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THE DISTURBED VIOLENT OFFENDER

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Executive Summary

This study has surveyed a small but significant part of the prisoner spectrum - the disturbed violent offender. Our purpose in this survey has been to investigate the relationship between mental disorder and criminal violence in the lives of individuals who qualify both as disturbed and as violent. Our research approach has combined three major strategies: (1) to examine the chronology of mental health and violence involvements over an offender's career, (2) to investigate differences in types of violence committed and (3) to develop an offender career typology based on statistical clustering methods.

Research design

A study of infrequent events, such as violence and mental illness, requires innovative approaches to developing a reliable and efficient method for identifying a sufficient number of subjects. Our approach to sample selection begins with a cohort (n= 8,379) of offenders entering the New York State prison system after having been convicted of a violent offense. We relied on a statutory definition of violence which encompasses a variety of offenses, including some burglaries. Our next step was to cross-reference the names and birthdates of the violent offenders with computerized service delivery records maintained by the state Office of Mental Health. We identified three groups of mentally disordered offenders in the cohort based on the type of

service they had received: offenders with a substance abuse history (n= 83), those with a psychiatric history (n= 540) and those with a combined substance abuse and psychiatric history (n= 141). A sample (n= 544) of violent offenders with no mental health background was selected as a comparison group.

Prison classification records provided information on criminal history and conviction offense. Based on this information we coded type and level of violence and eccentric offense behavior to supplement more standard descriptions of the conviction offense.

Statistical findings

Our analyses revealed that offenders with mental health backgrounds, especially those including substance abuse problems, had more extensive criminal histories than other offenders. All groups of mental health clients were more frequently arrested for breaches of public order, but former psychiatric patients were more often arrested for assaultive crimes, including rape and sodomy. Offenders with alcohol problems were disproportionately involved in arson, assault, reckless endangerment, and driving while intoxicated, while disturbed drug addicts more frequently engaged in burglary and mrug offenses. We also found that a greater propensity for nuisance offenses and for violence often characterized different sub-groups of former psychiatric patients, but sometimes reflected co-existing dispositions within the same person (such as among alcoholic offenders).

Differences in conviction offenses paralleled those found in criminal histories. Offenders with a psychiatric history disproportionately stood convicted of murder, assault, rape and sodomy, and substance abusers were found to be more heavily involved in burglary. The repeated involvement of disturbed substance abusers in property crimes suggests that these offenders are similar to other substance abusers in that they steal to finance their addiction. The offenders in all mental health groups were consistently more disposed to offend alone, while offenders with a relatively pure psychiatric record were more likely to murder a spouse or relative, and to assault strangers.

Felony-related violence, which we found to be the most common type of violence, proved less characteristic of offenders with mental health backgrounds than of other inmates. Unmotivated violence and sexual violence, particularly against children, was perpetrated much more often by offenders with psychiatric histories. Levels of violence varied greatly across offender groups, with substance abusers tending to be involved in less serious violence. In contrast, nearly one-third of former psychiatric patients, a proportion about twice that of offenders with no mental health background, engaged in extreme violence, which includes inflicting death, serious multiple injury and sex with violence.

Both mental health and violence career patterns showed the greatest chronicity for psychiatric patients. The

relationship between types of careers indicated that over the course of the lives of disturbed offenders evidence of serious emotional disorder was associated with an increased propensity to violent crime. Recency of emotional disorder also was associated with greater levels of violence.

Eccentric offenses were rare among offenders with no mental health background, while persons with a psychiatric history were overrepresented in all categories of eccentricity. Many violent incidents by disturbed offenders showed ineffectual or counterproductive behavior such as leaving behind incriminating evidence, violent overkill or other behavior suggesting a frenzied state of mind, and conduct one generally thinks of as "symptomatic" of mental disorder. In addition, almost two-thirds of the offenders with substance abuse histories were intoxicated at the time of offense, and many offenders in this group displayed ineffectual behavior and could not recall details of their crime.

These findings lead us to conclude that a category of offenses exists in which clinically-relevant attributes can be implicated in the violence picture of disturbed individuals. We also conclude that two contrasting dispositions -- that of the ineffectual criminal and that of the frenzied violent offender -- are on occasion combined among disturbed offenders.

Offender Clusters

The procedure we used to disaggregate offenders yielded offenders clusters which are relatively distinct, with different crime-related and mental health-related career patterns. The sample of inmates with relatively "pure" mental health histories divided into the following types:

1. Impulsive Burglars: This group comprised young, nonviolent offenders with violence histories, many of who were intoxicated at the time of their offenses. The crimes of this group tended to be eccentric and self-destructive, and had a nonprofessional flavor.

2. Impulsive Robbers: These were youthful robbers with negligible criminal histories, who tended to have mental health problems dating back to childhood. The offenders typically were ineffectual persons who had led a rootless existence.

3. Long-term Explosive Burglars: These robbers combined serious chronic offending with serious personal problems. They had high arrest records and extensive histories of violence as well as of mental health problems. One quarter of the group had been diagnosed psychotic, and a third had been certified as having intellectual deficits.

4. Young Explosive Robbers: These young disturbed offenders had violence histories which had largely been dealt with in the community. The youths tended to be aggressive, but showed indications of vulnerability.

5. Mature Muggers: These older disturbed offenders typically committed relatively nonserious violence of the sort one associates with younger delinquents.

6. Acute Disturbed Exploders: These older offenders committed extremely serious acts of explosive violence which often had a bizarre flavor. The offenders had substantial histories of mental health problems (including psychosis), but limited crime-related experience.

7. Chronic Disturbed Exploders: This was the largest cluster in the sample, and the most problematic to society. The violence of the offenders was invariably extreme and uncontrolled, and they had long-term histories of mental health problems and violent offending. There was consistency over time about the criminal career of these individuals and the mental health problems they demonstrated.

8. Disturbed Sex Offenders: These serious offenders were older men who were markedly disturbed, but mostly had no histories of violence. They were apt to become involved in sex offenses against children.

9. Composite Career Offenders: These older offenders perpetrated a variety of offenses. They were typically career offenders and career patients who had alternately spent time in prisons and hospitals.

10. Compensatory Offenders: These extremely disturbed persons often suffered from intellectual deficits. They

tended to commit very serious offenses, but were apt to be ineffectual, and often intoxicated, during their crimes.

* * * *

Our second disturbed sample combined mental health and substance abuse histories. This sample formed five clusters, which we classified as follows:

11. Dependent Burglars: These offenders were older persons with substantial arrest records. They were nonviolent but had violence histories as well as long histories of mental health involvements. The offenders were drug addicts who were often intoxicated during their burglaries.

12. Skid Row Robbers: This small cluster of middle-aged alcoholics was involved in robberies. They had long offense histories, and were invariably drunk at the time of their robberies.

13. Skid Row Exploders: This contrasting group of alcoholics consisted of disturbed persons whose violence was extremely serious, diversified and explosive. Most of the group, however, had sparse arrest histories, though they often had records of violence, and tended to be drunk when they lost control.

14. Composite Career Offenders: These offenders had mental health problems of early origin and were long-term drug addicts. They were very serious violent offenders, and combined careers of long-term mental illness, long-term addiction and long-term violent offending.

15. Multi-Problem Robbers: The group was responsible for less serious offenses and the offenders were nonrecidivistic. They were often alcoholics who were also drug addicts, and their behavior tended to be eccentric, and reflective of emotional problems.

The substance abuse offenders without generic mental health histories fell into four types, one alcohol-related cluster and three clusters of drug addicts. Two of the four groups, (Alcohol Exploders and Drug Exploders) were responsible for extremely serious violence, and two (Addicted Burglars and Addicted Robbers) for relatively nonserious violence.

Our comparison group, who had received no treatment in the community, yielded eight clusters. These included Inexperienced Burglars, Experienced Burglars, Acute Exploders, Patterned Exploders, Pre-career Robbers, Early Career Robbers, Late Career Robbers and Generalists.

Implications for Reform

One implication that was suggested by the data relates to the prevalence of disturbed offenders whose offenses are not violent. Such offenders are typically regarded as disturbed after they commit their offenses and before they are brought to trial, and many are found disturbed--or at least, impaired--when they arrive in the prison.

The offenders often demonstrate combinations of intellectual deficits and mental illness and/or substance abuse problems. They frequently manifest vagrant lifestyles

and chronic difficulties coping with life in the community. Their prison prospects are often enhanced because community agencies can no longer serve their needs, and are put off by their failure to respond to the services proffered to them. Prisons come to serve as an agency of last resort for such offenders or as a structured setting in which mental health services are delivered to them. One can argue that this use of the prison system is of questionable legitimacy, and causes problems for the inmates and the prison. The situation calls for diversion options at sentencing--for services that combine the resources of different agencies, since the offenders typically are multi-problem clients.

The second problem that is surfaced by the data has to do with hardcore disturbed and violent offenders, whose violence is serious and who are chronically disturbed. Our subjects required 57,542 mental health services while in the prison during our study period. Such services were required by the offenders with mental health histories, and disproportionately by offenders who had perpetrated extreme violence.

There is a need for settings that can accommodate long-term prisoners who must have mental health services and can benefit from concern with their violence propensities. Treatment-relevant grouping of inmates is desirable in such programs, but this does not mean that a setting must be small and homogeous. What is essential is that any programs for disturbed violent offenders have some autonomy, to give

them flexibility. Its is desirable to have staffing that involves teaming of correctional and mental health personnel. Inmate program membership is best viewed as a phase of a prison career leading to integration into the population, and allowing for formal mental health assistance as needed.

When I first read it this morning, I said to myself I never, never believed it before, notwithstanding my friends kept me under watch so strict, but now I believe I am crazy; and with that I fetched a howl that you might have heard two miles, and started out to kill somebody--because, you know, I knew it would come to that sooner or later, and so I might as well begin. I read one of them paragraphs over again, so as to be certain, and then burned my house down and started. I have crippled several people, and have got one fellow up a tree, where I can get him if I want him.

Mark Twain SKETCHES NEW AND OLD
Hartford Conn. American Publishing Co.
1893, p. 232.

Acknowledgements

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We are grateful to Professor David McDowell who helped us along the way as a consultant. Professor Emeritus Louis L. McQuitty, whose thinking guided us when we mapped our research, passed away as we began our study. We miss him and regret his passing, and dedicate this report to his memory.

CONTENTS

Chapter 1:

Introduction

The following pages provide a composite portrait of disturbed violent offenders. The subject is a tantalizing one--though admittedly depressing--but it is a surprisingly unexplored subject. This fact does not mean that there is a lack of interest in the area, nor lack of thought. Rather, reticence is the result of a number of problems, many of which are substantial enough to make one refrain from treading where terrain is possibly treacherous. Among reasons for hesitance are the following:

1. The history of the topic is inauspicious: In the period when criminology and psychiatry were in their infancy, the field was rife with overgeneralizations about possible links between psychological abnormality and crime. To claim such links seemed particularly inviting in thinking about violent crime (especially murder) because the extremity of the behavior seemed to suggest extremity of motive. Clinical science at its inception also overestimated its reach. Psychiatrists who interviewed (and sometimes tried to treat) exotic offenders often implied that these offenders were, in essential respects, typical. These pioneers also espoused ambitious theories of crime causation, and their form of documentation--freely constructed case histories--made it impossible to disprove enticingly unfolded schemes.[1] Other

clinical progenitors were more eclectic (this group included Benjamin Rush, a signer of the Declaration of Independence) and they favored typologies of offenders, including groups to be medically treated.[2] The evidence used by such alienists to classify persons as normal or pathological, unfortunately, was often sketchy, and prominently centered on the severity of the offenders' crimes. At other times the material was a promiscuous assembly of data, permitting emphases to taste.[3]

More serious problems occurred as a result of this history. Overblown claims had annoyed a generation of social scientists, who condemned the substance of the clinicans' concerns as well as their methods. Most early textbooks in criminology (written by sociologists reared in the positivistic tradition) took pains to stress the "normalcy" of crime--meaning <u>all</u> crime. This understandably parochial stance created a disjuncture in the field, whereby ruminations about crime causation diverged from clinical thinking, which was thereby denuded of criminological theory. Psychologists and psychiatrists who aspired to enter the "forensic" area were trained without benefit of crime-related expertise, while criminologists routinely dismissed offenders' mental health problems as having nothing to do with their criminal careers.

The reason why this developing situation mattered was that clinical practitioners--particularly social workers who for a time entered corrections in numbers--interfaced

blithely with delinquents, addicts and disturbed offenders, applying their "mainline" clinical thinking, which criminologists had dismissed as not relevant to crime causation, and hence, to recidivisim. In time, criminologists and their allies--armed with masses of data which showed that "nothing (i.e., no treatment) works"--brought this activity into disrepute.[4] Clinicians continued to function in reduced numbers in correctional settings, but were mostly seen as "mental health staff" or ameliorators of medical conditions, and not as rehabilitators of special groups of offenders.

To be sure, exceptions remained to the rule that mental health staff were not regarded as crime experts. These exceptions, however, were not contributions to clinical criminology. One exception was the demand that clinicians estimate the future probability of violent offenders' recidivism (dangerousness). The other exception involved the requirement that clinicians contribute to judgments as to the "sanity" of (mostly violent) defendants in courts. The former enterprise was inauspicious because many experts adjudged it to involve dubious extrapolations.[5] The second task, per contra, was seen as too circumscribed to be compatible with clinical theory.[6]

2. <u>The insanity defense provides a distracting criterion of crime related emotional problems</u>: The insanity defense originated as a way of ensuring that crazed assassins and other transparently demented offenders were not dragged,

kicking and screaming, to the scaffold.[7] It is important to keep this goal in mind because it means that the concern was with avoiding farcical displays of punitiveness rather than with excluding disturbed persons in general from punishment. The point of the insanity defense was to define the limits of what one could sensibly call blameworthy conduct. This issue was important to judges, who resolved it by concluding that blame should not attach to any act committed by a disturbed person who did not know what he or she was doing while he or she was doing it. The earliest versions of this doctrine were formulated during the reign of Edward I (1272-1307).[8] Later, routine pardons were accorded to murderers classed as "lunatics" by virtue of "not knowing more than wild beasts;" historians further noted that "madness became a complete defense to a criminal charge" under the liberal auspices of Edward III (1327-1377).[9]

The insanity defense preceded the advent of clinical science by several centuries. By 1843, however, when the contemporary insanity defense was formulated, (the action was taken in an uproar over a case reminiscent of that of John Hinckley) medical evidence was introduced in the trial, as in others in which insanity was an issue. The landmark case which sparked controversy was that of Daniel McNaghten, about whom physicians testified that he "labored under an insane delusion" that he was persecuted, by (among others) the prime minister of England. McNaghten was acquitted "on the ground of insanity" of shooting the prime minister's

secretary, and the judges of England were challenged by indignant legislators to justify their verdict. The McNaghten doctrine which defines insanity to this day is annunciated in the key paragraph of the judges' reply, which reads:

> The jury ought to be told in all cases that . . . to establish a defense on the ground of insanity, it must be clearly proved that, at the time of committing the act, the party accused was labouring under such a defect of reason, from disease of the mind, as not to know the nature and quality of the act he was doing, or if he did know it, that he did not know he was doing what was wrong.[10]

It is obvious in reading this definition that the issue for the judges was not that the offender suffered "from disease of mind"--though he had to be mentally disturbed for the definition to apply. The issue, rather, was that the offender must be oblivious to his actions or their impact, as a result of being disturbed. This criterion is narrow, and describes (a) a purely hypothetical, metaphysical state of mind, which (b) is difficult to ascertain by an observer, particularly in retrospect. The criterion is also not spontaneously thought of by psychiatrists when they are left to their devices in dealing with patients. Given the narrowness and apparent irrelevance of the rule it was not surprising that physicians found it uncomfortable almost as soon as it was formulated. The American psychiatrist Isaac Ray led a spirited attack on the insanity defense in the 1860's, and convinced the courts in his home state (New

Hampshire) to expand the definition. He felt strongly that psychiatrists should be allowed to present evidence as they saw it as to the mental condition of the offender and its expected impact on his crime.[11] Similar pleas for open-ended testimony have been made by many influential psychiatrists concerned with insanity. A committee for the Group for Advancement of Psychiatry, for instance, wrote about the insanity defense that

> The rules place a premium on intellectual capacity and presuppose that behavior is actuated exclusively by reason and untrammeled choice. On the one hand, this overemphasizes the importance of the intellect, reason and common sense; on the other hand, it underemphasizes the emotional pressures that energize behavior.[12]

The insanity defense, however, remains largely circumscribed. It is a legal - not clinical - criterion designed to apply (and applied) to a small minority of very seriously disturbed offensers whose offenses are extreme.[13] The existence of the rule helps make salient the question of whether offenders are disturbed, but otherwise creates a problem, because it invites the presumption that the law distinguishes between disturbed offenders and nondisturbed offenders, which it largely does not. The critical fact is that the overwhelming majority of disturbed offenders are processed without the question of their sanity being raised. This does not mean that these persons' mental state is irrelevant, nor that their offenses are untainted by their condition. The fact that some offenders are adjudged

"insane," however, creates the implication that offenders not so adjudged must be "sane" persons who commit "normal" offenses.

