The Clinical Treatment of the Criminal Offender in Outpatient Mental Health Settings

New and Emerging Perspectives

Nathaniel J. Pallone
Sol Chaneles
Editors

ROUTLEDGE

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Sol Chaneles, PhD, was Chairman of the Department of Criminal Justice, Rutgers University, New Brunswick, New Jersey, and an elected trustee of the New Jersey Association on Correction until his untimely death in January 1990. The author of "Growing Old Behind Bars" in *Psychology Today*, September 1987, and many other articles in professional journals, Dr. Chaneles was completing a non-fiction book on art looting during World War II at the time of his death.

Introduction

Nathaniel J. Pallone

CRIMINAL OFFENDERS AND "MAINSTREAM" OUTPATIENT MENTAL HEALTH CARE: EMERGING PERSPECTIVES

It is likely folly to expect consistency in human perception and behavior in any arena, so it is not surprising that inconsistencies abound in our societal responses to criminal behavior. During the same elections in which a "Get Tough, Hang 'Em High" presidential candidate who avows wider application of the death penalty is overwhelmingly preferred over one whose posture toward prison furloughs bespeaks at least an implicit belief in the prison as an institution whose purpose is rehabilitation, and in which regional and local candidates who reveal the same "Get Tough" posture by endorsing mandatory custodial sentencing for all sorts of felony crime are similarly preferred, the same electorate declines to support the issuing of public debt bonds to support the construction of prison facilities to house those offenders who are the focus of just such policies, let alone disdaining the increased taxes required to support the staffing of those facilities.

Nor are these most recent inconsistencies singular. The same era that brought the historic *Pugh v. Locke* decision in Mr. Justice Johnson's Federal District Court in Alabama (1978), which promised to reform the prisons of the nation by requiring not only humane housing and sanitary conditions but also "meaningful programs" staffed by qualified personnel, also yielded in the Federal Congress the Kennedy-Thurmond Act of 1984, which effectively eliminated parole in the Federal prison system. A decade after *Pugh v. Locke*, dozens of states had been placed under Federal court order respecting one or another aspect of prison operation; half a de-

cade after Kennedy-Thurmond, the Federal courts operate under constraint of a set of criminal sentencing guidelines which, by design, recapitulate the parole decision guidelines operative in the Federal prisons for the dozen years prior to enactment of the Kennedy-Thurmond legislation.

Though the number of offenses and the number of jurisdictions subject to mandatory custodial sentences increases apace, the population of the nation's prison facilities grows but modestly; nor, in the face of Federal court constraints interacting with the refusal of the taxpayer to approve construction of new facilities, could one reasonably expect otherwise. New and technologically sophisticated methods of electronic surveillance of probationers (and, in some jurisdictions, of parolees) are introduced, holding promise to relieve (whether by explicit design or by fortunate effect matters little) what would otherwise prove to be intolerable overcrowding in the prisons and jails likely to result in yet other Federal court orders. Whether by design, by happenstance, or as a sort of subliminal compensation for enacting "Get Tough" laws, other legislation (e.g., that governing the processing of alcohol and drug users in several states through pre-trial intervention programs) permits some offenders who are both formally guilty of criminal behavior *and* psychiatrically (or biochemically) disordered to be diverted from the criminal justice system into the mental health "system," even when the essential features of their disorder(s) can provide no basis for exculpation by the stringent criteria for the insanity or the "diminished responsibility" defenses, with the effect that prison populations remain relatively stable while the roster of those offenders for whom responsibility has been shifted to the mental health community rises dramatically.

There is a delicious perversity in the reading of recent social history, especially when the cast of characters remains relatively stable. Thus it is instructive to recall that it was Mr. Justice Johnson who also handed down the *Wyatt v. Hardin* and *Wyatt v. Stickney* decisions of 1971, upheld by the Supreme Court four years later in the landmark case that reformed the mental hospitals in Alabama and, by extension, of the nation, by affirming the right of patients to treatment and establishing standards to govern the ratio between patients and professional staff as well as a panoply of aspects of

hospital operation. It may be even more instructive to recall that, between 1970 and 1976, as benchmarks for assessing the impact of the *Wyatt* decisions, the budget for mental hospitals in Alabama had *increased* by 230% while the patient population had *decreased* by 58%, with the "unserved" segment apparently diverted from inpatient to outpatient treatment via a network of community mental health centers not subject (or perhaps not *yet* subject) to judicially imposed standards for patient care (Pallone, 1986, pp. 33-35; Stickney, 1976).

If the judicial, legislative, and electoral arenas reveal contradictory trends, what can be said of the operational arena? Here one encounters a substantially clearer direction, perhaps readily predictable in consequence of those contradictory trends in the arenas which establish constraints and policies; and that direction is certainly a readily discernible movement away from incarceration and toward "community treatment" of one or another sort. That movement, further, appears to have occurred even in the absence of a formal (and radical) restructuring of the process of sanctioning criminal behavior of the sort proposed by von Hirsch (1985) and other proponents of the much-misunderstood "just deserts" school. Indeed, it can readily be demonstrated that formal adoption of a "just deserts" approach would likely result in imposition of more modest sentences, whether to incarceration or community supervision, than are presently yielded through an irregular, Byzantine process which aggregates charges associated with only conceptually differentiatable aspects of the same episode of criminal behavior, then permits wide-ranging plea bargains to an unrealistically magnified set of indictments, and eventuates in concurrent sentences for reduced charges.

