¹⁰⁰

California Medical Facility Classification Committee. Upon transfer to the Medical Facility, each inmate appears before the institutional Classification Committee, composed of eight top administrative and clinical personnel, headed by the Superintendent, who review his case and assign the individual to work or occupational therapy, housing quarters, academic and vocational classes.¹⁰¹ The inmate is given an opportunity to ask questions and state his preferences and reasons. After the interview is completed, the Board discusses his disposition, votes on assignment, and makes appropriate entries in the inmate's Cumulative Case Summary.

Each inmate's case is reviewed within sixty days from the time of his initial classification and at least once a year.¹⁰² Any transfer in treatment or work within the institution is reviewed by the Committee as well as requests or recommendations for transfer to another institution.¹⁰³

One of the objectives of the Committee is to secure the inmate's cooperation in the program

to which he is assigned.¹⁰⁴ Patients are encouraged to participate in group therapy.¹⁰⁵ "The Committee is also responsible for the preparation of inmates for release and for the proper co-ordination of the activities of the institution and the Division of Adult Paroles regarding inmate release programs."¹⁰⁶

Clinical Services. "The hub of the treatment program at the Medical Facility is the clinical services offered. It is the orientation of all activities around the clinical services which has made for the unique hospital atmosphere of the prison."¹⁰⁷ The principal method of treatment is group psychotherapy, as it has been since 1951.¹⁰⁸

Group psychotherapy should be distinguished from group counseling¹⁰⁹ already described in connection with the Reception-Guidance Center. Since 1960, group counseling has been utilized at the Medical Facility for men assigned to institutional maintenance and not at the institution primarily for treatment.¹¹⁰ Group counseling is conducted by lay personnel and deals primarily with reality situations.¹¹¹ One of the objectives is to contribute to the safe confinement and smooth operation of the prison as well as to the rehabilitation efforts.¹¹² Custodial personnel act as group leaders with the result that the custody officials become more familiar and sympathetic with inmate problems and inmates recognize that cus-

¹⁰⁴ *Id.* at 152.

¹⁰⁵ Keating, *op. cit.* *supra* note 101, at 5.

¹⁰⁶ Rouse, *op. cit.* *supra* note 102, at 152.

¹⁰⁷ Keating, *op. cit.* *supra* note 101, at 5.

¹⁰⁸ Ernst & Keating, *Psychiatric Treatment of The California Felon* at 4 (undated, unnumbered typed material at California Medical Facility, Vacaville, California).

¹⁰⁹ "Group counseling in California prisons began somewhat spontaneously in the Reception-Guidance Center at San Quentin in 1955. As a part of the reception process, instructors from local school districts were employed to teach academic subjects so that the newly admitted prisoners would be immediately involved in an educational process. Within a few months it was noted that inmates preferred to use class time to talk about their problems, and as a result the classes were soon converted into discussion groups. In group meetings the newly committed men were able to channel their initial anxiety in an acceptable way. The groups were found to be extremely useful in helping men to understand the purposes of the program and in reducing tension." Rouse, *op. cit.* *supra* note 62, at 220.

¹¹⁰ Rouse, *op. cit.* *supra* note 102, at 221.

¹¹¹ *Id.* at 226.

¹¹² Harrison, *Mental Health Applications in California Correctional System* at 7, May 24, 1960 (mimeograph at California Medical Facility, Vacaville, California).

ual of Clinical Processing Procedures of the Reception-Guidance Center Northern Branch ¶160.04 (April, 1959).

⁹⁸ *Ibid.*

⁹⁹ *Ibid.*

¹⁰⁰ *Ibid.*

¹⁰¹ Keating, *California Medical Facility* at 5, May, 1960, (unnumbered mimeograph at California Medical Facility, Vacaville, California).

¹⁰² Rouse, *The Problem of Adult Corrections: A Case Study of State Penal Administration in California* at 152, April, 1961, (unpublished doctoral thesis in Claremont Graduate School Library).

¹⁰³ *Id.* at 153.

tody officials are more than just "watchdogs" at the institution.¹¹³

Group psychotherapy,¹¹⁴ on the other hand, is handled by professionally trained personnel who utilize professional techniques¹¹⁵ to effect therapy "in depth." This more intensive treatment is designed for the mentally ill or disturbed individual whose problems often originate in faulty family or social relationships experienced in early life. Groups of ten to twelve men discuss their problems under the guidance of a leader who fills the role of a parent while the group members react as family members. The objectives include greater understanding by inmates of their problems, tolerance for the problems of others, acceptance of authority as something not necessarily hostile or punitive, the substitution of wholesome attitudes and relationships for the unhealthy ones

¹¹³ Rouse, *op. cit. supra* note 102, at 250.