3. Disturbed violent offenders are difficult to locate and to define: We have noted that the violent offenders adjudged not guilty by reason of insanity must first be disturbed offenders. (The group is small, however, and wildly unrepresentative because it is extreme.) Other disturbed offenders are dispersed in a variety of settings. Once located, moreover, they are apt to present definitional problems in that cross-sectional and historical portraits may yield different admixtures of emotional problems, offenses and violent behavior, particularly over time.

Mental health varies over a person's lifespan, and violent offenses take place at particular junctures in time, during which the person may be disturbed or nondisturbed. Even where the person is disturbed and commits an offense, however, this does not mean that the occurrence of the offense, its nature or its quality, are affected by the person's mental condition. Psychological problems, moreover, cover a wide range, and a line between "disturbed" and "nondisturbed" is very hard to draw. Violence is also a spectrum, ranging from moderate to extreme and from sporadic to habitual.

If we define a disturbed violent offender as a person who is sometimes disturbed and commits offenses involving

violence, such a person may be located among mental patients at a given point in his life, and among offenders at other points. The former fact has been a matter of concern because the admixture of disturbed violent persons and other disturbed persons helps to stigmatize mental patients as violence-prone.[14] To neutralize this stigma some observers have stressed that mental patients may statistically appear more criminogenic than non-mental patients, because mental patients who have criminal records are responsible for the difference.[15] The implication is that this subgroup consists of mainline offenders who would look more at home in prisons, emphasizing that they are different from other (noncriminogenic) residents of mental hospitals. This characterization is descriptively correct and humanely destigmatizing but disguises circularity of argument unless we can further describe the subpopulation at issue.

A comparable point holds for offenders in the criminal justice system--particularly inmates in prisons--who have mental health problems that require attention. Such persons have frequently had problems in the community, and received services, including in hospitals. This fact invites the charge that chronic patients become inmates because they are prematurely discharged or "dumped," landing in prisons by default.[16]

Neither crime-accentuating nor pathology-accentuating portraits accommodate a third possibility, which is that many persons are both legitimate patients and legitimate

offenders, and become legitimate clients of both systems, or of one or the other system at different points in time.

To be sure, agencies may make an effort to exclude each other's clients. The insanity defense can be regarded as such an effort by the courts, as can the competency examination, which is designed to avoid criminal trials in which the defendant is so handicapped that he does not understand what is happening around him.[17] Mental health programs in their turn can exclude offenders at intake (claiming lack of security or irrelevance of service), and may discharge patients with behavior problems as unacceptably "disruptive." There are also more complex and subtle screening procedures, which include rejecting multi-problem clients on the ground that they are better served elsewhere.

The issue of "multi-problem clients" is particularly germaine to disturbed offenders because such offenders are often disadvantaged persons who manifest a variety of deficits. This observation is familiar to service providers today, but could have been advanced decades ago because the sociologists' original case against the clinical approach was buttressed by statistics demonstrating that crime was associated with social disadvantages that were known to also produce other undesirable consequences.[18]

The recognition that social disadvantages can produce multiple handicaps is important because it not only means that the same person can have two or more problems, but that

these problems can reinforce each other in a variety of ways. The fact has become increasingly obvious to scholars and is illustrated by changes in perspective about causal links such as those between family problems, educational deficits, unemployability and addiction on the one hand and delinquent careers on the other.[19] The accommodation of contemporary criminology to increased complexity of causation is stimulated by longitudinal studies which permit us to order events in time so that we can trace antecedents and consequences. [20]

Such developments are helpful to us but the evolving model does not include mental health problems, nor can it do so because the proportion of offender populations who have such problems is small. This means that whereas more prevalent deficits (such as drug addiction and school failure) can be plugged into criminological equations emotional problems are likely to remain as noise in such equations.

Violence as a variable suffers from the opposite problem, in that a good deal of the offense spectrum includes violence, which complicates the task of disentangling violent crime from nonviolent crime, except at extremes. Long careers are apt to be heterogeneous, in the sense that they include both violent and nonviolent offenses.[21] The specialized "violent offender" is a rarity, and definitions of violent offenders must accommodate mixed careers that include repeated violent involvements. Even

where this is done, however, the dependent variable in studies that use such definitions is more saliently the chronicity of crime than the violence of the offenses committed.

4. It is uninviting to think of people as both mad and bad. We implied that the insanity defense is unpopular and has been controversial since its inception. One reason is that where harm is salient, the notion of exculpation (and escape from punishment) is uncongenial to the public. A second reason has to do with the connotations of crime and mental illness, which make these concepts hard to reconcile and combine.

One tends to equate crime with malevolence and illness with helplessness. Crime, therefore, invites resentment, and illness, sympathy. It is hard to summon up sentiments that contrast so sharply, assuming it were possible to envision malevolent helplessness (or helpless malevolence), as a target of feelings.

Combinations of madness and badness are also puzzling, and the mind rejects them. Fortunately badness tends to be documented, while madness is at best postulated. The harm crime does is a tangible fact while the offender's hypothesized disability is an issue in dispute by experts who assert and deny its existence. This makes it easy to resolve the problem of logical dissonance by classifying mad/bad persons as bad persons who are of somewhat eccentric dispositions, and whose badness preempts our attention.

The problem is eased by sequencing of conduct. If a person behaves madly today and acts badly tomorrow he is not deemed mad/bad but mad-turned-bad. After the person offends he becomes an offender, and can be dealt with as such. After the same person breaks down (provided he is not offending at the time) he becomes a patient, and we can then treat him.

The formula of personal transmutations is convenient, but it must often be applied in strangely compartmentalized ways. If symptoms are destructive or misbehavior is bizarre different aspects of the same act can invoke disparate responses in tandem. Deadpan punitiveness can precede therapy, or vice versa. This sequential process implies assumptions such as that treatment can restore the person-as-patient to a condition such that the person-as-offender can be punished. The person-as-offender can then become a person-as-patient as soon as his medication wears off and/or his punishment commences.

(5) Recidivism studies support a segmented view of disturbed offenders: Offenders and patients, and combinations of the two (such as insanity acquittees, defendants adjudged incompetent and disturbed offenders adjudicated as "dangerous") have been tracked down in follow up studies, to ascertain rates of rehospitalization and reoffending.[22] One would think that investigations such as these would point to linkages between mental illness and crime, but the research has the opposite import, even where the persons who are studied are disturbed violent offenders when they become subjects of study.

This outcome of research is a combined effect of the facts unearthed in the studies (variables predicting one sort of recidivism or the other) and the approaches to the garnering of these facts (how one goes about recidivism research, which means locating variables that predict recidivism). Segmentation of the disturbed offender as subject occurs because reoffending is correlated with one set of facts--age, for instance, and type of offense--and rehospitalization, with another set of facts.[23] Even where unquestionably disturbed offenders are followed into the community, different failures of members of the group can be traced to different predictors, making it appear that the group contains (1) chronic offenders who happened to be disturbed, (2) chronic patients who happen to have offended, and (3) a composite type of offender whose offense behavior and emotional problems exist side by side, responding to different drummers in compartmentalized ways.[24]

The bifurcated view of recidivism persists in reviews of research trends over time. When we compare newer studies with older studies, we see more recidivism reported among patients.[25] As noted, this trend is then attributed to an influx of Group 1 Persons (offenders) whose presence among nonoffending patients gives them a bad name. Contemporary prisons are similarly characterized as increasingly permeated with Group 2 persons (patients), and the absence of patients is seen as accounting for the fact that early studies showed no disproportionate pathology among prison inmates.[26]

Recidivism statistics as data pose a problem for disturbed violent offenders because the most likely violence to be associated with pathology (non-felony related) is relatively nonrecidivistic.[27] The violent offender thus invites being classed as a Type 2 (disturbed) or Type 3 (mixed, compartmentalized) phenomenon, which is why psychiatrists are invoked to predict "dangerousness."

(6) Settings may recognize complexity but may not label it: One assumes that practitioners cannot avoid facing "mixed" client problems and dealing with them. Schools, for example, must manage students who are not only disruptive and disturbed but obviously disruptively disturbed or crazily disruptive. While recognition of such problems is inevitable, administrative considerations may constrain classifications of problems, which means that perceptions need not translate into veridical labels.

Classifications of people may become side products of resource allocation. In schools, for example, the proportions of students with misbehavior as opposed to mental health problems may be adjusted to accord with programmatic emphases in campaigns against problem areas such as truancy, drug use, vandalism, suicide prevention and educational deficits. In this sort of calibration adding mental health staff expands the pool of mental health clients. One can also try to ignore one's resources and expand or contract labels of people as one thinks they are needed, as in smoking/non-smoking sections of airplanes. In some large jails, for example, the numbers of "mental health beds" vary from count to count, with services and facilities remaining roughly the same.

Operational definitions can be enacted which bear no resemblance to the substance of client problems. In jails, for example, "mental health problems" are equated with suicide potential.[28] This means that an inmate who talks about killing himself (which clinicians call "suicidal ideation") may be attended to, while prisoners who are less obtrusively disturbed are neglected. The strategy could be defensible if its aim were to address inmate despondency, but the goal--"suicide prevention"--is one of controlling behavior rather than improving mental health.[29]

Suicide poses issues of consequence because it reflects societal ambivalence about madness and badness. Szasz points out that suicide attempts have been historically

defined as violent crimes, but the insanity defense redefined the behavior as mental illness.[30] Similar redefinitions occur when persons are committed to psychiatric settings, given that the prevailing entrance requirements (danger to self or others) specify social harm, but treatment targets symptom reduction. To reduce symptoms may reduce dangerousness, but this is a corollary of more significant achievements such as restoring a person's contact with reality and ability to care for self. Mental health concerns, however, such as, Can this person feed and clothe himself? Can he follow a daily routine? Can he lead an independent existence? Can he relate to other people? do not define treatment candidates at entrance.

The situation is one in which mad/bad persons are defined as mad or bad at different junctures in time, or in contact with different agencies, or to subserve different aims. The result is humpty dumptyish in the sense that there is no integrated approach to the person as a whole. The situation also impedes reconstruction of lives that highlight the contribution of pathology to the genesis of misbehavior.

Describing Mad/Bad Careers:

We have suggested that there are difficulties that face us in thinking about disturbed violent offenders as subjects of research. Some of these difficulties are conceptual and others are strategic. Conceptual difficulties can compound strategic difficulties, which makes it necessary for a

researcher to at first operate atheoretically, holding conceptual problems in abeyance. One must arrive at operational definitions that must be adhered to leading to an internally consistent picture, though broader questions relating to the nature of crime (or violence) and mental illness remain unresolved.

One set of definitions one must arrive at have to do with the population one will study. One's subjects must be violent and disturbed, but few persons are adjudged violent and disturbed at the same time. This means that one must select one variable that is contemporary and that describes the person's status, while one makes do with a second variable that mainly describes his or her history. One must view persons who are currently definable as mad and/or bad, with records of madness and/or badness. Different selection strategies yield different subpopulations with different attributes.

Each variable (violent crime and mental health) yields interrelationships, but one variable (violent crime) is primarily dependent, in that it can be affected by the other variable (mental health) but is unlikely to affect it. Given the one-way nature of this relationship offender status makes a plausible criterion or outcome measure, and mental health status less so. This consideration suggests that we might start our inquiry with a population of violent offenders, whose mental health (as well as criminal) histories are available for review. The strategy has become

increasingly feasible with mental health systems keeping computer records of services they deliver to their clients.

Irrespective of which selection strategy one uses, one must recognize that definitions of madness or badness--official designations of offender and patient status--describe responses of agencies as well as the behavior of persons who are responded to. One can at times correct for artificial definitions (for instance, one can independently assess the violence level of behavior using descriptions of offenses), but one cannot escape the fact that a criminal conviction or a diagnosis is a judgment and not a behavior description.

Links between crime and mental illness are even more hypothetical, since they represent assumed relationships between assumed categories of behavior. Coexistence is a safer criterion. One can describe temporal patterns, starting with the premise that behavior classifications that coincide in time, or rapidly follow each other, provide clues to interrelatedness, and that more extended sequences provide more substantial cues, having to do with behavioral consistencies (if any) over time. The study of consistencies over time must be a core concern of motivational research because personality, as conventionally defined, means no more and nor less than consistency of behavior.[31]

The inferences one can draw from one's research depend on the range of behavior, particularly of "mental health

problems", one can subsume. Restricted definitions are always neater, but tend to describe extremes or (at worst) exotica. Moreover, neatness dissipates in longitudinal portraits given checkered careers--and mental careers are no less checkered than offense careers--which means that persons who at times are psychotic at other times manifest less consequential disabilities which occur with greater frequency. A more substantial argument against a restricted range model is that it obfuscates the multi-problem nature of disabilities which is already obfuscated by preclassifications of clients and the segmentation of mental health services.

The liabilities of extended range sampling (such as lack of precision) can be neutralized by disaggregating subject populations in consequential ways. This fact is a fortuitous asset because disaggregation is a strategy of choice for other reasons, such as the fact that our variables of interest (mental illness and violence) can intersect in many and diverse ways. The key questions one must speculate about are also ultimately psychological (motivational) questions, and to answer such questions one must get as close to the individual as one can, while preserving one's capacity to generalize to other persons.

"Consequential" disaggregation means that one ought to select attributes which have relatively substantial explanatory power, given the limitations of one's data set. Purely descriptive variables (such as physical attributes of

the offense) are probably dispensible because they carry only situational or criminalistic significance. And other recorded data (such as legal offense descriptions) must be beefed up through recoding to more closely approximate qualitative differences among persons or their behavior.

Disaggregation yields grouping or typologies, in this case types of offenders who differ in combinations of problems (violence and mental illness) they manifest. It probably is not critical whether one starts with subgroupings along one of these problem areas or the other because the shape of the product (variations of violence across mental health groupings or types of mental health problems across offense groupings) would have similar virtues, in permitting us to review representative clusters of contrasting offenders.

Our reference to mental health and offense histories reflects our view that research exploring links between categories of behavior (such as mental health-related behavior and offense-related behavior) should ideally be longitudinal research because sequences imply direction of causation or illuminate changes from one behavior category to the other. In particular, we see no way other than through review of lives over time to describe the paradoxical patterns of destructivensss and nonresilience that are represented among offenders who are at times violent and at times disturbed.

Notes

1. Psychoanalytic theorists relied on the case studies of patients to gain an understanding of psychological functioning, particularly of neurotics. The approach was applied to offenders under the auspices of the Juvenile Psychopathic Clinic in Chicago, and by Bernard Glueck at Sing Sing. In a seminal work (Roots of Crime, New York: Knopf, 1935) Franz Alexander and William Healy reviewed the personal histories of delinquent adolescents for "unconscious motives" rooted in childhood. In an earlier volume (The Individual Delinquent, Boston: Little Brown, 1914) Healy had tabulated psychological and social variables ("factors") in case histories of 823 repetitive juvenile offenders referred to his clinic by the Chicago juvenile court, and--among other things--found most of the delinquents disturbed. In a more sophisticated book-length study (New Light on Delinquency and its Treatment, New Haven: Yale University Press, 1936) Healy and Augusta Bronner paired cases of delinquents and nondelinquent siblings, using a matched experimental-control design. Healy and Bronner interviewed their subjects' parents and teachers, and incorporated both perspectives in describing the interactions leading to the unfolding of delinquency.