Instead, what one observes at the clinical level is a burgeoning in the number of accused or adjudicated offenders among the roster of those served not merely in those agencies whose purpose is offender rehabilitation in the community, but also and perhaps more significantly in "mainstream" settings for outpatient mental health care, so that offenders now constitute a highly visible fraction of the patient population in community mental health centers, substance abuse rehabilitation settings, social service agencies, and even private practice. As if to reflect such a trend at the clinical level, there

has been an increase between 1981-86 on the order of 400% in the number of articles in "mainstream" professional journals in psychiatry, psychology, and clinical social work which deal with issues related to the treatment of offenders. Unfortunately, no data base of national scope has yet been established to yield information about the aggregate total of offenders so served; about whether their involvement in outpatient treatment represents an act of volition, a formal diversion from criminal justice processing, a condition of probation, or a means to optimize community re-entry following parole; or about the range of formal diaghoses for which outpatient mental health treatment is sought and the putative relationship between such disorders and the criminal behavior of which offenders in outpatient treatment have been accused or convicted.

It is characteristic of outpatient mental health treatment (as indeed of clinical medicine; witness Legionnaire's disease or AIDS) that services are first provided to "new constituents" and only later are conceptual models developed which specify the ways in which such "new" constituents resemble or differ from "traditional" constituents and/or the ways in which traditional methods of treatment can or should be modified, or new methods of treatment developed, to meet the needs of "new" constituents; in this, as in much else we do, it may be appropriate that service leads and well-considered rationalization follows. Granted that we have developed a reasonable body of knowledge to guide professional intervention, for example, in the case of the depressive who occasionally undergoes a manic episode, with the mania expressed in a free-fall shopping spree which drives the Visa card balance heaven-ward, can we make the assumption that the same intervention strategies will yield positive results if the manic behavior results in assaultive behavior against a store clerk who bears the sad news that Visa's computer has declined further purchases? Or that those intervention strategies which have proved effective in treating "Sneaky Pete" alcoholics who cadge money from relatives and friends will avail when the resources to support the habit are garnered from burglary? Given the views of such neuropsychiatrists as Robert Wettstein (1987), who appears to believe that, whatever else may be true of the violent offender, it is very nearly universally the case that such offenders display neuropsychological anomalies "of sub-clinical etiol-

ogy," no less than the wide overlap between substance abuse and criminal behavior, it also seems apparent that clinical neuropsychology and psychopharmacology will perforce be called upon to contribute their special expertise to the development of treatment regimens and paradigms specifically honed to the "dually deviant" offender.

Not surprisingly, the addition of offenders to the roster of those served in outpatient mental health settings has proceeded largely in the absence of differentiated conceptual models. The "first words" are now being spoken; we shall doubtless wait decades before we are able to utter "last words." The papers in this volume thus represent a contribution to the gathering of "first words" in the emerging, profession-wide, effort to gain new, appropriate, and useful perspectives on the clinical treatment of the criminal offender in outpatient mental health and social service settings. Together, they suggest both the parameters and richness of the discussion and quite pointedly signal the intersection between the "traditional" interests of the community of corrections professionals and the outpatient mental health care community, particularly in domestic violence and alcohol and substance abuse.

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"Privatizing" the Treatment of Criminal Offenders

Harold W. Demone, Jr.
Margaret Gibelman

INTRODUCTION

In the ongoing debate about the respective roles and responsibilities of the public and private sectors, there are certain "indisputable" public arenas. These concern powers bequeathed by the Constitution specifically to the federal government or reserved to the states. (Local government has no constitutional authority. Its powers are derived from the states.) One example of a purely public function is the federal government's exclusive power to provide for the nation's defense. Although not as explicit, it would be reasonable to assume that ensuring public safety is a logical extension of this governmental power.

Protecting our lives, boarders, and property from real or potential threats from sources outside the United States and protecting the citizenry against the acts of individuals or groups within our society are generally acceptable public functions. They involve enacting and enforcing the law, wielding public authority, and financing programs of prevention, deterrence, rehabilitation or incarceration.

As is readily apparent in the United States' defense industry, the modern view of government's exclusive powers in this domain allows for some complexity. The largest portion of dollars to produce the goods for our national defense is routed through the federal government to private contractors. It is Lockheed, Grumman, General Electric, et al. who produce the weapons and other hardware of

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defense. Many services are also purchased. Similarly, the goods and, increasingly, services needed to protect public safety from the threats of individuals—offenders of one type or another—are increasingly provided by the private sector under contract to government. More than half the police in the United States and Canada are employed by the private sector. In the U.S., private security employs an estimated 1.1 million people. Expenditures for private security products and services are estimated at $22 billion for 1980, compared to federal, state, and local law enforcement expenditures of $14 billion for 1979 (U.S. Department of Justice, October 1984).

The public role, then, becomes increasingly mixed. When contracting is used, the public role is that of planner, financier and monitor, though ultimate accountability cannot be contracted. The government could contract evaluation or auditing, for example, retaining the policy and interpretive judgements.

Levinson (1985) identifies several ways in which the private sector is involved in corrections: planning of facilities; financing of construction; building of correctional facilities; managing the correctional facility; service contracts; and community-based programs. Consultation is another traditional role and volunteers have long been active in corrections, assuming many different responsibilities. Robbins (1986) adds another form of private sector involvement: private industry within the prisons. Here, the goal is to assist prisoners to become or return to being productive members of society by having them produce a product or perform a service that can compete in the marketplace. In addition, the "employee-prisoners" may earn a decent wage and develop skills.

Although it is "prisons for profit" that has most caught public and media attention, primary concern in this article is with service contracting and the use of the private sector for rehabilitation programs carried out in the community.

MYTHS AND REALITIES

All too often when attention is directed to one target, the major action is occurring elsewhere. The several bibliographies on the privatization of corrections are heavily weighted to articles and reports on the for-profit operation of public correctional facilities. The majority of the references are to articles in the daily press