¹¹⁴ "Group psychotherapy is almost fifty years old. In 1905, Dr. Joseph Pratt started doing group therapy with patients at the Boston Dispensary, which is now part of the New England Medical Center. Every Saturday morning he would get a group of neurotic women together to discuss their mutual problems. . . . In it the women relate their various symptoms and other difficulties and compare notes. World War II gave great impetus to the group psychotherapy program because literally millions of soldiers developed neuropsychiatric disturbances, and since there were not enough therapists to treat them all individually, they were treated in groups. The same problems exist now in institutions and clinics throughout the country. The only practical way to give as many patients as much treatment as possible, therefore, is to treat them in groups." Showstack, *Group Psychotherapy at the California Medical Facility*, May, 1952 (mimeograph at California Medical Facility, Vacaville, California).

¹¹⁵ "For the past two years the concepts and principles of transactional analysis and game analysis have been applied to the handling of my groups, both within the Medical Facility and elsewhere. Transactional analysis, as described by Eric Berne, takes as its premise that the personality structure can be understood in terms of its functional and phenomenological qualities: the *adult* is the thinking, logical, objectively oriented person; the *child* is the portion of the personality behaving in a manner similar or identical to the way the person handled living situations in actual childhood, controlled by and adapted to factors operative in this earlier (dependent) developmental time of life; and, third, there is the option of operating in the fashion of a *parent*—a parent being one who determines what and how psychological and physical nourishment will be dispensed as well as what will be prohibited and how prohibition will be effected. Parents define good and bad, what should be said and done and what should not be listened to or looked at. This portion of the psyche has been borrowed from older, physically developed, *real* individuals who determine the emotional environment of childhood." Ernst, *Use of Transactional Analysis in Prison Therapy Groups*, 8 CORRECTIVE PSYCHIATRY AND JOURNAL OF SOCIAL THERAPY at 121 (1962).

created by destructive and traumatic experiences in early life, and the acceptable discharge of tensions and anxieties before they reach an explosive point.¹¹⁶

Many of the aims and methods of the group psychotherapist and group counselor are similar, if not identical in some instances, and according to some, there is probably no conclusive functional or operative dividing line between the two.¹¹⁷

There are thirty-nine group counseling classes in operation among workers alone, and ninety psychotherapy groups meet once or twice a week for one and a half hour sessions.¹¹⁸ Patients usually stay with one psychotherapist. Group assignment relative to crime and psychiatric symptomology is preferably heterogeneous.¹¹⁹ The average patient spends about eighteen months in such groups.¹²⁰ Attendance is voluntary; however, both by reason of the Adult Authority's consideration of the participation in group session as an indication of the prisoner's cooperation with the rehabilitative program¹²¹ and the Medical Facility's policy of transferring non-participating inmates to other institutions in order to utilize the "chair" for more cooperative inmates, attendance is, in a sense, obligatory.¹²²

There is also individual psychiatric care; however, this is necessarily limited due to the number of psychiatrists and the number of patients as well as the demands on the psychiatrists by the group program.

Stress Assessment Unit. The Stress Assessment Unit was "created in order to evaluate inmates considered for release by the Adult Authority."¹²³ Although many factors are involved in the Stress Assessment Unit placement, one of the major factors is the violence potential in the inmate's background either in the offense or institutional behavior.¹²⁴

Archives Unit. The Department of Corrections also maintains an Archives Unit at the Medical Facility under the administrative supervision of the institution's Business Manager. Composed

¹¹⁶ Rouse, *op. cit. supra* note 102, at 226.

¹¹⁷ *Ibid.*

¹¹⁸ [1959-1960] CAL. DEPT. OF CORRECTIONS BIENNIAL REP. 48.

¹¹⁹ Ernst & Keating, *op. cit. supra* note 108, at 5.

¹²⁰ *Ibid.*

¹²¹ Rouse, *op. cit. supra* note 102, at 250.

¹²² Ernst & Keating, *op. cit. supra* note 108, at 4.

¹²³ Van Bortel, *Ice Unit*, CALIFORNIA MEDICAL FACILITY EMPLOYEE'S NEWSLETTER at 4 (Nov. 1963).

¹²⁴ *Id.* at 5.

of two units (Discharge and Certification, and Identification), it functions to provide information requested by superior courts, law enforcement agencies, welfare agencies, the Adult Authority, other institutions, and the general public pertaining to the records of all inmates, both present and those within the Department of Corrections back to 1851.¹²⁵ However, medical, psychiatric, and certain other information is treated as confidential and is not available to the general public.