Earlier uses of case materials in forensic psychiatry were less disciplined, and often incorporated prevailing biases and preconceptions. This fact is illustrated by a

"disorder" that was invented in the nineteenth century called Moral Idiocy or Moral Insanity (later dubbed psychopathy, sociopathy and antisocial personality disturbance). This disease entity--according to an early textbook--was a brain defect leading to "more or less complete moral insensibility and absence of moral judgment and ethic notions" for which "treatment . . . is without prospect of success," so that "these savages in society must be kept in asylums for their own and the safety of society" Krafft-Ebbing, R. von, Text-book of Insanity, Philadelphia: F.A. Davis, 1904, pp. 623, 626). The case material which documents such pessimistic prognoses suggests to modern readers that the diagnosis offered psychiatrists a way of expressing disapproval of uninviting clients:

> She was lazy, menadacious, chasing after men, and given to prostitution . . . She spent, in gormandizing and amusements, money which her brothers and sister gave her. She did the same thing with what she earned, whether it was in service or by prostitution . . . On account of her dissolute life she frequently had encounters with the police, for she offended public decency and gave no attention to police regulations. She found nothing improper in her manner of life . . . . She played the injured innocent, paid no attention to the regulations of the house, incited other patients to mischief, had constantly explosions of anger in her great irritability, always about her affair with the police. The police were her enemies, and tried to injure her, though she had never done wrong. Of her moral defect and her inability to direct herself she had no idea . . . The patient is impossible, coarse to brutality, afraid of work, tries to persuade others not to work, goes about disturbing and scolding others, trying to attract men, and demands her discharge; but she cannot say what she will do when she is put at liberty. The patient was transferred to an institution for chronic insane (Krafft-Ebbing, op. cit., p. 627).

The risk that case material may be used to document preconceptions and that patients may be unrepresentative of offenders restricts the utility of recent popular publications providing generalizations about violence, such as statements about murder-in-general, based on book-length case studies. An example of the genre is D. Abrahamson, The Murdering Mind (New York, Harper and Row, 1973). This book details a single case, which the author supplements with references to clinical experience, such as, "Having examined hundreds of people who have killed (and I exclude murders committed by organized crime), I have found that homicide usually does not originate because of a clearly defined impulse to murder, but is related to the intensity of inner conflicts" (p. 10), and "eleven defendants charged with threatening the president or other government officials (of whom I examined eight and studied the records of two others . . . all showed surprising similarities in their family background, their personality makeup and their pattern of behavior" (p. 18).

2. Benjamin Rush (1746-1813) was Physician General of Washington's Continental Army and became the "undisputed father of American psychiatry (whose) portrait adorns the official seal of the American Psychiatric Association" (Szasz, T.S. The Age of Madness, New York: Jason, 1974, p. 23). An example of Rush's penchant for taxonomy is the following:

> When the will becomes the involuntary vehicle of vicious actions, through the instrumentality of the passions, I have called it moral derangement. (My prior discussion of) the morbid operations of the will are confined to two acts, viz., murder and theft. I have selected those two symptoms of the disease (for they are not vices) from its other morbid effects, in order to rescue persons affected by them from the arm of the law, and to render them the subjects of the kind and lenient hand of medicine.

This passage dates from an 1812 publication (excerpted in Szasz, op. cit., p. 25). In the same essay, Rush prescribes "sober houses" - to be established "in every city and town in the United States" - for persons addicted to alcohol (Ibid., pp. 26-27). Rush's favored techniques included a chair of his invention (the "tranquilizer") to which many parts of a patient's body could be strapped (Kraepelin, E. One Hundred Years of Psychiatry, New York: Philosophical library, 1962, p. 17), bursts of cold water to be poured down a patient's sleeves (ibid., p. 64), and extensive bleeding.

3. The historian Rothman notes that collecting data for the construction of comprehensive case histories--such as those that can be found in the "folders" of offenders--was designed to illuminate causes of difficulties so that tailor-made treatment programs could be designed. This approach reflected what Rothman describes as faith in science, because it assumed that patterns will somehow emerge from comprehensive inventories of facts (Rothman, D., Conscience and Convenience, Boston, Little Brown, 1980).

4. The phrase derives from R. Martinson's article "What works? - questions and answers about prison reform," (Public

Interest, 1974, 35, 22-54). Martinson's conclusion was that "with few and isolated exceptions, the rehabilitative efforts that have been reported so far have had no appreciable effect on recidivism." A more recent summary of authoritative opinion based on review of the same data concluded that

> At the present time, no recommendation about ways of rehabilitating offenders could be made with any warranted confidence, and, therefore, no new major rehabilitative programs should be initiated on a widespread basis. At the same time, neither could one say with justified confidence that rehabilitation cannot be achieved, and, therefore, no drastic cutbacks in rehabilitative effort should be based on that proposition.

This conclusion was arrived at by a panel of social scientists convoked by the National Research Council (Sechrest, L., White, S.O. and Brown, E.D., eds., The Rehabilitation of Criminal Offenders: Problems and Prospects, Washington, D.C.: National Academy of Sciences, 1979, pp. 102-103).

5. Some limitations have to do with the unreliability of clinical judgments, and others relate to the low probability of violent behavior, except among very chronic violent offenders. This low probability creates a problem because "events that have low base rates are very difficult to predict with high levels of accuracy. Moreover, even the accuracy that is achieved comes at the cost of high rates of 'false positives,' that is, persons who are predicted to be dangerous but who will actually not display such behavior" (Shah, S.A. "Dangerousness: conceptual, prediction and

public policy issues", in Hays, J.R., Roberts, T.K. and Solway, K.S., eds., Violence and the Violent Individual, New York: Spectrum Publications, 1981, p. 161).

6. For a period of several years the District of Columbia provided a liberalized insanity standard (the Durham rule) which gave psychiatrists a more open ended opportunity to express their opinions. The three-judge panel of the United States Court of Appeals (headed by J. Bazelon) wrote that

> We find that as an exclusive criterion the right-wrong test is inadequate in that (a) it does not take sufficient account of psychic realities and scientific knowledge, and (b) it is based upon one symptom and so cannot validly be applied in all circumstances . . . . We conclude that a broader test should be adopted . . . . The rule we now hold must be applied on the retrial of this case and in future cases is not unlike that followed by the New Hampshire court since 1870. It is simply that an accused is not criminally responsible if his unlawful act was the product of mental disease or defect . . . . The legal and moral traditions of the Western world require that those who, of their own free will and with evil intent, commit acts which violate the law shall be criminally responsible for those acts. Our traditions also require that where such acts stem from and are the product of a mental disease or defect as those terms are used herein moral blame shall not attach and hence there will not be criminal responsibility. The rule we state in this opinion is designed to meet these requirements. (Monte W. Durham v. United States, 214 Fed. (2d) 862).

7. Weihofen, H. Insanity as a Defense in Criminal Law, New York: The Commonwealth Fund, 1933. A more contemporary perspective is that of Justice Bazelon, who wrote in the Durham decision (see Note 6 supra) that "our collective conscience does not allow punishment where it cannot impose blame."

8. Glueck, S.S., Mental Disorder and the Criminal Law: A Study in Medico-sociological Jurisprudence. Boston: Little, Brown, 1925.

9. Perkins, R.M. Criminal Law. New York: Foundation Press, 1957, p. 739.

10. Weihofen, op. cit. (Note 7 supra), p. 28.

11. Isaac Ray--one of the founders of the American Psychiatric Association--has been called "by far the most influential American writer on forensic psychiatry during the whole nineteenth century: (Overholser, W., "Isaac Ray, 1807-1881", in Mannheim, H., ed., Pioneers in Criminology, Montclair, NJ: Patterson Smith, 1973, p. 177). Like other psychiatric critics of the McNaghten rule, Ray objected to the premium placed on impairment of knowledge. he wrote that

> The error arises from considering the reason, or to speak more definitely, the intellectual faculties, as exclusively liable to derangement, and entirely overlooking the passions or affective faculties . . . . While the reason may be unimpaired, the passions may be in a state of insanity, impelling a man . . . to the commission of horrible crimes in spite of all his efforts to resist . . . . The whole mind is seldom affected; it is only one or more faculties, sentiments, or propensities, whose action is increased, diminished or perverted, while the rest enjoy their customary soundness and vigour. . . . True philosophy and strict justice require that the action of the insane should be considered in reference . . . to the faculties that are diseased (Ray, "Lecture on the Criminal Law of Insanity," The American Jurist, 1835, 14, p. 253).

More fundamentally, Ray opined that insanity was either a fact or not a fact, and "properly speaking, there can be no law on this subject other than the facts themselves"

(cit. Overholser, op. cit., p. 194). Ray felt that psychiatrists should be regarded as scientific experts, and dismissed as irrelevant the fact that they often disagreed as witnesses (he wrote that "very little evidence of any sort is completely harmonious" Ibid., p. 192). This position has been recently characterized as cavalier by critics such as Thomas Szasz, who writes that

> It is possible, in virtually any case in which psychiatric testimony is introduced, to secure psychiatric testimony in opposition to it. How are we to reconcile this fact? If we compare psychiatric to, say, toxicological testimony, a comparable situation would be one in which the toxicologist for the prosecution testified that a body contained a lethal amount of arsenic, whereas the toxicologist for the defense testified that it did not. This, of course, never happens, because one of the experts could be, and would be, proved guilty of perjury . . . . Mental illness is not the sort of phenomenon whose presence or absence can, at least according to current practices, be easily identified by scientifically impartial methods. Since there are no scientifically accepted ethical and social criteria of mental health - a concept corresponding to the permissible level of arsenic in the human body in our analogy - there can be no scientifically acceptable criteria of mental illness (Szasz, T. "Criminal responsibility and psychiatry," in Toch H., ed., Legal and Criminal Psychology, New York: Holt, Rinehart & Winston, 1961, pp. 162-163).

12. Group for the Advancement of Psychiatry, Committee on Psychiatry and Law. Criminal Responsibility and Psychiatric Expert Testimony. Report No. 26. Topeka, Kan.: 1954, p. 4. There are other psychiatrists who disagree with this view. Wertham, for instance, writes that

> The distinction between right and wrong is not a purely intellectual performance, but affects the whole personality and has definite and important emotional components . . . . So the rule inherently does include emotion and affect . . . The law allows the

> psychiatrist today all the proof of the diagnosis and degree of a mental disease before the court. According to scientific psychiatry, that includes necessarily the emotional part of the personality. If the law singles out one criterion for its own purposes, that does not mean that the psychiatrist has to seal off that aspect from the rest of the affected personality (Wertham, F., A sign for Cain. New York: Paperback Library, Coronet, 1969, p. 245).

13. Pasewark, R. "The insanity plea: A review of the research literature," Journal of Psychiatry and Law, 1981, 9, 357-401.

14. As has been pointed out by Shah (Note 5, supra) this stigma is increased by involuntary commitment criteria which emphasize "danger to self and other," leaving the impression that persons are hospitalized because they are violence-prone. Shah writes that

> there is the implicit, sometimes even explicit, assumption that by virtue of being mentally ill a person is more likely to engage in dangerous and violent behaviors . . . . Commitment laws for the mentally ill seem to be premised on the assumption (actually a belief) that, as a group, the mentally ill constitute one of the most dangerous groups in our society. Yet there is no sound or convincing empirical evidence to support such a belief" (Shah, op. cit., p. 168).

15. Actually, the statistic at issue is misleading. Hospitalized ex-offenders have higher arrest rates than the general population, but arrest rates for violent crimes of the group are similar to those of the population when both are compared to offenders released from prison (Steadman, H.J., Cocozza, J.J. and Melick, M.E. "Explaining the increased arrest rate among mental patients: the changing

clientele of state hospitals," American Journal of Psychiatry, 1978, 135, 816-820).

16. This charge is premised on another assumption, which is that disturbed persons in correctional settings have proliferated in proportion to inmate populations. This assumption is universally endorsed by jail and prison administrators but cannot be substantiated given (1) the paucity of trustworthy epidemological surveys, and (2) disagreement about the definitions of mental illness one would have to agree upon for epidemological research to take place. One stumbling block, for example, is that rates can be inflated or deflated through the inclusion or exclusion of the "antisocial personality" construct (see Note 1) as a formal diagnosis. In one prison survey, for example, 78% of male inmates were diagnosed as sociopathic (Guze, S., Criminality and Psychiatric Disorder. New York: Oxford University Press, 1976).

17. Halleck points out that the doctrine of pretrial competency, which dates to the seventeenth century, is "fundamental to the integrity and dignity of the legal process" because "trying individuals who may not even understand why they are on trial is inherently absurd, as well as incomptabile with the commitment to justice" Halleck, S. The Mentally Disordered Offender. Washington, D.C." National Institute of Mental Health, 1986, p. 20. Halleck also notes, however, that competency to plea bargain is rarely at issue. Given that the defendant is in theory a

party to the plea bargain--which presupposes his active participation--the failure to raise the "competency" question at this key juncture is mystifying, especially since most criminal cases are resolved through guilty pleas presupposing plea bargains.

18. Shaw and McKay of the Chicago Area Study, for example, ask:

> Many other "problem" conditions might be listed, each representing a state of affairs considered undesirable by most citizens. These would include various forms of unemployment, dependency, misconduct, and family disorganization, as well as high rates of sickness and death. It may be asked: Do these other phenomena exhibit any correspondence among themselves and with rates of boys brought into court? (Shaw, C.R. and McKay, H.D. Juvenile Delinquency and Urban Araas, Chicago: University of Chicago Press (1942), 1972, p. 90).

Shaw and McKay answer this question affirmatively. They report the highest correlations among variables in the most disorganized neighborhoods of metropolitan areas and conclude that "any great reduction in the volume of delinquency in large cities probably will not occur except as general changes take place which effect improvements in the economic and social conditions surrounding children in those areas in which delinquency rates are relatively high" (Ibid., p. 321).

19. Thornberry, T.P. "Toward an interactional theory of delinquency," Criminology, 1987, 25, 863-891.

20. Farrington, D.P., Ohlin, L.E. and Wilson, J.Q., Understanding and Controlling Crime, New York: Springer, 1986.

21. Wolfgang, M.E., Figlio, R.M. and Sellin, T., Delinquency in a Birth Cohort, Chicago: University of Chicago Press, 1972.

22. The third category includes two "natural experiments," in which courts of appeal ordered the release of disturbed offenders who had been retained in prison hospitals because they had been adjudged dangerous a number of years earlier. The offenders did relatively well after they had been released into the community. See Steadman, H.J. and Cocozza, J.J., Careers of the Criminally Insane, Lexington, Mass.: D.C. Heath (Lexington), 1974; Thornberry, T.P. and Jacoby, J.E., The Criminally Insane, Chicago: University of Chicago Press, 1979.

23. The three classic variables that predict offender recidivism are age, prior criminal record and present offense (See O'Leary, V. and Glaser, D., "The assessment of risk in parole decision making," in West, D., ed., The Future of Parole, London: Duckworth, 1972). Among the variables that predict rehospitalization are age, past mental illness, marital status and diagnosis (Zigler, E. and Phillips, L. "Social competence and outcome in psychiatric disorder," Journal of abnormal and social Psychology, 1981, 63, 254-271; Schofield, W., Hathaway, S., Hastings, D. and Bell, D. "Prognostic features in schizophrenia," Journal of Consulting Psychology, 1954, 18, 155-166; Morrow, W. and Peterson, D. "Follow up of discharged psychiatric offender,"

Journal of Criminal Law, Criminology and Police Science, 1966, 57, 33-34.

24. Two authors who represent this view write that "the correlates of crime among the mentally ill appear to be the same as the correlates of crime among any other group: age, gender, race, social class, and prior criminality. Likewise, the correlates of mental disorder among criminal offenders appear to be the same as the correlates of mental illness among other populations: age, social class, and previous mental illness" (Monahan, J. and Steadman, H., "Crime and mental illness: an epidemiological approach," in Morris, N. and Tonry, M., ed., Crime and Justice: An Annual Review of Research, Vol 4., Chicago: University of Chicago Press, 1983, p. 181).

25. Among the earlier studies, which show lower rearrest rates, are Ashley, M.C. "Outcome of 1,000 cases paroled from the Middletown State Homeopathic Hospital," State Hospital Quarterly 1922, 8, 64-70; Pollock, H.M. "Is the paroled patient a menace to the community?" Psychiatric Quarterly, 1938, 12, 236-244; Brill, H., and Malzberg, B. Statistical Report of the Arrest Record of Male Ex-Patients, Age 16 and Over, Released from New York State Mental Hospitals During the Period 1946-48. Albany: New York State Department of Mental Hygiene, Albany, 1954. (American Psychiatric Association, Mental Hospital Service Supplementary Mailing 153. August 1962), and Cohen, L.H., and Freeman, H. "How dangerous to the community are state hospital patients?"