Research. The Department of Corrections initiated research programs at the California Medical Facility in July 1958 designed to investigate areas of new treatment approach.¹²⁶ The Department's Data Processing Center, located at the Medical Facility, carries on research into parole and narcotics treatment.¹²⁷ Currently, a pilot study is being conducted in an attempt to establish a "Base Expectancy" for particular classes of inmates and to evaluate the effects of psychotherapy treatment on prospective parolees by setting up "control groups" who receive therapy to be compared with groups of similar classification who do not undergo therapy.¹²⁸

Other studies are connected with California universities and colleges, some of which are financed by private grants from research foundations and Federal funds. The feasibility of developing liquid diets for astronauts, for example, is presently being tested on volunteer inmates in cooperation with the University of California Medical School and the Federal National Aeronautics and Space Agency.¹²⁹

In-Service Training. One authority divides the prison staff into two groups: (1) the custody staff, "consisting of guards and their supervisory officer,"¹³⁰ and (2) "the rehabilitative and reformative personnel, including medical, psychiatric, and psychological services, educators, recreational and guidance directors, chaplains, and industrial supervisors."¹³¹ The Medical Facility, however, "does not consider its staff as

business, professional, and custodial but conceives of its employees as a single staff, consisting of specialists in the various functions of operation."¹³²

"The maintenance of such a therapeutically oriented staff demands that every employee understand something about and give his support to the work of each other specialist."¹³³ Training is continuous and is essential in connection with efforts to instill proper motivation and provide encouragement toward self-improvement on the part of the inmate population.¹³⁴

All employees are involved in in-service training which is designed to provide: (1) *knowledge* of the objectives of the Department of Corrections and the Medical Facility, including new developments in the behavioral and medical sciences, as well as the dynamics of human behavior and relationships; (2) *understanding* and the ability to analyze and interpret facts and form valid judgments concerning them, accomplished through discussion, panel groups, research assignments, etc.; (3) *attitudes* appropriate to the maintenance of a therapeutic climate in which treatment may be enthusiastically pursued by employees and accepted by inmates; and *skills* by which the knowledge and understanding gained may be applied.¹³⁵

In general,¹³⁶ the training program includes the use of lectures, seminars, demonstrations and films, and covers laws and rules of civil service, retirement, legal responsibilities, concepts of crime and treatment methods, penal history, the correctional program of the State and characteristics of inmates.¹³⁷ Under regulations of the Department, each new employee is required to attend fifty-three hours of in-service training during the first year and a minimum of eighteen hours each succeeding year.¹³⁸

The Associate Superintendent, Psychiatric Services, is responsible for the training of all psychotherapists. Weekly seminars are scheduled during which cases of inmates with special psychiatric problems are presented and discussed by the staff. Panel discussions, lectures, films, and reviews of

¹²⁵ Seymour, *Archives Unit*, CALIFORNIA MEDICAL FACILITY EMPLOYEE'S NEWSLETTER at 4 (Nov. 1963).

¹²⁶ [1959-1960] CAL. DEPT. OF CORRECTIONS BIENNIAL REP. 47.

¹²⁷ Rouse, *op. cit. supra* note 102, at 287.

¹²⁸ Interview with Staff Psychiatrist, California Medical Facility at California Medical Facility, Vacaville, California on Nov. 11, 1963.

¹²⁹ Keating, *The California Medical Facility* at 5 (undated, unnumbered mimeograph at California Medical Facility, Vacaville, California).

¹³⁰ TAPPAN, CONTEMPORARY CORRECTION at 158 (1951).

¹³¹ *Ibid.*

¹³² Keating, *op. cit. supra* note 101, at 8.

¹³³ *Ibid.*

¹³⁴ *Id.* at 9.

¹³⁵ *Id.* at 8, 9.

¹³⁶ For a sample schedule of In-Service training carried on at the California Medical Facility, consult Appendix I, *infra*.

¹³⁷ Rouse, *op. cit. supra* note 102, at 109, 110.

¹³⁸ Keating, *The California Medical Facility* at 5 (undated, unnumbered mimeograph at California Medical Facility, Vacaville, California).

books and journal articles on current developments in psychiatry are also presented.¹³⁹

The In-Service Training Officer supervises the program for custodial, clerical, and other classes of employees, which include study of custodial procedures, Departmental policies and regulations, and some phases of the clinical program.¹⁴⁰ More specialized training is provided custody personnel in self-defense methods, use of firearms and gas equipment, and physical fitness.¹⁴¹ Further, actual participation of custodial personnel in group counseling sessions serves an important function in their training as well as contributes to the break-down of barriers between custody officials and the inmate population.

In addition to In-Service Training conducted by the institution, employees are encouraged to further their educations by courses at nearby universities and colleges and by extension courses which may be conducted at the institution.¹⁴²

Also, through formal agreements with educational institutions, such as the University of California, undergraduate and graduate students receive credit for field work at the Medical Facility where they obtain practical experience as a type of "internship" which frequently leads to their employment by the Department of Corrections.¹⁴³

Educational Services. The California Medical Facility has a program of vocational and academic education consisting of elementary, high school, and college instruction. "Approximately fifty per cent of the patients are enrolled in school either half-time or full-time."¹⁴⁴ Inmates are instructed by accredited instructors from the Vacaville Union High School and receive their diplomas from that school.¹⁴⁵

Recreation. Under the direction of a professionally trained supervisor, inmates participate in intra-mural contests. Emphasis is placed on sports as a constructive use of leisure time, maintenance of physical fitness, a method of teaching

tolerance and respect for the rights of others, and as an opportunity to release pent-up energies and hostilities incident to their backgrounds and institutional confinement.¹⁴⁶

Arts and Crafts. Inmates participate in a program designed to provide an outlet for creative skills in the area of arts and crafts. A well equipped hobby shop is in operation, the costs of which are defrayed by sales made to employees of the institution and members of the general public at the Arts and Crafts Store in the main administration building. Ten per cent of the sales price is deducted and placed in a revolving "inmate welfare fund."¹⁴⁷ Two Art Shows are held annually and have achieved such prominence within the State that coverage is afforded by Sacramento and San Francisco newspapers and television stations as well as by local reporting agencies and serves to attract members of the general public from all parts of the State to view and purchase the significant work of the institution's artist-inmates. Because of the increased market at such shows, twenty-five per cent is deducted from the sales to boost the inmate welfare fund.

Adjustment Committee. Disciplinary problems are handled by the Adjustment Committee which serves functions similar to the Disciplinary Committees existing at other penal institutions. The difference in name is descriptive of the peculiar orientation of this Committee at a psychiatric prison hospital. It must be determined that the inmate appearing before the Committee is "in touch with reality" before any sanctions such as isolation are imposed. The maximum term of isolation is thirty days, as at other institutions within the Department, however, the isolation does not include the traditional "strip cell" treatment or loss of smoking or radio privileges but rather segregation from the activities of the general prison population.

PRISON POPULATION

When the Medical Facility at Vacaville was planned, it was anticipated that the construction of a one thousand unit hospital would serve the ten per cent of an estimated ten thousand prison population in need of the services of a mental hospital, despite the fact that they were in the eyes of the law "legally sane." However, as a result of the population growth, the Department of Correc-

¹³⁹ *Ibid.*

¹⁴⁰ *Ibid.*

¹⁴¹ Rouse, *op. cit. supra* note 102, at 110.

¹⁴² *Ibid.*

¹⁴³ *Id.* at 113, 114. "A recent development in this area is the grant of funds from the National Institute of Mental Health, U.S. Public Health Service, to provide for field work training for graduate students in correctional social work from the University of California, Berkeley. This training project, first established at the California Medical Facility at Vacaville in 1960, provides student stipends of \$1000 a semester and the salary of a full-time field supervisor."

¹⁴⁴ Keating, *op. cit. supra* note 129, at 3.

¹⁴⁵ *Ibid.*

¹⁴⁶ Keating, *op. cit. supra* note 101, at 7.

¹⁴⁷ *Ibid.*

tions is now responsible for twenty-six thousand confined persons, plus another ten thousand on parole, and the Medical Facility can only serve four percent of the commitments. Therefore, only the most acutely disturbed can be admitted and the remaining six per cent are distributed among the other institutions of the Department, where the full compliment of specialized services which are provided at the Medical Facility does not exist.¹⁴³

This four per cent committed to the Medical Facility share a common characteristic in their history of crime with offenses involving property, sex, forgery, homicide and narcotics, predominating in the order named.¹⁴³

There is a relatively clear-cut group of approximately three hundred psychotics. Schizophrenia is the leading psychosis and delusions and auditory hallucinations the most common symptoms. Through treatment, many of these patients are able to handle their problems, but if further treatment is needed at the expiration of sentence, commitment is made to a State hospital under the jurisdiction of the Department of Mental Hygiene.¹⁵⁰

Those afflicted with personality and emotional deviations are more difficult to label and treat. There are those who are mentally deficient, others afflicted with convulsive syndromes, post-encephalitic and other cerebral organic changes. The majority have long-standing behavior patterns of the obsessive-compulsive type, characterized by sex offenses, drug addiction and other deviations. The Medical Facility Staff regards perversions, addiction and other fixed conduct patterns as symptoms of deep-seated psychic disorders, not definite clinical entities.¹⁵¹