Connecticut State Medicine Journal 1945. 9, 697-700. Among later studies, which show higher rearrest rates, are Rappeport, J.R., and Lassen, G. "Dangerousness--arrest rate comparisons of discharged mental patients and the general population," American Journal of Psychiatry 1965 121, 776-783; Rappeport, J.R., and Lassen, G. "The dangerousness of female patients: a comparison of arrest rates of discharged psychiatric patients and the general population," American Journal of Psychiatry, 1966, 123, 413-419; Giovannoni, J.M., and Gurel, L. "Socially disruptive behavior of ex-mental patients," Archives of General Psychiatry, 1967, 17, 146-153; Zitrin, A., Hardesty, A.S., and Burdock, E.T. "Crime and violence among mental patients," American Journal of Psychiatry, 1976, 133, 142-149, and Durbin, J.R., Pasewark, R.A., and Alberts, D. "Criminality and mental illness: a study of arrest rates in a rural state," American Journal of Psychiatry, 1977, 134, 80-83.

26. One well informed researcher concludes that "the literature, albeit methologically flawed, offers at least modest support for the contention that the mentally ill are being processed through the criminal justice system" Teplin, L. "Managing disorder: Police handling of the mentally ill," in Teplin, L., ed., Mental Health and Criminal Justice, Beverly Hills: Sage, 1984, p. 54. On the other side of the fence, researchers contend that "mental hospitalization is an ever increasing occurrence for those with histories of criminal activity" (Cocozza, J., Melick,

M. and Steadman, H., "Trends in violent crime among ex-mental patients," Criminology, 1978, 16, 317-334, p. 330.

27. See O'Leary and Glaser, Note 23 supra; also, Kassebaum, G. Ward, D. and Wilner, D., Prison and Parole Survival: An empirical Assessment. New York: Wiley, 1971.

28. Steadman, J.J., McCarty, D.W. and Morrissey, J.P., Developing Jail Mental Health Services: Practice and Principles. Washington: National Institute of Mental Health, 1986.

29. Toch, H., Men in Crisis, Chicago: Aldine, 1975. A sad fact which makes the practice ironic is that despondent inmates who are isolated through suicide prevention in jails often experience exacerbated difficulties, including completed suicides.

30. Szasz, T. "Insanity and irresponsibility: Psychiatric diversion in the criminal justice system." In Toch, H., ed., Psychology of Crime and Criminal Justice, New York: Holt, Rinehart and Winston, 1979, pp. 139-141.

31. Allport, G. W. Pattern and Growth in Personality, New York: Holt, Rinehart and Winston, 1961.

Chapter 2:

Research Strategy

In considering our approach we began with the knowledge that serious violent crime and serious mental illness are relatively uncommon events, and, since our interests lie in persons who qualify as experienced on both counts, we anticipated that the difficulties inherent to a study of infrequent events would be exacerbated. The challenge we faced was that of insuring an adequate sample size while working within real-world limitations, such as customary resource and time constraints. Given these considerations, we could rule out, for example, a strategy of locating mentally ill violent offenders by drawing a random sample arrest populations given that a study of 1,382 police-citizen encounters uncovered only three incidents in which violent crimes were committed by persons who showed evidence of mental disorder.[1] By narrowing our sampling frame to a group of mentally disordered individuals or to a group of violent offenders, we could increase the efficiency of sampling procedures, but evidence suggests that the improvement would be marginal. In a recent followup study of 3,858 mental patients only 50 were arrested for violent crimes within nineteen months of discharge to the community.[2]

What we needed is a reliable and efficient procedure for identifying a substantial group of mentally disordered violent offenders. One such procedure is to start with a group of convicted violent offenders, narrowing the group down to

offenders who have mental health involvement. This procedure gives us a pool of individuals, recently violent, who at some point in the past might have been mentally ill. We can then collect more information and refine our categorization of offenders as mentally disordered on the basis of details about the service they needed.

Sampling

We begin with an entry cohort of inmates who have been sentenced to a term of incarceration in the New York prison system after having been convicted of a violent offense. During the time period that defines the cohort we reviewed -- January 1985 through December 1985 -- 12,764 offenders were admitted to the prison system.[3] Among this group of offenders, 8,379 were sentenced for a statutorily defined violent offense, a criterion which covers a wide range, including some burglaries.[4]

Our next step was to match names and birthdates of the offenders in the cohort with computerized client records maintained by the NYS Office of Mental Health.[5] These records allowed us to identify persons who had been admitted to service at state-operated psychiatric facilities. The comparison yielded a total of 1833 matches, which means that 22% of the entering prisoners had experienced some contact with the state mental health system. Our next step was to obtain a detailed service delivery record, which could be used to infer the nature and severity of the mental problems of each inmate.

Upon examining the service records, we found that most (66%) of the offenders had been forensic clients, for whom there was

little or no treatment information. This picture contrasted sharply with that of the civil patients we identified who, for the most part, had extensive service delivery records. We also found that a significant number of offenders had been treated for alcohol and drug problems at psychiatric facilities. This finding was particularly interesting to us, since the relationship of substance abuse disorders to violence could plausibly differ from the effects of other emotional disorders.

At this point in our procedures we had identified a pool of "mentally disordered" violent offenders with the following characteristics: (1) most of the offenders were forensic patients for whom we could not otherwise confirm a history of serious emotional disorder; (2) some offenders had received services for drug and alcohol problems. (While substance abuse is listed as a psychiatric disorder, many treatment programs are run by para-professionals in quasi-therapeutic settings, and inmates who were exclusively clients of these programs were not identified.) And (3) the pool excluded clients who had exclusively received services in private psychiatric facilities. In view of these considerations, we turned to another source of data -- the correctional files -- to refine our classification procedures.

The Department of Correctional Services maintains a central office file on each inmate. These files contain a variety of records, many of which relate to prison experiences. Of particular interest to us, however, were intake and classification documents which describe the offender's past mental health involvements and his or her criminal history. Since this information could only be retrieved manually, it was

impractical for us to collect data on the entire cohort. We therefore invoked a sampling strategy, selecting all offenders with civil psychiatric records, a total of 625 inmates, for inclusion in the sample.[6] We also randomly sampled from forensic patients (sampling ratio 1:7; n= 145) as well as from inmates with no mental health records (sampling ratio 1:12; n= 540). We collected information on recorded mental health contacts and participation in community substance abuse programs from the correctional files, and these data were merged with the Office of Mental Health records, eliminating redundancy as indicated by dates and treatment facilities. Also, while searching the correctional files, we coded details of each offender's criminal history (dates and offenses) and conviction offense.

By invoking correctional files as a source of information, we verified more substantial service delivery for some forensic clients, and identified some of the offenders initially placed in the no service group who had received treatment. The details of the composite treatment information (correctional files and mental health files) for the initial sampling groups (forensic, civil, no service) become as follows: in the forensic group, 13% of offenders received psychiatric evaluations only, 8% had been clients of substance abuse programs, 22% were psychiatric patients, and 2% showed combined psychiatric and substance abuse problems. This leaves over one half (56%) of the forensic group for whom we were unable to locate any information regarding treatment services. Among offenders with civil mental health records, 1% had psychiatric evaluations only, 5% were in

substance abuse programs, 73% had received psychiatric services, and 21% were treated for combined (addiction-mental health) problems. Finally, we found that among the group initially classified as no services 7% had been subject to psychiatric evaluation, 8% were clients of substance abuse programs, 15% had been psychiatric patients, and 2% were treated for combined psychiatric and substance abuse problems.

Our final step consisted of reclassifying the initial sample into three mental health groups -- substance abuse (n= 83), psychiatric (n= 540) and combined psychiatric and substance abuse (n= 141) based on the composite service delivery information.[7] Offenders with no history of mental health treatment (including those who were only subject to psychiatric evaluation as well as forensic clients for whom we were unable to verify service delivery) became our comparison group (n=543).[8]

Data analysis

Our data analysis was divided into two major sections which are (1) comparisons of offenders and violent incidents, and (2) development of a career typology describing histories of violent offense behavior and mental health involvement.

In making comparisons between offenders we focus on differences in criminal histories and mental health histories (where applicable). We are especially interested in the frequency, nature and timing of offense and mental-health related involvements since this information becomes critical to us later, when we develop a typology that is largely based on history. Differences in social and demographic variables such as age,

race, and marital status must also be examined.

Our comparison of violent incidents relates to the conviction offense which has led to the offender's current term of imprisonment. The information covers legal attributes such as statutory category and sentence length, as well as type of attack (e.g., threat, physical assault), weapon use, location of incident, and victim-offender relationship. In collecting the latter information we limited our coverage to two victims, giving priority given to victims who experienced the greatest injury. (This strategy did not prove too much of a limitation since only 15% of cases involved three or more victims.)

Legalistic descriptions may gloss over important communalities between violent incidents; since statutory schemes are developed as punishment-relevant classifications, they do not always describe the uses to which violence is put. For example, an offender who attacks his or her spouse in a jealous rage might be convicted of either murder or assault depending on the post-attack condition of the victim, which in turn can be influenced by such factors as the celerity of medical attention. The legal scheme may draw our attention to a distinction in one area (the victim's physical condition) at the expense of another (the offender's motivation). In similar fashion, a burglary, which is usually a non-violent offense, can involve either threatened or actual violence against a confronted victim. We therefore developed a supplementary classification of violent incidents to describe the type and level of violence. This coding was based on offense descriptions provided by the prison system in the "description of pattern of criminal behavior" document which is

generated as part of the inmate classification process.

In describing types of violence we tried to keep the categories as close to the act as possible. We divided violent acts into unmotivated, retaliatory, felony-related, sex - adult, sex - child, weapon-related, arson, against police, burglary, auto and institutional violence. Though we sometimes used the legal designations of the offenses (i.e., burglary, arson), at other times we restated the statutory categories into broader terms (i.e., sex offenses, weapon offenses) or made victim-related distinctions that were not always reflected in the designations conviction offenses (i.e., victims as adults, children, police). Where useful, we also incorporated motivational (i.e., unmotivated, retaliatory) or situational (i.e., felony-related, auto - as weapon / institution - as setting) elements to help us to describe violent behavior.[9]

Since offense categories encompass substantial variation in levels of violence, we developed a four-category ordinal scale to summarize the degree of harm that was inflicted on the victim. The categories used were no (personal) violence, less serious (threat or minor damage), serious (physical damage and nonconsensual sex) and extreme (death, serious multiple injury, or sex with violence). This scheme allows us to describe non-violent encounters that are statutorily defined as violent, as well as less predatory offenses that involve only a potential for violence or that result in minor physical harm. Through the use of both coding schemes a complete classification of incidents results which describes both the type and degree of violence.

Eccentric aspects of offense behavior

We are obviously concerned with relationships between mental illness and violence, and, in particular, the ways in which serious emotional problems can shape the expression of violence. In studying violent incidents, it struck us that some offenders, particularly offenders with a history of mental health involvement, do not come across as stereotypic criminals in that their offenses show peculiar, odd or eccentric features. These attributes are clearly not reflected in legal classifications nor are they fully captured by our supplementary categorizations. We therefore developed a third code of unusual or eccentric offense attributes to capture peculiarities of violent behavior. There are many such attributes, but the general categories we used are: ineffectual behavior, frenzied mental state, symptomatic behavior, no apparent motivation, no memory of event.[10] Such impressions were systematically collected on the entire sample so as to allow for comparisons between the groups of offenders.

Career framework

We have noted that any study of emotional disorders and violence must accommodate the fact that mental health problems and offense behaviors, and relationships between the two, change over time. A concept that helps to organize this developmental complexity is that of an offense-mental health "career". The dictionary tells us that, apart from a sequence of vocational progression, a career can connote "a course of continued progress as in the life of a person". Within the social sciences, a

career framework has been used to study a variety of situations, including the socialization of medical students, the development of drug addiction and the community adjustment of mental patients. In these contexts, a "career" describes sequences of experiences that are common to groups of individuals.

The goal of our research is to illuminate sequences of offender behavior in which the advent of criminal acts and of symptoms that are serious enough to justify diagnosis and treatment can be located in time. Such patterns of behavior over time permit us to show when a person is unambiguously disturbed, when he is engaging in crime, and when he is both. Given a large enough sample, temporal patterning permits the grouping of offenders into types that are characterized by different admixtures and sequences of offenses and symptomatology. Over a life time, such types describe composite careers of criminality and mental illness; over limited periods they describe composite career segments.

Career types are different chains of career segments which imply different relationships between personal problems and offense behavior. For example, offenses that are always committed when an offender has discontinued outpatient care and medication carry different implications than those that occur when the offender is receiving mental health services, or when the offender has not yet been diagnosed. A career in which early emotional problems are followed by a long, rootless existence (unemployment, homelessness and so forth) which eventually leads to criminality is different from a career of chronic delinquency and of incarceration followed by a psychotic breakdown.

The career concept lends itself to the development of a career typology depicting common patterns of experience over time. As a descriptive tool, a career typology can be particularly useful in that it organizes large amounts of data into meaningful and relevant sub-categories. By including both offender and offense attributes in the same typology, we can develop a composite picture of persons, histories and behavior, and such combinations can provide clues to offense motivation and to other psychological processes associated with offending.

Various strategies can be used in the development of a typology. When relatively few dimensions or items comprise a typology, all possible or logical combinations can be easily examined. However, when the number of items involved is large, this strategy becomes unwieldy, and we need a way to isolate significant combinations of variables. A statistical technique that is particularly well-suited to the development of discriminating classification schemes is cluster analysis.

Cluster analysis is a statistical procedure for identifying groups or classes of objects with common attributes, the results of which can be viewed as a natural (confluence) taxonomy. The procedure has intuitive appeal because sorting things on the basis of like and unlike features is one of the basic ways we organize experience. Cluster techniques are built around this familiar grouping strategy, and, by sorting a large heterogeneous group into smaller more homogeneous sub-groups, cluster analyses can discover order and regularity in complex phenomena. Applications of the technique are generally considered

atheoretical in the sense that hypotheses or theoretical propositions are not part of the clustering process. However, there are several methodological issues that arise in the use of cluster analysis, and we will briefly outline these areas, documenting the strategies we ourselves employed. The issues are (1) choosing variables for inclusion in the analysis, (2) selecting a clustering technique, (3) measuring similarity and (4) deciding on the number of clusters in the final solution.

The selection of variables to be included in a cluster analysis is important because there are limitless ways of describing objects, and, by definition, omitted variables can not form part of the taxonomy. We can narrow the universe of descriptive items by eliminating those that seem conceptually irrelevant to the task at hand. Yet, after taking this step, many options still exist, and choices can make a difference in producing a more or less meaningful classification scheme. Since we are concerned with offense-mental health careers, we had to include historical information on mental health and criminal justice experiences in our analysis. We also had to enter a description of the conviction offense which, given the procedures we used to identify the sample, represents the capstone of the offender's violence career. The conviction offense was recorded in terms of type and level of violence, which we had coded as described. On the negative side we decided to exclude most demographic variables from the analysis because we felt that an initial focus on static background characteristics would prove distracting, particularly in the context of most other items which illuminate sequences of pathology and violence.[11] (We do

list demographic variables as "covariates" in our description of final cluster solutions.)

The second issue with which we are confronted is that of selecting a clustering technique. Numerous types of clustering techniques have been developed, and within a given type there are a variety of specific methods.[12] We decided to use a hierarchical technique which is well-suited to the types of data we collected and is among the more commonly used clustering procedures. Hierarchical techniques operate in an agglomerative manner, which means that at each step two groups are joined together, becoming a unit for subsequent mergers. In a sense, the technique fashions a tree by starting with many individual branches and ending with a single trunk.[13] The specific clustering method we used is average linkage between groups, which tends to produce more homogeneous clusters than the single linkage method.[14]

The third issue involves the choice of a proximity measure to indicate degree of similarity or dissimilarity between objects. A problem researchers often face is that variables of different measurement levels are combined in an analysis, which means that selection of any single proximity measure involves compromise. In our situation, most of the variables in the analysis are nominal so that it was convenient to convert the data to binary (yes, no) format. We therefore generated dichotomous variables to represent the presence or absence of each of the nominal categories in the data set, and in some cases this made it necessary to reduce the level of measurement (as in

the case of age) to accommodate this scheme. After trying several proximity measures, we decided to use the Jaccard measure, which is one of several appropriate for binary data.[15]

The final issue is that of deciding on the number of clusters in the final solution. Hierarchical techniques generate from one to as many clusters as there are data points, and it is up to the researcher to decide where in the process to draw the line. Mechanical strategies have been developed to address this issue, but these methods are concerned with finding the "correct" number of clusters, a notion that is often of questionable relevance to hierarchical techniques. An important consideration is the conceptual "meaning" or "coherence" of the items that form the clusters, and we used these criteria to assess various solutions. The point at which the disaggregation process no longer makes useful or meaningful distinctions (or conversely when the agglomeration process obscures useful distinctions) is the juncture identified as the final cluster solution.