Faced with the ills of such a population the principle of *triage* is utilized in order to live with problems of over-crowding and insufficient number of trained treatment personnel to adequately and effectively treat each inmate according to his needs. The stated medical objective in the psychiatric treatment of the incarcerated California felon is "to cure him of his psychological and social

tactics that eventuate in loss of his behavioral options and then loss of control over his responses; or, if you will, the relearning of how to use previously unpracticed social options for initiating or responding to conversations, . . . (thereby providing) the inmate with a measure of social control previously not available to him"¹⁵²

In the old time "tough" prisons, there was ample opportunity to put "one's time and life on the 'I dare you' line." Present California penology is directed toward diminishing the uniqueness of being a bad guy, and at the Medical Facility there is clearly little reward for contrasocial behavior thus eliminating the prestige that comes to those who can take physical punishment and prolonged segregation, and the consequent development into case hardening situations. The result is a reduction of time spent by inmates in a postgraduate school of criminology, convict style, and an increasing of the favorable influences on the inmate.¹⁵³

RESEARCH

Statements are commonplace as to the lack of empirical and statistical data¹⁵⁴ to provide evidence of the efficacy of group treatment; however, such factors as the staff confidence in the group program and the participation by large numbers of inmates have caused the Department's continuance and approval of the techniques employed.

According to some, "there is evidence that prison treatment is related to a reduction of prison rule violations,"¹⁵⁵ and that those "involved in group counseling did 'their time' peacefully."¹⁵⁶ Further, it is pointed out that "group treatment is relatively economical . . . (and) can, over a period of time, reach most of the inmates."¹⁵⁷

What the Department of Corrections is attempting in the pilot study presently being conducted at the Medical Facility is confirmation of the effects of a particular operation: the effectiveness of group therapy on recidivism. Current data is too meager to be meaningful in view of the rela-

¹⁵² Ernst & Keating, *op. cit. supra* note 148, at 3.

¹⁵³ *Id.* at 13.

¹⁵⁴ EATON, STONE WALLS NOT A PRISON MAKE at 163 (1962); Fenton, *Group Counseling: A Preface To Its Use in Correctional and Welfare Agencies* at 101 (1961); Kassebaum, Ward, & Wilner, *Group Treatment by Correctional Personnel: A Survey of the California Department of Corrections* at 37, Jan., 1963 (Monograph No. 3).

¹⁵⁵ Eaton, *op. cit. supra* note 154, at 187.

¹⁵⁶ *Ibid.*

¹⁵⁷ *Id.* at 53.

¹⁴³ Ernst & Keating, *Psychiatric Treatment of the California Felon* at 3 (undated, unnumbered typed material at California Medical Facility, Vacaville, California).

¹⁴⁹ Keating, California Medical Facility at 4, May, 1960 (unnumbered mimeograph at California Medical Facility, Vacaville, California).

¹⁵⁰ *Ibid.*

¹⁵¹ *Id.* at 5.

tively short duration of the study, and because "it is extremely difficult to isolate out the effect of any one program,"¹⁵³ it is not certain "that we will ever have a clear idea as to what extent group counseling (or therapy) has any positive impact on (parole) adjustment."¹⁵⁹

"In prisons, as in all applied social science fields, conclusive answers exist for only a very few practices,"¹⁶⁰ and "few decisions can wait for a thorough study of pertinent evidence."¹⁶¹ Perhaps, the enthusiastic reception of group techniques is itself justification for continuance of the program; however, its long range effectiveness will largely depend on the scientific confirmation of its usefulness at a time when its fervor may otherwise wane.

"Group treatment has not become the creed of a new cult."¹⁶² Other correctional programs are pursued, including academic education, vocational training, recreation and arts and crafts, as well as individual psychiatric treatment, the value of which are presumably as rehabilitating within the penal institution as they are worthwhile to members of the general public outside its fences. No one approach may be the final answer to the quest for certainty in judging the effectiveness of rehabilitative programs; however, the functions served by the present programs—the hub of which is group therapy at the Medical Facility¹⁶³—have not been found to be destructive in the sense that previous correctional programs have been before investigations and reform have corrected them.

Custody. Today the task of the custody officer is far more complex due to the evolution of treatment programs including psychiatrists, psychologists, physicians, and social workers as well as to the introduction of representatives from administrative and social welfare agencies into the pattern of prisoner rehabilitation and reform. As each new service has entered the field, new attitudes and often new duties are required of the custodial staff.¹⁶⁴ "The liberalization of recreation, correspondence, and visiting privileges has [also] complicated the picture."¹⁶⁵

¹⁵⁸ Harrison, *Mental Health Applications in the California Correctional System* at 17, May 24, 1960 (mimeograph at California Medical Facility, Vacaville, California).