Chapter 2:

Footnotes

1. This figure does not include traffic-related incidents. See, Teplin, L. "Criminalizing mental disorder: The comparative arrest rate of the mentally ill." American Psychologist, 1984, 39, p. 799.

2. Steadman, Cocozza and Melick (Chapt 1, Note 15), p. 187.

3. The prison intake cohort includes only new admissions. It does not include offenders returned to prison for violating parole.

4. We used the statutory definition of a violent offense which includes a few crimes that traditionally might not be considered violent. The statutory definition of violence is the criterion used to determine which criminals qualify for penalty enhancements under specialized violent offender laws, and the extension of legally defined violence to include some property crimes probably reflects a concern for the violence potential of these offenses. We defined violence broadly because some offenders in our cohort who were convicted of property offenses may have threatened or harmed a victim.

5. Cross-referencing of computerized corrections and mental health records was done on the basis of last name, first two letters of first name and date of birth.

6. We also included the handful of patients with extensive forensic treatment records in this group.

7. This combination is one example of the multi-problem mental health client. A recent newspaper article documents the fact that the mental health system has difficulty treating persons with combined psychiatric and substance abuse problems. The article notes that between one-fifth and one-half of the mentally ill are substance abusers, and a state Commission estimated that there are 100,000 such dually-disabled persons in New York. Even though an effective treatment strategy has yet to be developed, mentally ill substance abusers consume a disproportionate share of mental health resources. In the article the father of a schizophrenic alcoholic is quoted as complaining that "The alcoholism programs can deal with alcoholism. The mental health programs can deal with mental illness. But my son has both and they don't know how to deal with that." At least one reason for this situation is that treatment approaches of alcoholism programs, which are often confrontational, and of psychiatric programs, which often use drugs supplemented by emotional and social support, can be incompatible. ("Mental health system fails alcoholics, drug abusers", Times Union, March 13, 1988, Albany: New York, pp. A-1, A-4.)

8. Substance abusers are defined by participation in either alcohol or drug treatment programs operating under psychiatric or non-psychiatric auspices. Psychiatric patients are individuals who received outpatient or inpatient mental health treatment, exclusive of outpatient psychiatric evaluations.

9. The breakdown of legal categories of conviction offense by types of violence is as follows:

Retaliatory:

37% murder, 1% kidnapping, 6% robbery, 48% assault, 4% reckless endangerment, 2% burglary, 3% weapon.

Felony-related:

4% murder, 0.7% kidnapping, 86% robbery, 3% assault, 0.2% reckless endangerment, 4% burglary, 0.2% rape, 0.7% weapon.

Burglary:

5% robbery, 0.5% assault, 0.5% reckless endangerment, 93% burglary, 1% weapon.

Unmotivated:

25% murder, 10% robbery, 57% assault, 2% reckless endangerment, 2% burglary, 4% weapon.

Adult sex:

1% murder, 3% kidnapping, 7% robbery, 3% assault, 64% rape, 13% sodomy, 8% sex abuse, 1% weapon.

Child sex:

1% murder, 2% robbery, 43% rape, 38% sodomy, 16% sex abuse.

Weapon:

2% murder, 3% robbery, 5% burglary, 91% weapon.

Arson:

97% arson, 3% sex abuse.

Police victim:

29% robbery, 50% assault, 4% reckless endangerment, 7% burglary, 4% rape, 7% weapon.

Institution / auto:

29% murder, 25% robbery, 25% assault, 18% burglary, 4% weapon.

10. The specific items that constitute the general categories of eccentricity are: ineffectual behavior - turned self in to police, failed to leave the scene of crime when given the opportunity, left behind personal identification or other highly incriminating materials, made several attempts at the crime before succeeding; frenzied mental state - violent overkill including multiple stabbing or shooting, potentially fatal beating or assault, torture or mutilation; symptomatic behaviors - psychotic symptoms such as hallucinations or delusions, paranoia, dazed, bewildered, confused or disoriented mental state, poor personal hygiene, depressed, withdrawn or crying, and self-injury.

We collected data on several types of eccentric offense behavior that are not reported. One category, behavior disproportionate to stimulus, was deleted because it appeared in over 50% of the cases and did not discriminate between offender groups. In contrast, other eccentricity categories (matricide, fratricide or infanticide; excessive destruction of physical property) proved to be extremely infrequent. Still other eccentric behavior (arson, sexual violence, child victim) is better described by the type of violence codes we developed.

The category of "unmotivated offense" appears in both the type of violence and eccentric offense behavior classifications. The type of violence code describes the primary nature of the violence and thus applies only to violent incidents. The eccentricity code includes non-violent and potentially violent encounters.

11. We included age in the analysis since time, as it relates to opportunity (or in our case risk), is implicit in the notion of career which describes developmental sequences.

12. Everitt, Brian, Cluster Analysis. New York: John Wiley and Sons (Halstead Press), 1974, pp. 7-22. Among the more frequently used clustering techniques are hierarchical, optimization-partitioning, density or mode-seeking, and clumping. Hierarchical clustering methods include single linkage or nearest neighbor, complete linkage or furthest neighbor, centroid, median, average linkage between or within groups, and Ward's method.

13. Anderberg, Michael Cluster analysis for applications. New York: Harcourt Brace Jovanovich (Academic Press), 1973, p. 131.

14. Average linkage is similar to single linkage which is among the most popular clustering methods. However, average linkage is less influenced by extreme values and therefore less subject than single linkage to "chaining", which refers to the tendency for new clusters to be composed of a single case.

15. In a 2x2 table with frequencies a, b, c, d in respective cells (1,1) (1,0) (0,1) (0,0) the jaccard measure is computed by a/a+b+c. Anderberg describes this measure as "the conditional probability that a randomly chosen data unit will score 1 on both variables, given that data units with 0-0 matches are discarded first. The 0-0 matches are treated as totally irrelevant" (Supra, Note 13, p. 89).

Chapter 3:

Results of Statistical Analyses

In this chapter we examine the social, criminal and mental health background of inmates in our sample. This review serves several purposes. First, it is a descriptive device that provides contextual material which allows for comparisons with other offender populations. The data also help us develop a frame of reference for subsequent analyses in that some findings can be used to identify areas for investigation, and others facilitate explanations of results. In addition, by scrutinizing the criminal history of mental patients we broach the issue of relationships between emotional disorder and violence. And, more importantly, by mapping the type and timing of criminal and mental health involvements, we create a foundation for the career typology we shall describe in subsequent chapters.

This chapter will include a detailed comparison of the violent involvements of emotionally disordered and other offenders, a task that is directly relevant to our main concerns, which center on the distinctive features of violence among offenders with emotional problems. Our approach to this analysis is two-fold in that we include legal nomenclature and conventional offense attributes such as victim-offender relationship as descriptive items, as well as comparisons based on the violence typology and the eccentricity codes we described in Chapter 2.

Social characteristics and criminal history

Table 3.1 displays the social characteristics and the criminal history of offenders in the samples. We find that in all three mental health groups white, non-hispanic inmates are overrepresented, with the highest percentage found among offenders with combined substance abuse and mental health problems (57%). We also note that inmates with a history of psychiatric problems show the lowest level of preincarceration employment, and are least likely to be married. Finally, we see that inmates in the mental health groups tend to be older than other inmates, with the greatest difference found among the two groups of substance abusers.[1]

We find that offenders with mental health records have more extensive criminal backgrounds, and this tendency encompasses violent offenses. In particular, the average number of arrests for substance abusers is almost twice that for the comparison group which makes it unsurprising that inmates with substance abuse problems are also more apt to have done time in prison. The average age of first contact with the criminal justice system is relatively constant across inmate groups, so observed differences in criminal histories can not be attributed to earlier onset of offender careers. Another possible explanation for the differences in arrest histories is that they are an artifact of age disparities since older offenders have had more time to accumulate contacts with the criminal justice system. However, when we group offenders into relatively homogeneous age strata,[2] we find comparable differences in arrest histories by mental health background, confirming that offenders with

Table 3.1 Social characteristics and criminal history by type of mental health experience

Social Characteristics	Type of mental health experience: No history (n=544)	Substance abuse history (n=83)	Psychiatric history (n=540)	Substance abuse and psychiatric history (n=141)
Ethnicity				
White	15%**	44%**	39%**	57%**
Black	58	34	46	30
Hispanic	27	22	15	13
Gender				
Male	98%	96%	96%	96%
Female	2%	4%	4%	4%
Marital status				
Single	64%**	65%**	77%**	71%**
Married	36	35	23	29
Highest education level				
Grade school	22%	20%	22%	19%
Some high school	64	61	56	59
High school graduate	16	19	21	23
Age (at prison entry)	$\bar{x}$= 26.0[a] sd= 7.7	$\bar{x}$= 30.4[a] sd= 6.6	$\bar{x}$= 28.6[a] sd= 9.4	$\bar{x}$= 30.0[a] sd= 7.6
Criminal history				
Age at first offense[b]	$\bar{x}$= 18.4 sd= 6.1	$\bar{x}$= 17.6 sd= 2.8	$\bar{x}$= 18.4 sd= 8.0	$\bar{x}$= 17.8 sd= 4.4
Number of prior offenses	$\bar{x}$= 5.7[a] sd= 5.7	$\bar{x}$= 10.0[a] sd= 7.1	$\bar{x}$= 7.9[a] sd= 7.5	$\bar{x}$= 10.3[a] sd= 7.5
Number of prior violent offenses	$\bar{x}$= 1.4 sd= 1.7	$\bar{x}$= 1.9 sd= 2.4	$\bar{x}$= 1.8 sd= 2.2	$\bar{x}$= 2.0 sd= 2.2
Prior prison experience	27%**	43%**	31%**	48%**

** - Chi-square, p. less than .01
[a] - T-test, p. less than .01
[b] - The conviction offense is used as the first offense for offenders with no criminal history.

emotional problems show higher levels of criminal involvement irrespective of chronological age.

Patterns of prior offenses

The number of prior violent crimes is strongly associated with the number of non-violent crimes (pearson correlation =.62). This finding confirms that violent offenders lead checkered offense careers, and raises the possibility that the more extensive violence histories we observe among offenders with mental health problems may reflect a general increased propensity to commit crime. One means of addressing the latter issue is to examine the relative proportion of prior offenses by type, as displayed in Table 3.2. The data indicate that inmates in the comparison group are more likely to have been arrested for robbery while those in the three mental health groups have been disproportionately arrested for public order offenses. Both categories of substance abusers show greater past involvements in burglary and DWI (driving while intoxicated), with the substance abuse group also gravitating towards prostitution and drug offenses. Finally, we notice that the psychiatric group has been disproportionately arrested for assault, including sexual assault (i.e., rape and sodomy), as well as criminal mischief.[3]

In sum, the data indicate that offenders with mental health histories, particularly substance abuse problems, have more extensive criminal records than other offenders. Members of the psychiatric group show a greater tendency to have engaged in assaultive offenses, including serious sexual assaults, while substance abusers more frequently engage in burglary. At the

Table 3.2 Distribution of types of prior offenses by type of mental health experience

Type of prior offenses	Type of mental health experience: No history (n=3067)	Substance abuse history (n=810)	Psychiatric history (n=4179)	Substance abuse and psychiatric history (n=1429)
	(Percent)			
Murder	0.5	0.4	0.3	0.4
Kidnapping	0.1	0.2	0.2	0.3
Arson	0.5	0.6	0.4	0.5
Rape, sodomy, sex abuse	1.5	1.6	2.7	1.6
Robbery	14.0	9.4	8.9	9.1
Assault	6.7	5.6	9.5	6.9
Reckless endangerment	1.2	1.7	1.8	1.8
Burglary	14.3	17.7	14.4	16.9
Grand larceny	11.6	10.6	9.4	8.5
Possess stolen property	5.6	4.9	4.3	4.2
Petit larceny	8.3	8.4	9.2	10.6
Forgery, fraud	2.9	3.1	4.6	4.3
Prostitution	0.2	3.1	0.9	0.3
Drug	6.6	8.1	4.2	6.4
Marihuana	4.5	3.3	1.9	2.7
Firearm	4.0	3.1	2.9	2.4
Public order	3.2	5.1	6.1	5.3
Criminal mischief	2.1	2.7	3.8	2.4
Criminal trespass	3.9	2.3	3.9	3.3
Harrassment	1.2	1.1	2.0	1.8
Escape	0.4	0.7	0.6	1.0
Resisting arrest	1.5	1.4	1.1	1.4
Gambling	0.7	0.5	0.8	0.1
DWI	0.7	2.5	1.3	2.2
Other auto	1.1	1.2	1.5	1.9
Juvenile delinquency	1.8	0.5	1.5	2.7
Person in need of supervision	1.0	0.1	2.1	0.7

same time, all mental health groups show disproportionate involvement in nuisance offenses, such as those considered breaches of public order. These somewhat paradoxical findings raise the question of whether tendencies to commit violent and nuisance offenses coexist in the same individuals, or in non-overlapping subgroups of offenders. We pursued this issue by examining the association between the number of violent and public order offenses, and found substantial pearson correlations among substance abusers (.24) and among offenders with composite psychiatric-substance abuse problems (.37). In contrast, correlations were considerably lower among offenders with a psychiatric history (.15) or with no record of mental health involvement (.13).

There is a connection between the presence of substance abuse problems and the kinds of crimes offenders commit. When we look at criminal histories by type of addiction we find that alcoholics show a greater propensity to engage in arson, assault, reckless endangerment, public order offenses, and driving while intoxicated.[4] In contrast, drug addicts are apt to be involved in burglary and drug offenses, including marihuana offenses. These findings are not surprising because they confirm that drug addicts can be financially motivated to commit property offenses in support of their addiction, and that one consequence of laws intended to curb the use of drugs is that of turning addicts into repeat offenders.

Contrasting criminal proclivities, such as engaging in social nuisance and violent offenses, have a greater tendency to

appear in tandem among substance abusers. This finding requires us to bring a new perspective to the fact that offenders with alcohol problems disproportionately engage in a variety of antisocial behavior that range in degree of seriousness from public order offenses to arson. It is not only the case that portraits of alcoholics as annoying disorderly drunks and as disinhibited bellicose inebriates both contain an element of truth, but, more significantly, we find that these representations often describe coexisting dispositions in the same intoxicated individual. Along this line, the violence pattern (arson, assault, reckless endangerment) among alcoholics points to a phenomenon that reinforces another familiar argument, postulating a link between severe drinking, emotional disinhibition and impaired social judgment.

Offender career patterns

We now examine mental health and criminal justice careers based on the chronology of treatment involvements and criminal arrests.[5] In order to simplify the analysis, we characterized past events as remote (more than three years from the conviction offense) or recent (less than three years). Patterns of mental health contacts are displayed in Table 3.3. We note that more than half (56.3%) the substance abusers have a treatment history confined to the remote past. The other groups show problems of greater currency. Three-fifths (60.7%) of the psychiatric group and seven-tenths (70.2%) of the compounded group show evidence of shotr-term or recent mental health problems. In particular, we note that offenders with combined substance abuse and psychiatric

Table 3.3 Career patterns of treatment history and of violence history by type of mental health experience

Note: Remote history refers to events taking place more than three years prior to the conviction offense, and recent history refers to events within three years of the conviction offense.

Chronology of treatment history	Type of mental health experience: Substance abuse history (n= 80)	Psychiatric history (n=537)	Substance abuse and psychiatric history (n=141)
Remote	56.3%	39.3%	29.8%
Recent	18.8%	8.8%	5.0%
At the time of conviction offense	3.8%	8.8%	3.5%
Remote and recent	12.5%	12.7%	42.6%
Remote and at conviction offense	6.3%	13.2%	8.5%
Recent and at conviction offense	1.3%	5.6%	4.3%
Remote, recent and at conviction offense	1.3%	11.7%	6.4%

Violence history	Type of mental health experience: No history (n=544)	Substance abuse history (n= 83)	Psychiatric history (n=540)	Substance abuse and psychiatric history (n=141)
No prior violence	38.6%	27.7%	34.1%	22.7%
Remote violence	30.9%	44.6%	R32.4%	51.1%
Recent violence	16.7%	9.6%	14.6%	9.2%
Recent and remote violence	13.8%	18.1%	18.9%	17.0%

problems are most apt to have a client status spanning both the remote and recent past (42.6%).

Offenders in the psychiatric history group often have received services at conviction (39.3%), but treatment histories limited to that point in time are rare, and we find that offenders who receive services at conviction tend to have a previous record of mental health involvement. We also see that the former psychiatric patients contain the largest proportion of chronic mental health clients, defined as offenders with service involvements across the three time periods (11.7%).

Also displayed in the table are chronological patterns of violence. The comparison group has the highest proportion of offenders with no violence history (38.6%), while the combined substance abuse and psychiatric group has the lowest proportion (22.7%). Both substance abuse groups tend to have violence histories limited to the remote past (44.6% and 51.1%), while the psychiatric group shows the greatest degree of violence chronicity (18.9%).

We examined the relationship between temporal patterns of mental health contacts and violence, and the results of this analysis are displayed in Table 3.4. The data indicate that a remote violence history is most characteristic of substance abusers, regardless of treatment chronology, and that chronic substance abusers contain the largest proportion of offenders with a chronic violence history (29.4%).

Both groups of psychiatric patients, those with relatively pure emotional problems and those with substance abuse problems, show similar relationships between chronologies of treatment and

Table 3.4 Relationship between treatment career patterns and violence career patterns by type of mental health history

Note: In this table, recent treatment history includes services delivered after the conviction offense.

Offenders with a substance abuse history:

Treatment history		Violence history: No Violence	Remote Violence	Recent Violence	Remote and recent violence
Remote	(n= 45)	26.7%	44.4%	11.1%	17.8%
Recent	(n= 18)	33.3%	50.0%	11.1%	5.6%
Remote and recent	(n= 15)	23.5%	41.2%	5.9%	29.4%

Offenders with a psychiatric history:

Treatment history		No Violence	Remote Violence	Recent Violence	Remote and recent violence
Remote	(n= 211)	28.4%	42.2%	10.9%	18.5%
Recent	(n= 94)	52.1%	13.8%	19.1%	14.9%
Remote and recent	(n= 232)	31.9%	31.0%	16.4%	20.7%

Offenders with a substance abuse and a psychiatric history:

Treatment history		No Violence	Remote Violence	Recent Violence	Remote and recent violence
Remote	(n= 42)	23.8%	57.1%	7.1%	11.9%
Recent	(n= 12)	50.0%	25.0%	8.3%	16.7%
Remote and recent	(n= 87)	18.4%	51.7%	10.3%	19.5%

violence. Offenders with a longterm treatment history most often have a violence history that is confined to the same time frame (42.2% and 57.1%), while half or more of the offenders who only recently became mental health clients have no violence history (50.0% and 52.1%). Chronic psychiatric patients show nearly equal proportions of offenders with a history of no violence (31.9%) or of remote violence (31.0%), and chronic psychiatric patients with substance abuse problems more often than not have a remote violence history (51.7%). Both groups of chronic psychiatric patients disproportionately include chronically violent offenders (20.7% and 19.5%).

Overall, we see that many offenders with a history of psychiatric problems have a longstanding history. More significantly, we find that offenders who raise mental health issues after their violent offense usually have a history of prior mental health difficulty. In contrast, patterns of treatment among substance abusers are more circumscribed, and less often span the remote and recent past. Substance abusers, who also tend to be the oldest offenders in our samples, also have violence careers that are limited to the remote past, while other offenders are more likely to have a recent history of violence. Violence careers show somewhat greater chronicity among offenders with a history of mental health problems, and this finding is consistent with our previous analyses.

The relationship between mental health and violence careers shows a consistent and significant pattern among both groups of former psychiatric patients. Offenders with a remote history of

psychiatric treatment tend to have a violence history that is confined to the same time frame. By the same token, offenders who only recently have developed emotional difficulties tend to have no history of violence and are often first-time violent offenders. We also find that psychiatric patients with more chronic treatment histories tend to have more chronic violence histories. Thus, as we track the course of treatment involvements over time, periods of serious emotional disorder repeatedly coincide with an increased propensity to violent crime, and this pattern suggests a connection between mental health problems and violence among seriously disturbed offenders.

Offense descriptions

The data in Table 3.5 group conviction offenses, and show that offenders with psychiatric histories stand least often convicted of robbery and weapon possession, and more often of murder, assault, rape and sodomy. We also see that the degree of injury inflicted on victims is highest for the psychiatric group. We note that offenders in both substance abuse groups are more apt to have been convicted of burglary, and do the least damage to their victims.

In the same table we also see that offenders with psychiatric histories who are convicted of murder, arson, rape and weapon offenses receive longer sentences than others similarly convicted. Inmates with combined substance abuse and psychiatric problems are subject to relatively longer sentences if convicted of robbery or assault, and to relatively shorter sentences if convicted of weapon possession. Finally, offenders

Table 3.5 Conviction offense and sentence length by type of mental health experience

Conviction offense	No history (n=544)	Substance abuse history (n=83)	Psychiatric history (n=540)	Substance abuse and psychiatric history (n=141)
	Type of mental health experience			
	(Percent)			
Murder	8.8	6.0	10.4	5.7
Kidnapping	0.2	0.0	0.9	0.7
Arson	1.1	2.4	3.0	2.8
Robbery	46.6	44.6	32.4	44.7
Assault	9.4	7.2	16.1	12.1
Reckless endangerment	0.4	1.2	1.1	1.4
Burglary	15.8	24.1	16.1	21.3
Rape	5.2	4.8	9.3	3.5
Sodomy	2.0	2.4	5.7	0.0
Sex abuse	1.1	2.4	2.4	0.0
Weapon	9.4	4.8	2.6	7.8

Conviction offense	Min	Max	Min	Max	Min	Max	Min	Max
	Mean sentence length							
	(Months)							
Murder	56	163	42	107	67	182	61	153
Kidnapping	a	a	a	a	46	108	a	a
Arson	20	50	a	a	28	73	a	a
Robbery	37	85	43	84	37	82	42	94
Assault	38	80	39	87	39	86	30	71
Reckless endangerment	a	a	a	a	27	61	a	a
Burglary	31	72	32	72	32	71	33	72
Rape	55	140	a	a	55	125	54	130
Sodomy	32	88	a	a	39	103	a	a
Sex abuse	16	48	a	a	16	49	a	a
Weapon	28	50	a	a	32	67	21	47
Life sentence (percent)	4.2		3.6		3.5		2.1	

a - Statistic not reported because there are less that five cases.

with substance abuse problems who are convicted of murder seem to be sentenced to shorter terms of incarceration than other murderers. With regard to the proportion of offenders under community supervision at the time of the offense, convicted by trial, or sentenced to life imprisonment, we do not find differences across groups of inmates.

In summary, inmates with psychiatric histories are more often sentenced for serious violent crimes, while substance abusers are more frequently incarcerated for burglary, and these differences in conviction offense parallel those observed in arrest histories. This confluence of findings is significant because it suggests that there are reliable differences in criminal propensity between groups of offenders, and that there is some continuity of offense behavior over time. Although a number of considerations which we have not examined enter into sentencing decisions, the data support the proposition that mentally disordered offenders receive more severe penalties than other offenders convicted of similar violent offenses.

Patterns of offense behavior

We now describe aspects of violent crimes (e.g., location, weapon use, victim-offender relationship) commonly reported in prior research. In reviewing the findings, we see that they suggest a modal or typical pattern, around which there was modest variation for each crime type. We can therefore begin to report the findings with a composite description of the "typical" offense as represented by the comparison group, and can note any deviations from this pattern by mental health groups. (The

statistics we report refer to the percent of cases with a particular attribute.)

Murderers commit most of their offense on the street (43%) or at the victim's residence (26%), use a gun (56%), and are often accompanied by a co-offender (38%). The victim is typically a male (75%) friend or acquaintance (46%). In contrast, murderers with psychiatric histories are more likely to act alone (84%) at their own residence (25%), using a blunt instrument (14%) as a weapon, and kill a relative or spouse (21%).[6] Both assaulters and murders are characteristically similar. Assaults by the comparison group tend to occur on the street (47%) against a male (80%) friend or acquaintance (53%). The incidents frequently involve a gun (49%) and the victim usually requires medical treatment (71%). Offenders with psychiatric histories prefer to act alone (85%) in off the street locations (62%) assaulting female (43%) strangers (38%). They rarely use a weapon (15%), but when they do the preferred instrument is a knife (52%), and the attack is less likely to precipitate medical assistance (48%). Inmates with combined psychiatric and substance abuse histories disproportionately assault a relative or spouse (41%), and when a weapon is used, more often than not it is a knife (65%).

Robbers constitute the largest offender group in the sample. The typical scenario finds the offender acting in concert with others (71%), on the street (47%) with a weapon (70%), which is usually a gun (44%). The victim is nearly always a stranger (84%) who is physically assaulted (65%). Several contrasts with this picture are found among the substance abusers. Both groups

(specialized, compounded) of substance abusers tend to commit their robberies without assistance (46% and 65%) against commercial establishments (41% and 49%). The victim is usually threatened (65% and 62%) with a weapon (84% and 80%) and the offender makes off with a substantial amount of money (36% and 38% - over $250).

Sex offenders almost always act alone (91%). They commit the sex offense at their or (40%) or the victim's (27%) domicile against a relatively young (53% - under 17 years of age) female (87%) who is either a friend (44%) or stranger (31%). Weapons are infrequently (29%) involved in these incidents. The mental health groups display the same pattern, with the exception of the psychiatric group which is somewhat more likely to select a male victim (18%).

Burglars, acting in concert (49%), usually target a private dwelling (86%) belonging to someone unknown to them (87%). The crime often produces substantial material gain (45% over $250) and victims are rarely physically assaulted (13%). A similar pattern emerges for mental health groups, except that they show a greater propensity to act alone.

Weapons offenses usually involve a lone offender (75%) who is discovered carrying a weapon on the street (65%). Only in rare instances is a victim attacked (8%). A similar pattern is found among the mental health groups, although these incidents seem to carry a greater potential for violence. For example, offenders with psychiatric histories are more likely to be found carrying weapons in commercial establishments (21%), and more

often attack a victim (21%).

In sum, the composite picture describing many, but certainly not all, murders and assaults among the comparison group is that these offenses are the product of street encounters among groups of male acquaintances in which a dispute arises and someone is shot. Major departures from this scenario for offenders with mental health histories, particularly psychiatric care, are: (1) these offenders are more disposed to act alone, (2) the incident is less likely to take place on the streets, (3) the offender less often uses a gun, (4) murders more frequently involve nonstranger victims, specifically a spouse or relative, while (5) strangers and females have greater chances of being assault victims.

One difficulty in interpreting these findings is that several explanations can apply to them. Differences in criminal behavior may reflect variations in the social activities or lifestyles of offenders, or may capture different motivational or situational aspects of violent encounters. Later we will examine the violent incidents from an alternative viewpoint that partly illuminates this issue. However, at this point we can venture some speculations.

The most consistent difference we find, pertaining to almost all crime categories, is that offenders with mental health backgrounds are more disposed to act alone. This fact suggests that group-influenced motivations are less apt to produce violence among mentally disordered offenders. The data may also reflect the familiar fact that mental patients lead relatively marginal lifestyles, which include a greater degree of social

isolation. The finding that incidents by mental patients occur less frequently on the streets also suggests that differences in social or situational attributes exist. Given that guns are less often used by mental patients, one infers that they are less prone to share the view that possessing a gun is a necessary means of protection or serves as a visible symbol of toughness. More generally, however, access to firearms can be a function of associating with persons who have access to illegal markets, and in this regard mental patients may be at a disadvantage.

The finding that relatives or spouses are disproportionately victims of murder implicates domestic problems as situations that can provoke extremely violent reactions from mentally disordered offenders. Familial incidents can involve an escalation of grievances (including legitimate, exaggerated or imagined grievances). Yet, intimates suffer a greater risk of victimization if offenders lead reclusive lives.

In contrast, victims of assault are more often strangers, suggesting that unprovoked attacks or short-term escalations may be more prevalent among mentally disordered offenders. It is harder to explain why females are more often chosen as victims, but it may be that some disturbed offenders lack disinhibitions including chivalrous norms which hold that women are out of bounds as sparring partners. Moreover, if some mentally disordered offenders selectively seek out weaker victims, a presumed lack of physical strength among females may make them attractive targets.

Among violent or potentially violent acts that incorporate a profit-motive (i.e., robbery), offenders with substance abuse problems stand out as heavily involved and substantial figures. These offenders (1) appear more comfortable working alone, (2) usually target lucrative commercial establishments, and (3) are likely to carry a gun, which hypothetically allows effective control of the situation, thereby reducing the chances of physical violence.

Patterns of violence

We now examine differences in types of violence across groups of offenders. The data in Table 3.6 indicate that the most common type of violence for which offenders are imprisoned is that of felony-related violence. However, proportions of felony-related violence vary across groups, ranging from half of the comparison group to one-third of the psychiatric group. The second most common offense type is burglary, which most people would consider a property crime. As we have noted before, burglars are disproportionately represented among substance abusers. Specifically, more than a fifth of the substance abusers (both groups) are burglars, which is about one and a half times the proportion of burglars in other inmate groups. The next most common offense type is retaliatory violence, and the proportion of inmates in this category is not different across groups.

The remaining violence types are relatively uncommon but show significant variations across groups. As one might expect, both groups of inmates with a history of psychiatric problems

Table 3.6 Type and level of violence and eccentric offense behavior by type of mental health experience

		Type of mental health experience			
		No history (n=544)	Substance abuse history (n=83)	Psychiatric history (n=540)	Substance abuse and psychiatric history (n=141)
Type of violence	Sig. level[a]	(Percent)			
Retaliatory	.40	12.5	10.8	15.7	14.4
Unmotivated	.00	1.2	0	6.5	5.8
Felony-related	.00	50.8	45.8	33.7	43.9
Sex - adult victim	.00	3.7	7.2	8.5	2.9
Sex - child victim	.00	4.5	3.6	10.7	0.7
Weapon	.00	8.7	3.6	2.0	5.0
Arson	.17	1.2	2.4	3.1	2.9
Police victim	.31	1.7	3.6	2.8	0.7
Burglary	.02	13.1	21.7	14.4	22.3
Auto / institution	.82	2.3	1.2	2.4	1.4
Level of violence	Sig. level[a]				
No violence	.11	18.9	20.5	15.9	24.5
Less serious	.00	33.6	43.4	21.1	35.3
Serious	.03	30.3	22.9	31.5	20.1
Extreme	.00	17.2	13.3	31.5	20.1
Eccentric offense behavior	Sig. level[a]				
Ineffectual	.00	3.5	8.4	10.9	10.6
Frenzied	.00	1.8	2.4	9.8	8.5
Symptomatic	.00	1.8	0	7.8	4.3
No Motive	.00	1.1	1.2	8.0	4.3
No memory	.00	1.3	10.8	6.1	13.5

a - Chi-square, specified category versus all others.

more frequently engage in unmotivated violence, which includes situations in which the offender can not offer plausible explanations for his or her act. The two disturbed offender groups are also more likely to stand convicted of sexual violence, both against adults and children. The proportion of sex offenders is substantial, in that it amounts to nearly one fifth of the psychiatric group. Inmates with substance abuse problems are also more frequently sentenced for sexual violence, but only with adult victims, while the comparison group is more often convicted of weapon offenses. Finally, we note that proportions of arson, violence against police, violence in an institution and assault with an automobile do not vary across offender groups, though there is an indication of a difference for arson.

Seriousness of violence ratings show substantial variation across mental health background. We find that in nearly one-third of the violent involvements of persons with psychiatric histories the level of violence is extreme. This proportion is the highest among the offender groups and almost twice that of the comparison group. Other analyses indicate that recency of psychiatric problems is associated with extremity of violence. More than three-quarters (77%) of the psychiatric patients who received mental health services at the time of their conviction offense engaged in serious or extreme violence. While the perceived need for treatment can be influenced by degree of violence, career patterns show that most offenders who become patients after arrest have mental health records predating the offense, which weakens the argument that violence is a

contaminating diagnostic criterion. We also find that the proportion of serious or extreme violence for offenders with a recent and a remote psychiatric history is 66% and 61%, again suggesting that recency of emotional problems increases the probability of serious violence.

Inmates with substance abuse problems engage in offenses that involve little or no violence, a finding we might anticipate since these offenders are most frequently engaged in burglary. On the other hand, the role of alcohol and drugs stands out in the violence committed by offenders with substance abuse problems. Sixty percent of offenders with alcohol or drug problems and 64% of offenders with combined substance abuse - psychiatric problems were described as under the influence of an intoxicating agent at the time of their offense. These proportions compare with 38% of the psychiatric group and 27% of the comparison group who were similarly intoxicated.