¹⁵⁹ *Ibid.*

¹⁶⁰ Eaton, *op. cit. supra* note 154, at 187.

¹⁶¹ *Id.* at 188.

¹⁶² *Id.* at 193.

¹⁶³ Keating, *op. cit. supra* note 149, at 1.

¹⁶⁴ Tappan, *Contemporary Correction* at 162 (1951).

¹⁶⁵ *Ibid.*

"The custodial group is responsible for the maintenance of order and discipline, the prevention of escapes, and a number of activities which merge with those of the rehabilitative agencies."¹⁶⁶ It is the custody officer who is in daily contact with the inmates and is in a position to observe their relationships as well as unguarded behavior within the prison. "There is considerable evidence . . . that the most effective influence in a prison, whether for good or bad, is the custodial staff, who compose over 59% of the prison personnel of this State."¹⁶⁷

In-Service Training leading to assignment of custody personnel as group leaders of counseling sessions has been encouraged by the Department of Corrections as a means of bringing them within the therapeutic program.¹⁶⁸ "In addition to enlisting their good will and support . . . it was also necessary to capitalize on their treatment potential and involve them personally"¹⁶⁹ within the program. Traditional "caste differences . . . deeply rooted in law and custom" between the inmate and custody world¹⁷⁰ are falling,¹⁷¹ but not yet fallen, as a result of the improved communications.

In order to obtain more qualified and competent custody personnel, the State of California is paying the highest state salary for this group of employees (starting at \$463 a month with a maximum of \$562 reached through regular merit salary adjustments¹⁷²) and has developed a career service for correctional officers under the State Civil Service system.¹⁷³

According to its recent Director, "the history of the Department of Corrections is a history of staff development."¹⁷⁴ "The correctional officer has come a long way from the old-time guard whose job eventually transformed him into a special sort of prisoner."¹⁷⁵

¹⁶⁶ *Id.* at 160.

¹⁶⁷ Rouse, *The Problem of Adult Corrections: A Case Study of State Penal Administration in California* at 119, April, 1961 (unpublished doctoral thesis at Claremont Graduate School Library).

¹⁶⁸ *Id.* at 251.

¹⁶⁹ *Ibid.*

¹⁷⁰ Eaton, *Stone Walls Not A Prison Make* at 121 (1962).

¹⁷¹ [1959-1960] CAL. DEPT. OF CORRECTIONS BIENNIAL REP. 33.

¹⁷² As of January 1, 1964, a 10% increase of wages for Correctional Employees became effective.

¹⁷³ Rouse, *op. cit. supra* note 167, at 121.

¹⁷⁴ McGee, *Group Treatment by Correctional Personnel: A Survey of the California Department of Corrections* at 3, Jan. 1963 (Monograph No. 3).

¹⁷⁵ *Id.* at 5.

To the extent, however, that custody officials remain merely guards without contact with the clinical program either as group leaders or in training for such a position, their peculiar orientation will not materially enhance the therapeutic programs and may in some instances detract from its effectiveness by virtue of the military backgrounds which bear more purely authoritarian and less personalized characteristics. It is a significant advance in custodial development that custody personnel in California receive better than average pay and participate in the clinical program through group counseling, but as long as their number is restricted to sergeants, lieutenants, and captains, and does not include the turn-keys and wing officers, there is ample room for further training and possibly further civil service requirements for training in the behavioral sciences.

One of the major objections to custody, even within areas of minimum security where it is greatly decreased, is that certain inmates are in no need of the traditional form of restraint and custody, and rather than serving a constructive function, the imposition of security measures is either wasted, or worse, destructive of rehabilitative efforts from a therapeutic view by the very fact of its presence. This is not to deny the importance of custody where it is necessary for the security of the general community or where it serves an ancillary function to treatment. Perhaps, clearer distinctions regarding the application and extent of custody will result in a more intelligent use of the taxpayers' money both as to the quantity and quality of custody personnel.

At the Medical Facility, the modernization of construction along the "telephone pole" plan has resulted in a therapeutic atmosphere without any breakdown of necessary security. Physical communications are excellent within the institution and between its inner components. Between the custody staff and the inmates and the treatment staff and the custody staff, communication is a goal which to some extent has already been realized; however, neither the treatment nor custody staff will deny the necessity for greater communication, nor will they deny the necessity for intensification of In-Service Training, further wage increases to attract more career-minded employees, and greater utilization of custody personnel in therapeutic programs.

CONCLUSIONS

Under the present system, sentenced felons are referred to the Reception-Guidance Center for diagnostic study and transfer to an appropriate institution within the Department of Corrections. If the individual has mental problems acute enough to place him within the four per cent requiring necessary hospitalization and psychiatric treatment, he is transferred to the Medical Facility.