Patterns of eccentricity

As expected, we find eccentric violence to be rare among members of the comparison group. Ineffectual behavior, which is the most frequently appearing item, characterizes only 3.5% of conviction offenses, while proportions of other eccentricities fall under 2%. The substance abuse offenders show much more ineffectual or counterproductive behavior (8.4%), and more often claim to have no memory of the criminal event (10.8%). Offenders with psychiatric histories are overrepresented in all categories of peculiar offense behavior. Many violent incidents by disturbed inmates incorporate ineffectual or counterproductive

behavior, such as leaving behind incriminating evidence (10.9%), violent overkill, or violence reflecting a frenzied mental state (9.8%), or conduct one thinks of as symptomatic of a mental disorder (7.8%). In 8.0% of violent incidents there was no plausible motivation for the offense, while in 6.1% the offender could not recall his crime. Offenders with combined substance abuse and psychiatric problems showed the greatest difficulty recollecting details of their offense (13.5% of incidents). This group is also overrepresented in other categories of eccentricity, but less so for motiveless and symptomatic violence when compared to the psychiatric group.

Although proportions of incidents with eccentric features are not very large (ranging from 6.1% to 13.5%), disproportionate appearance of symptomatic nuances argues for recognition of "symptomatic violence," meaning situations in which clinically-relevant attributes can be implicated in the violence picture of disturbed offenders. A history of emotional problems can decrease a person's competence as a violent offender, and increase the damage done in acts of blind rage.

We conclude that a view of mental illness and criminality as totally unrelated, independent attributes is not appropriate for some patient-offenders. The argument for a more integrated perspective is strongest in situations where symptoms and violence coincide, and we will take a closer look at offenses of this kind. We also conclude that two contrasting images -- that of the ineffectual criminal and that of the frenzied violent offender -- can converge among disturbed individuals. Such

combinations of person-related attributes and offense-related attributes deserve further scrutiny, and we take up this task in the next chapter, where we discuss the findings that emerged from cluster analysis.

Chapter 3:

Footnotes

1. When Steadman and his associates compared demographic profiles between hospital patients who are arrested and other patients, the differences suggested that the arrestees resembled offender populations (i.e., young, minority group members with prior criminal records) (Steadman, H., Cocozza, J. and Melick, M. "Explaining the increased arrest rate among mental patients: The changing clientele of State hospitals," American Journal of Psychiatry, 1978, 135, 816-20). The other side of the coin is that we find that offenders with mental health backgrounds demographically resemble the client population of psychiatric hospitals (i.e., older, white individuals).

2. Mean arrest rates across age categories and offender groups (1 - comparison, 2 - substance abuse, 3 - psychiatric and 4 - combined substance abuse-psychiatric) are:

Age at conviction offense	Mean number of prior arrests Offender group 1	2	3	4
20 years and younger	3.4	4.1	5.0	4.6
21 to 25 years	5.3	7.1	7.0	7.9
26 to 30 years	6.6	9.1	9.5	11.1
31 to 35 years	8.0	10.0	10.0	10.4
36 to 40 years	8.9	17.1	8.6	10.9
41 years and older	8.5	15.4	9.5	20.5

The data indicate that offenders with mental health backgrounds have more extensive criminal histories than other offenders across age groups. The difference is greatest for offenders with substance abuse problems, especially in the older age groups, where we find very substantial criminal records.

3. In order to investigate if offenders with mental health backgrounds have a greater tendency to specialize in violence we examined the proportion of violent to total crimes among offenders with ten or more prior arrests. The analysis revealed that the distribution of this proportion was virtually identical across offender groups. Descriptive statistics on the distributions are as follow: Comparison group - mean 22, std. dev. 15, median 19; Substance abuse group - mean 20, std. dev. 16, median 16; Psychiatric group - mean 23, std. dev. 18, median 19; Combined substance abuse and psychiatric group - mean 20, std. dev. 16, median 17.

4. The distribution of types of prior offenses by type of substance abuse problem is:

	Alcohol (n=698)	Drug (n=1229)	Both (n=312)
		(Percent)	
Murder	0.4	0.4	0.3
Kidnapping	0.4	0.2	0
Arson	1.1	0.2	0.6
Rape, sodomy, sex abuse	1.7	1.5	1.9
Robbery	9.6	9.1	8.7
Assault	8.3	6.0	3.8
Reckless Endangerment	2.9	1.0	2.6
Burglary	13.6	18.6	19.9
Grand larceny	9.3	9.6	8.0
Possess stolen property	3.3	5.0	4.8
Petty larceny	8.9	10.4	9.6
Forgery or fraud	5.0	3.7	1.9
Prostitution	0.3	1.2	3.2
Drug offenses	2.4	9.8	6.4
Marihuana offenses	0.9	4.1	3.2
Firearm offenses	2.1	2.8	2.9
Public order	9.6	2.8	4.8
Criminal mischief	3.4	1.5	4.5
Criminal trespass	2.7	3.1	2.9
Harassment	3.2	0.9	0.6
Escape	0.6	1.3	0.3
Resisting arrest	1.9	1.0	1.9
Gambling	0	0.3	0.3
DWI	4.9	1.1	1.3
Other auto offenses	1.6	1.5	2.6
Juv. delinquency	1.6	2.0	1.9
Person in need of supervision	0.3	0.5	1.0

5. Information regarding the timing of service delivery was sometimes not available for mental health contacts recorded in correctional files. The fact that the degree of completeness of treatment chronologies varied by individual presented us with a problem. If we limited our analyses to individuals for whom we had complete information on all contacts, a substantial number of cases would be excluded for missing data. On the other hand, if we analyzed only events with complete information, descriptions

of many individual mental health careers would be incomplete. We resolved the dilemma by assigning mental health contacts to the remote history category when the year of contact was unknown. We chose this strategy because among events with complete information a disproportionate number occurred more than three years prior to the conviction offense. Although this procedure introduces a bias that leads us to overestimate the frequency of remote mental health involvements, the error is less than if we listed events with missing dates in one of the other time categories. We also assigned June 30 as the date if only the year of contact was available, and we used the 15th of the month if only the day was missing. Finally, we included psychiatric evaluations at time of conviction in the career chronology, though these evaluations were not used in the initial classification of the mental health samples.

6. Although the proportion of offenders who murder a relative is small (5%), we find that matricide, fratricide and patricide occur only among offenders with psychiatric histories.

Chapter 4:

Types of Offenders as they Emerged through Cluster Analysis

This chapter will summarize findings of our cluster analysis of four samples of violent offenders: (1) offenders with histories of general mental health services, (2) offenders with histories of mental health services including substance abuse services, (3) offenders with mental health histories confined to substance abuse services, and (4) a group of violent offenders who have no histories of mental health involvements.

The results of our cluster analysis are recorded in Tables 4.1 through 4.4. One fact we note in reviewing these tables is that each yields one or more clusters covering offenders convicted of Breaking and Entering. Burglary is only technically a violent offense. Burglars are nonetheless of interest to us, since they anchor the spectrum covered by our samples. Moreover, imprisoned burglars have felony records, which include violent offenses.

Our analysis yields types which provide sharp contrasts on consequential variables. We shall

see differences in types of offense, level of violence, criminal and violence history, and age. Substance abusers are often differentiated by histories of drug or alcholol abuse. Within offense categories (burglary, robbery, extreme personal violence) types differ on historical variables--such as presence or absence of violence records--and demographics (e.g., age). Such distinctions are gratifying given the number of variables we clustered, which could combine in impressively messy ways, given substantial heterogeneity.

We have attached descriptive labels to types, but shall reserve their deployment for subsequent chapters, which provide illustrations of the types. What follows is a summary of statistical highlights of twenty-six types of violent offenders.

1. Offenders with Mental Health Histories:

The mental health group is our principal sample, and consists of offenders who have received mental health services, exclusive of substance abuse services. As with our other samples, the group yields a cluster (Type 1) which comprises burglars whose offenses involve

Table 4.1 Results of Cluster Analysis for Offenders with Psychiatric Histories

	(Percent)									
	Impulsive Burglar (n= 56)	Impulsive Robber (n= 39)	Long-term Explosive Robber (n= 53)	Young Explosive Robber (n= 40)	Mature Mugger (n= 22)	Acute Disturbed Exploder (n= 51)	Chronic Disturbed Exploder (n= 90)	Disturbed Sex Offender (n= 65)	Composite Career Offender (n= 60)	Compensatory Offender (n= 19)
Offense type										
Unmotivated	0	0	0	0	0	26	19	5	0	0
Retaliatory	0	5	2	8	0	51	39	8	5	11
Felony-related	0	74	85	75	100	12	7	9	17	58
Sex - adult victim	0	10	2	5	0	2	19	14	8	11
Sex - child victim	0	3	6	8	0	2	4	43	20	11
Weapon	2	0	0	0	0	0	0	5	12	0
Arson	2	5	2	3	0	0	0	12	3	11
Police victim	0	0	4	3	0	6	3	3	5	0
Burglary	96	0	0	0	0	0	0	0	28	0
Auto / institution	0	3	0	0	0	2	9	2	2	0
Violence level										
No violence	98	0	0	0	0	0	0	5	35	0
Less serious	0	62	50	53	100	0	0	0	10	11
Serious	2	21	47	43	0	0	0	89	52	90
Extreme	0	18	4	5	0	100	100	6	3	0
Alcohol/drug influence	55	44	34	33	32	22	46	31	32	47
Eccentricity										
Ineffectual behavior	7	5	8	8	5	29	11	11	12	21
Frenzied mental state	0	3	2	3	0	35	30	2	0	5
Symptomatic behavior	0	5	4	0	0	29	8	14	3	11
No apparent motive	2	3	2	0	0	29	18	9	0	0
No memory	5	5	3	0	5	10	10	6	5	11
Psychotic dx	5	5	23	5	23	53	28	25	37	53
Low IQ	9	5	30	25	23	22	22	20	18	53
Violence history										
None	63	100	0	0	27	59	0	85	2	5
Recent	27	0	47	88	27	24	47	6	27	68
Remote	18	0	100	33	55	18	94	9	98	42
Arrest hx										
Low	32	87	4	40	23	67	7	51	2	42
Medium	48	13	4	45	64	28	28	35	37	58
High	20	0	93	15	14	6	66	14	62	0
Psychiatric hx										
Instant	27	28	19	10	23	78	31	65	37	84
Recent	41	28	40	28	46	53	41	32	37	79
Remote	70	67	85	83	73	55	89	63	93	79
Age										
Low	68	82	13	98	0	0	13	15	0	11
Medium	29	13	68	3	100	53	46	37	8	84
High	4	5	19	0	0	47	41	48	92	5
Prison experience	18	0	59	8	18	2	51	14	73	16
Under supervision	32	15	36	45	32	10	24	12	30	37
COVARIATES										
Single	77	95	77	90	76	80	63	77	59	94
High school graduate	25	13	26	0	14	33	21	25	34	33
White	60	31	42	23	29	35	31	60	45	26
Employed	71	54	73	58	68	71	67	71	86	67

no violence. Over half this group are intoxicated at the time of their offense; two-thirds (70%) have long-term mental health histories, despite the fact that most of the group (68%) is young. The group's violence history is modest, and so is its history of arrests and imprisonment. The group's educational achievements are limited (9% high school graduates), and over half the group is caucasian.

Four clusters in the sample (Types 2, 3, 4 and 5) stand largely convicted of felony-related violence. These offenses involve relatively serious violence, but one group (Type 2) stands out as not showing past violence, having virtually no arrest record and no prison experience. This group consists of younger offenders, few of who (2 of 39 men) have been diagnosed as psychotic. The employment history of the group is negligible (54%), the educational level is low (13% high school graduates), and virtually none of the offenders (5%) are married.

By contrast with Type 2 other robbery offenders with mental health histories (Type 3) show a long-term history of violence, and most members of the group (93%) have substantial

arrest records. Two-thirds of the group have been imprisoned, and one-third are under supervision at the time of their offense. One-quarter of the group (23%) have been diagnosed psychotic, and a substantial minority (30%) register low levels of intelligence. The group averages median age, but most of its members (85%) have long-term mental health problems.

A third group of robbery-related offenders (Group 4) is young. The group mostly has a recent history of violence (88%) but negligible prison experience (8%). Many members of the group (45%) are under probation supervision at the time of their offense. Though these offenders are rarely (10%) regarded as mentally ill at the point they are arrested and few (5%) have been diagnosed as psychotic, most (83%) have long-term mental health problems. No member of the group has graduated from high school.

The fourth cluster (Type 5) is a small group, and comprises offenders who engage in robberies that involve no physical violence. The offenders are of median age, three of four (73%) have a history of violence, and a third of the group (37%) are on probation at the time of their offense.

The most serious violent offenses in the sample are committeed by the most seriously disturbed offenders (Types 6 and 7). The offenses of these groups invariably involve extreme violence, and most consist of vicious retaliatory overkill or unmotivated offenses. In almost every case, there is an indication of bizarreness in the crime, and most of the offenders in the first group (Type 6) are seen as disturbed at the time of their offense. Over half the group (53%) has been diagnosed as psychotic, but an appreciable portion (59%) have no history of violence. Moreover, the arrest records of the offenders tends to be modest, and only one member of the group has prison experience.

The second cluster (Type 7) includes some violent rape offenders, and many persons (46%) who are intoxicated at the time of their offense. The offenders have long-term histories of violence and long arrest records. They also have long-standing histories of mental health problems. Half the group (51%) has prior prison experience.

Another cluster (Type 8) contains a large proportion (57%) of sex offenders, particularly (43%) of offenders engaged in child molestation.

The cluster also contains some arsonists (12%). The violence-level of the offenses is high, and the offenses often show bizarreness. However, most of the group (85%) has no history of violence, and half the group (51%) have never been arrested. One of four persons in the group have been diagnosed psychotic: their mental health problems are both current (65%) and long-term (63%). The group tends to be made up of older offenders, and two-thirds (60%) are caucasian.

The remaining two clusters (Types 9 and 10) include persons who commit a variety of offenses. The first cluster (Type 9) is made up of older offenders who have long-term violence problems and mental health involvements. Most of the group (73%) has prison experience, and many members of the group (45%) are white offenders. The second cluster (Type 10) is small; over half the offenders (11 of 19) have committed robberies which are violent and bizarre. The offenders are uniformly regarded to have mental health problems at the time of their offense, and they have histories of mental health involvements. Ten of 19 have been diagnosed as psychotic; 9 of 19 are intoxicated

at the time of their offense; ten of 19 have scored low on intelligence tests.

2. Offenders with Mental Health and Substance Abuse Histories:

The group with mental health and substance abuse histories contains one cluster (Type 1) of burglary offenders whose offenses include no violence. Most of these offenders (70%), however, have long-term histories of violence, and extensive (80%) arrest histories. Half the offenders in the cluster have prison experience, and half are under supervision (probation or parole) at the time of their offenses. Most of the group (85%) has early mental health problems, most (90%) is addicted to drugs, and two-thirds (65%) is intoxicated at the time of the offense. The group tends to be of median age, low level of education (10% high school graduates), and 75% of the group is white.

A small cluster (Type 2) consists of robbery offenders whose violence is nonserious. Almost all of the offenders (89%) are intoxicated at the time of their offense and have long-term violence histories, and most (8 of 9) have very long arrest records. The group's mental health problems are of long duration, and the offenders are addicted to alcohol. The members of the

Table 4.2 Results of Cluster Analysis for Offenders with Compounded Substance Abuse and Psychiatric Histories

(Percent)

	Dependent Burglar (n= 20)	Skid-Row Robber (n= 9)	Skid-Row Exploder (n= 35)	Composite Career Offender (n= 37)	Multi-Problem Robber (n= 28)
Offense type					
Unmotivated	0	0	6	16	0
Retaliatory	0	0	37	14	4
Felony-related	0	100	11	54	71
Sex - adult victim	0	0	6	5	0
Sex - child victim	15	0	0	0	4
Weapon	0	0	9	3	0
Arson	0	0	9	3	0
Police victim	0	0	3	0	0
Burglary	85	0	17	3	21
Auto / institution	0	0	3	3	0
Violence level					
No violence	95	0	20	3	21
Less serious	5	89	9	43	57
Serious	0	11	31	40	18
Extreme	0	0	40	24	4
Alcohol/drug influence	65	89	80	54	46
Eccentric behavior	10	11	29	32	14
Psychotic Dx	5	11	6	27	7
No memory	10	22	23	8	14
Low IQ	20	0	17	8	14
Violence history					
None	25	0	9	5	75
Recent	20	11	43	30	14
Remote	70	100	71	89	14
Arrest hx					
Low	5	0	17	0	61
Medium	15	11	43	27	39
High	80	89	40	73	0
Psychiatric hx					
Instant	25	11	26	14	25
Recent	25	33	60	27	32
Remote	85	78	54	92	68
Drug hx					
None	10	89	86	0	43
Recent	55	11	14	19	25
Remote	50	0	0	87	36
Alcohol hx					
None	85	0	6	89	64
Recent	10	33	57	5	21
Remote	5	89	54	5	18
Age					
Low	0	0	14	3	39
Medium	65	0	49	46	36
High	35	100	37	51	25
Prison experience	50	89	37	73	4
Under supervision	50	22	31	32	25
COVARIATES					
Single	60	44	86	62	86
High school graduate	10	22	21	27	25
White	75	67	54	49	61
Employed	90	89	88	81	85

group are older, tend to have prison experience, and are mostly (6 of 9) white.