In their Second Report, the Special Commissions on Insanity and Criminal Offenders have recommended the transfer of non-criminally responsible, but dangerous individuals to the custody of the Department of Corrections for treatment at the California Medical Facility.¹⁷⁶ The Commissions base their recommendation on the following factors; (1) certain patients of the Department of Mental Hygiene have already been transferred to the Medical Facility because their presence at Mental Hygiene institutions has proved unduly disruptive of the therapeutic programs,¹⁷⁷ and (2) "The California Medical Facility . . . is suitable for providing therapeutic treatment in a secure environment for individuals who are dangerous, and who are not, as a substantial consequence of mental disturbance, accountable before the criminal law."¹⁷⁸

This appears reasonable in view of the security and therapeutic features of the Medical Facility and the Department of Mental Hygiene's increasing utilization of treatment methods "characterized by open grounds, open wards, and open quarters insofar as possible."¹⁷⁹ However, the Medical Facility is already over-crowded and able to serve only four per cent of the prison population.¹⁸⁰ The impact of an increase of transfers from Mental Hygiene to the Medical Facility is that the present non-dangerous mentally ill criminals at the Medical Facility will have to be transferred elsewhere within the existing facilities of the Department of Corrections or to facilities to be created by the legislature similar to the Medical Facility.

¹⁷⁶ CALIFORNIA SPECIAL COMMISSIONS ON INSANITY AND CRIMINAL OFFENDERS at 34 (Second Report, Nov. 15, 1962).

¹⁷⁷ CALIFORNIA SPECIAL COMMISSIONS ON INSANITY AND CRIMINAL OFFENDERS at 35 (First Report, July 7, 1962).

¹⁷⁸ *Id.* at 36.

¹⁷⁹ *Ibid.*

¹⁸⁰ See note 148, *supra*.

One need only consider the general criticisms¹⁸¹ of the M'Naghten test for criminal responsibility to see the fallacy of present distinctions between legally sane, but mentally ill, criminals and legally insane, but non-criminally responsible, individuals. The criterion of dangerousness proposed by the Commissions is not dependent on the M'Naghten test, but is directed specifically at the issue of dangerousness which would be resolved at a second trial following the initial trial in which the accused was found to be not criminally responsible.

The Commissions have not directly addressed themselves to the disposition of legally sane, but mentally ill, criminals who are already at the Medical Facility and have not reported on the problems inherent in an increase of transfers from the Department of Mental Hygiene to the Department of Corrections. The Commissions, however, have recognized that among persons not found responsible "(a)t one extreme is a group who require almost total attention to the question of security"¹⁸² while "(a)t the other extreme are those persons who require almost total attention to psychiatric treatment and care."¹⁸³ Together with the finding regarding the unsatisfactory application of M'Naghten, it is inferrable that this same dichotomy of the need for custody and the need for treatment without traditional custody applies in the case of those found sane under M'Naghten, but diagnosed as mentally ill. This view is supported in part by the Reception-Guidance Center's diagnosis of the psychosis and borderline psychosis in cases referred to the Medical Facility,¹⁸⁴ by the fact that six per cent of the original estimate of ten per cent of prisoners requiring psychiatric treatment are transferred to the general prison community where specialized treatment is unavailable,¹⁸⁵ and by the findings made in connection with the pre-sentencing diagnostic services that a greater portion of the prison population is suffering from organic brain damage and mental impairment than presently known.¹⁸⁶ Since custody can have a detrimental effect on the legally sane, but mentally disturbed, the Commissions' criterion of dangerousness should be applied to this group of prisoners as well as to the legally

insane. If custody is found to be detrimental to the one group, it is unreasonable to assume that the same detriment is not encountered in treatment of the legally sane but mentally disturbed.

Certain penologists¹⁸⁷ would welcome an extension of the Commissions' proposals concerning the criterion of dangerousness to a determination of the propriety of utilizing probation and parole in connection with out-patient institutions for individuals who are achieving little rehabilitative help and perhaps encountering destructive forces within the prisons and who might be better off outside their walls. There is evidence that prisons continue crime rather than combat it, and that "the less imprisonment the better."¹⁸⁸

Authorities advocating withdrawal of custody do not support withdrawal where the individual is dangerous.¹⁸⁹ One authority has stated that "the only reason for an institution is the protection of society."¹⁹⁰ Neither do these authorities advocate withdrawal of custody without institutions replacing it, such as half-way houses,¹⁹¹ increase of

¹⁸⁷ BARNES & TEETERS, *NEW HORIZONS IN CRIMINOLOGY* at 672 (rev. ed. 1945); Tannenbaum, *Foreword* to BARNES & TEETERS, *NEW HORIZONS IN CRIMINOLOGY* at v (rev. ed. 1945).

¹⁸⁸ Tannenbaum, *op. cit. supra* note 187, at v.

¹⁸⁹ *Ibid.*

¹⁹⁰ Interview with Associate Superintendent, Reception-Guidance Center, at California Medical Facility, Vacaville, California, on Nov. 22, 1963.

¹⁹¹ San Francisco Chronicle, Nov. 20, 1963, p. 46. The following is a reprint of the article, *S. F. Rehabilitation Project*:

BREAKING THE CRIME CYCLE

A project aimed at breaking a familiar pattern among law breakers—jail, more crime, and jail again—was announced here yesterday.

During the next three years, about 150 men and women who normally would be jailed will be turned over to the care of the Northern California Service League, a United Crusade agency which has done extensive work with county prisoners.

From the league, the offenders will get special intensive treatment designed to rehabilitate them, and at a cost to the taxpayer less than half that of sending them to jail.

ENTHUSIASM

The project, actually launched earlier this month with "wonderful enthusiasm" from judges and probation officers, will be financed with a first-year grant of \$36,800 from three San Francisco institutions—the Columbia, Rosenberg, and San Francisco Foundations.

Imprisonment is necessary for those who pose a threat to the community or themselves, noted league president Charles deYoung Elkus Jr.

"But for those who are not dangerous, a jail term is an ineffective and costly method of temporarily meeting a problem."

"Many leave jail embittered toward society, with greater problems than before . . . and often with greater sophistication as to the techniques of crime."

¹⁸¹ Hacker & Frym, *The Legal Concept of Insanity and the Treatment of Criminal Impulses*, 37 CALIF. L. REV. 575 (1949).

¹⁸² California, *op. cit. supra* note 177, at 36.

¹⁸³ *Ibid.*

¹⁸⁴ See note 96, *supra*.

¹⁸⁵ See notes 12 and 148, *supra*.

¹⁸⁶ See note 82, *supra*.

effective probation and parole supervision, and institution of work houses and rehabilitation camps.¹⁹²

The "new prison"¹⁹³ as it is sometimes called is in reality not a prison at all, but rather a diagnostic depot performing much the same function as the Reception Guidance Center as well as treatment functions according to a variety of plans and programs which would require differences in individuals contact with out-patient institutions. Certain individuals would be required to work at

the institution and live at home; others, to live at the institution and work in the community; still others, to live and work at the home with occasional visits to the institution. Other plans for different types of cases would be formulated to meet individual needs.¹⁹⁴ To a limited extent, this type of program is already in effect. Present judicial and administrative policies of granting probation and parole to non-dangerous individuals and by the appearance of rehabilitation programs, sponsored by private foundations.¹⁹⁵ However, until the State enters the field with the resources at its disposal, private programs will be voices "crying in the wilderness."

Other social advantages, such as decrease in public support of the incarcerated individual's family and reduced costs of prison administration are also to be considered in connection with the propriety of such plans.

These remarks directed to the problem of incarceration of the non-dangerous, legally sane, but mentally disturbed individuals may have significance in their application to the general prison population, and it is this writer's belief that they have such application; however, concerning the other institutions within the Department of Corrections, evaluation must be reserved for want of study, and reliance placed on the observation that, where prisons are required for the protection of society, the California Medical Facility "may become a prototype of future correctional institutions."¹⁹⁶ It is hoped that this will be so.

RESPONSIBILITY

This they learn in jail. But if sent to the league by a local judge and probation officer, counselors, psychiatric social workers and others will try to provide them "lessons in responsibility," as well as help in finding work, medical care, recreation, and in caring for their families.

Most of the care will be after working hours, at night, in the project office at 693 Mission street. But some treatment will be given in offenders' homes.

Earl Dombross, a psychiatric social worker who will direct the project, looks at it as a welcome "third alternative" for judges, who now have the choice of putting a law breaker in jail or on probation, where he or she gets comparatively little counseling.

FIRST

Four offenders of a first group expected to total 35 have already begun care—a burglar, a sex offender, a prostitute, and a man convicted of assaulting a policeman.

All are young—18 to 24—and have previously been on probation or in jail. This is expected to be typical of those cared for in the project.

Said Elkus:

"We hope to reveal new ways of treating offenders safely and productively in their home communities with savings in human resources and costs to the public."

¹⁹² BARNES & TEETERS, *op. cit. supra* note 187, at 672.

¹⁹³ *Ibid.*

¹⁹⁴ *Ibid.*

¹⁹⁵ See note 191, *supra*.

¹⁹⁶ Rouse, *op. cit. supra* note 167, at 192.