The most violent group (Type 3) also comprises disturbed alcoholics. A portion (40%) of the violence that is committed by this group is extreme, and the group uniformly (91%) has violence histories. Offenses of the group range widely; eight out of ten involve intoxication, 29% demonstrate eccentricity, and one of four includes loss of memory. Few members of the group (6%) have been diagnosed psychotic, but most have recent (60%) and or long-term (54%) mental health problems. The group varies in age, a third (37%) have prison experience, and half (54%) are white.

Another violent group (Type 4) consists of long-term drug addicts. The offenses of this group are also diverse. Most of the group (89%) have long-term violence problems, most (73%) have long arrest records and have prison experience. A third of the group's offenses reveal eccentricity, and one out of four members of the group have been diagnosed psychotic. The group has long-term (92%) mental health problems. Its members are of median (46%) or advanced (51%) age, and half the group is caucasian.

Another cluster (Type 5) consists of nonseriously violent offenders with no violence history and limited arrest records. The group contains mostly robbers and burglars with no prison experience. It consists of younger offenders with either drug (61%) or alcohol (39%) problems, and most of the group (61%) is white.

3. The Substance Abuse Treatment Group:

The substance abuse treatment group consists of offenders who have received services for substance abuse problems under auspices of the mental health system, but who have not been otherwise dealt with as disturbed.

The group yields two fairly small clusters, and two which are larger. One of the small clusters (Type 1) comprises persons who stand convicted of nonviolent offenses, all of which are burglaries. The offenders have no histories of violence, but have arrest records, and almost half (five out of eleven) are on probation at the time of their offense. The group is of median age; it contains persons with drug problems and alcohol-related histories. Several

Table 4.3 Results of Cluster Analysis for Offenders with Substance Abuse Histories

(Percent)

	Addicted Burglar (n= 11)	Addicted Robber (n= 11)	Alcohol Exploder (n= 33)	Drug Exploder (n= 20)
Offense type				
Unmotivated	0	0	0	0
Retaliatory	0	0	15	20
Felony-related	0	91	36	55
Sex - adult victim	0	0	12	5
Sex - child victim	0	0	6	5
Weapon	0	0	6	0
Arson	0	0	6	0
Police victim	0	0	6	5
Burglary	100	9	9	10
Auto / institution	0	0	3	0
Violence level				
No violence	100	0	12	5
Less serious	0	91	27	55
Serious	0	0	39	25
Extreme	0	9	21	15
Alcohol/drug influence	27	55	70	27
Eccentric behavior	0	9	27	0
No memory	0	0	24	5
Low IQ	27	9	9	10
Violence history				
None	73	64	21	0
Recent	9	18	30	40
Remote	27	18	70	85
Arrest hx				
Low	9	46	18	0
Medium	55	55	39	5
High	36	0	42	95
Drug hx				
None	27	0	70	5
Recent	27	27	18	15
Remote	55	82	12	90
Alcohol hx				
None	73	91	6	85
Recent	27	9	46	10
Remote	0	0	67	10
Age				
Low	9	27	12	5
Medium	82	46	36	40
High	9	27	52	55
Prison experience	18	9	39	70
Under supervision	45	27	33	40
COVARIATES				
Single	64	55	85	40
High school graduate	18	36	24	5
White	36	45	63	30
Employed	73	70	82	90

members of the cluster are of relatively low intelligence.

The second small cluster (Type 2) consists of offenders who have engaged in felony-related, nonserious violence. This group has no violence history, a modest arrest record, and no history of imprisonment. The members of the group are drug addicts; six out of the eleven are intoxicated at the time of their offense.

Of the two larger clusters, one consists of persons addicted to drugs, and the other, of long-term alcoholics. The groups are made up of older offenders who arrive in prison convicted of offenses committed while the offender is intoxicated. Otherwise, the two groups differ: The offenders with histories of alcohol problems (Type 3) commit serious violence, some of which is bizarre, and some of which is accompanied by amnesia. Most of the group has a history of violence. The group is demographically distinct, in that two-thirds (21 of 33) of the men are white.

The violence level of the drug-addicted group (Type 4) is lower, but its history of violence appreciable. The members of the group have arrest records, and most (70%) have prison experience. More than half the group is

married, and nine of ten have employment histories.

4. The Comparison Group of Violent Offenders:

The comparison group is designed to include violent offenders and to exclude persons with mental histories. However, the group contains two clusters (Types 1 and 2) of nonviolent offenders and two clusters (Types 3 and 4) that feature disturbed offenders whose violence level is high.

Each nonviolent group consists of burglars (63%) and of persons convicted of weapons offenses (37%). Two-thirds of one group (Type 1) show no past violence and no arrest history. Few of the offenders (8%) have prison experience. By contrast, the other group (Type 2) contains persons with extensive criminal histories, including long-term violence problems. The offenders are also recidivistic, in that four out of ten (79%) have been in prison and half are under supervision when rearrested. The second group is appreciably older than the first; it contains few white offenders (8%) compared to the first group, which is one-third (34%) white.

Table 4.4 Results of Cluster Analysis for Offenders with No Mental Health History

(Percent)

	Inexperienced Burglar (n= 60)	Experienced Burglar (n= 38)	Acute Exploder (n= 67)	Patterned Exploder (n= 30)	Pre-Career Robber (n= 73)	Early Career Robber (n= 76)	Late Career Robber (n= 50)	Generalist (n= 63)
Offense type								
Unmotivated	0	0	5	0	0	0	0	0
Retaliatory	0	0	36	87	0	3	0	13
Felony-related	0	0	15	0	99	83	96	51
Sex - adult victim	0	0	8	7	0	3	0	13
Sex - child victim	0	0	22	3	0	0	0	10
Weapon	37	37	0	0	1	7	2	0
Arson	0	0	6	0	0	0	0	3
Police victim	0	0	3	0	0	1	0	5
Burglary	63	63	0	0	0	3	2	0
Auto / institution	0	0	49	13	0	5	0	37
Violence level								
No violence	90	95	0	0	0	4	0	0
Less serious	10	5	0	0	66	66	96	0
Serious	0	0	57	7	22	22	2	89
Extreme	0	0	43	93	12	8	2	11
Alcohol/drug influence	15	26	39	57	26	16	16	32
Eccentric behavior	0	3	21	27	6	4	0	5
No memory	2	0	2	7	0	3	0	0
Low IQ	17	16	30	10	15	21	10	25
Violence history								
None	68	0	99	13	99	0	0	5
Recent	20	13	2	43	0	75	40	35
Remote	13	97	0	67	1	45	98	84
Arrest hx								
Low	60	0	75	30	90	53	0	13
Medium	33	24	22	60	8	36	46	32
High	7	76	3	10	1	12	54	56
Age								
Low	45	3	18	13	52	86	0	2
Medium	37	45	58	17	41	9	72	65
High	17	53	24	67	7	5	28	33
Prison experience	8	79	6	13	0	20	64	48
Under supervision	27	50	9	13	8	42	44	24
COVARIATES								
Single	66	53	57	55	81	80	49	52
High school graduate	20	16	18	24	19	12	6	10
White	34	8	22	21	16	5	10	19
Employed	81	79	81	93	79	62	88	77

One group of disturbed offenders (Type 3) includes persons convicted of retaliatory violence (36%) and of sex offenses (30%), including child molestation (22%). The violence committed by these offenders is either serious (57%) or extreme (43%), many of the offenders are intoxicated at the time of their offense, and some of their offenses are eccentric in nature. On the other hand, only one offender in the group has been previously involved in violence, and four-fifths of the group have no arrest history. The group varies in age, contains few (6%) persons with prison experience and a high proportion (30%) of offenders of limited intelligence.

The second group (Type 4) contains offenders who engage in violent overkill. Most violence done by the group (87%) is retaliatory, and the harm inflicted is mostly extreme (93%). Evidence of unusual dispositions is provided by the fact that 57% of the offenders are intoxicated when they commit their offenses, 27% of which are bizarre. Most of the offenders (87%) have records of past violence, two-thirds have been arrested, but few (13%) have been imprisoned. The offenders are also older than average (67% high age group).

Three of the four remaining clusters (Types 5, 6, and 7) contain mostly robbers--offenders engaged in felony-related violence. The third cluster (Type 7) features nonserious violence, a history of violence (98% long term) and records of arrest. Two-thirds of this group has served time in prison; almost half (44%) are on probation or parole when arrested. The group is mostly of median age, contains a number (49%) of married inmates, but shows limited educational attainment (6% high school graduates).

The other two groups (Types 5 and 6) demonstrate some serious violence, but one group (Type 5) comprises inmates with no violence experience (97%), no arrest record (90%) and no history of imprisonment. The age of the group is either median or young and one-third of the group's offenses involves intoxication (26%) or eccentricity (6%). The remaining robbery group is uniformly (86%) young and violence-experienced (75% recent, 48% long term). Half the group has arrest records, one-fifth has been in prison before, and half (42%) are under supervision when arrested. The group contains almost no white inmates (5%), and only a modest proportion of the group have been employed.

The final cluster (Type 8) is harder to characterize. Offenses committed by the group invariably involve serious violence (89% serious, 11% extreme), but the offenses include a variety of crimes. Almost all of the offenders have violence histories, and most (87%) have arrest records; half (48%) have been imprisoned. One out of four of the the offenders fall in the low intelligence group, and a third are intoxicated at the time of their offense. The group thus resembles the disturbed serious violence clusters (Types 3 and 4) but contains more robbery offenders (51%) than these groups of explosive individuals.

Chapter 5:

Offenders with Mental Health Problems

The core sample comprises former clients of mental health services other than substance abuse services. Cluster analysis subdivides this sample into ten types. These range in terms of the seriousness of the violence the offenders have perpetrated and in terms of the extent to which professional contacts are deemed needed after the offender is arrested. The offenders have histories of mental health contacts, and most have histories of violence involvements.

1. Impulsive Burglars:

The first type stands out because its members are not violent offenders (54 of 56 are convicted burglars), though four of ten have committed violence in the past. The offenders are mostly young, and a surprising number (over half) are intoxicated at the time of their offense.

We call members of this group "impulsive burglars" because (1) they are non-professionals who (2) demonstrate mixed motives for offenses which are often ineffective and self-destructive.

A case in point is that of an eighteen year-old man imprisoned for a spree of four burglaries, in which he steals mostly jewelry. The offender's problems begin early

with learning disabilities compounded by anxiety and destructiveness. Antisocial acts in school include disrupting classes and theft of a teacher's purse. There is also a burglary (at age thirteen) involving an abandoned building. A year later there is another burglary in which the offender breaks into a house, steals jewelry and a pair of socks, and is placed in a residential program, from which he absconds. This sequence is followed by other burglaries, other residential placements and more escapes.

For his last offenses the man is placed in the job corps. Job Corps staff report that "he had numerous behavioral problems" and add the following as examples of his behavior record while at Job Corps:

> Assaulted another student with a chair during an argument over a candy cane.
>
> Carried two small cans of gasoline to the dorm with the idea of setting the dorm on fire.
>
> Numerous fights with other male students over trivial matters.
>
> Suspected of being involved in a break-in of a center residence and the center canteen.

The offender is jailed, and soon requires mental health services. The jail staff report that

> he was hospitalized twice in the Forensic Unit of the County Jail because of suicidal potential. First admission was after he attempted to hang himself in the bullpen with his shoelaces. He was discharged in an improved condition (and) was re-admitted because a noose was found in his cell and he threatened to kill himself in order not to go to state prison. On second admission he also exhibited psychotic symptoms, an underlying schizophrenic condition.

The offender ascribes his suicide attempts to difficulties he experiences in obtaining drugs. The same passive infant-like stance characterizes the man when he enters prison, where staff complain that he "seems to be lacking in . . . motivation."

A similar non-professional flavor permeates a second case, that of a twenty-three year-old burglar. This man's difficulties begin at age six, and include "family problems." Among these are a sadistic, abusing father who "used to beat him and handcuff him to his bed or a back porch railing" and a half-brother who sexually abuses him.

One site the man burglarizes is a program from which he has received services. He also breaks into the home of a friend who has helped him with legal fees, clothing and shelter. The man invariably commits offenses when placed on probation and parole, requiring that he be institutionalized. A social worker observes that "he seems almost to want to be punished or at least caught, particularly in light of his constant, flagrant violations of probation and curfew." The offender himself says that he is "a person who can be talked into anything," and claims he is "afraid someday someone will talk him into killing someone." Such statements do not invite lenient dispositions.

2. Impulsive Robbers:

Impulsive robbers are youthful robbers who have no histories of violent crimes and negligible criminal

histories. Like impulsive burglars, such persons also have childhood problems, including mental health problems.

The pattern is illustrated by a twenty year-old offender serving his first prison sentence for a residential robbery involving an occupied house whose owner is manhandled but not hurt. The offender is a drug and alcohol abuser, and he is intoxicated at the time of the offense. He is also a long-term patient, having been hospitalized for eight years starting at age eleven. He has recently committed himself to a hospital after seeing his mother stabbed by her boyfriend, and he has to be rehospitalized after he arrives in prison.

The offender is a victim of child abuse, and has been brain injured in infancy. He is virtually illiterate, and is borderline mentally retarded. He is also psychotic, and claims he hears voices that instruct him to hurt himself and other people.

The man is easily intimidated, which causes him many problems in prison. Other problems have to do with his impulsive aggressivity, which makes him assault other inmates and destroy furniture. However, the man is deathly afraid of guards (he thinks they will beat him for "not making his bed right") and invites exploitation by peers, to which he then reacts.

This offender's prison career consists of transfers between the prison hospital (where his deportment improves under medication) and disciplinary segregation settings. As

a result of this pattern his chances for program involvement are slim, and his prospects of community adjustment negligible.

This offender is somewhat more disturbed than most impulsive robbers, but typifies the attribute of the type, which is a combination of youthfulness, rootlessness and inadequacy, which augurs the threshhold of inauspicious careers.

3. Long-term explosive Robbers:

Long-term disturbed robbers have high arrest records and extensive histories of violence. They also have longstanding mental health problems, and have led checkered--and singularly unsuccessful--careers.

One robbery offender who typifies the pattern is a twenty-eight year-old man who has a propensity for beating women during the process of stealing their pocketbooks. He explains that he assaults his victims because they refuse to part with their bags. He says that he covets bags "because my mother has money in her pocketbook all the time." He also explains that he does not victimize men "because I don't want them to come after me."

The offender is a chronic schizophrenic who is often hospitalized. He is mentally retarded, and is described by prison staff as "simplistic, polite and cooperative." Despite his extensive offense history (ten prior felony arrests) and his predatory crimes, the man must be placed in

protective, structured settings, where he does well under continuing medication.

Another twenty-eight year-old robber has been arrested nineteen times in ten years. He has now robbed a supermarket at knifepoint and resisted arrest, injuring a police officer. In a prior offense he has entered a cookie store, demanding samples, and assaults a customer who has turned her back on him and "didn't apologize."

The offender has been committed to several different hospitals, and on one occasion has been found incompetent to stand trial. He has also attempted suicide. In prison the man is described as "bizarre, babbling and (showing an) incoherent speech pattern." When he is not in hospital, the man "dwells on the subject of masturbation inordinate amounts of time," refuses to wash and "presents a fire problem," which makes him (and others like him) an odd exemplar of hardened recidivism.

4. Young explosive Robbers:

Young disturbed robbers have violence histories but have not served time in prison, though they are often on probation when they are arrested. These robbers also tend to commit offenses which involve appreciable levels of violence.

One offender fitting the category is a nineteen year old man who serves his first prison term for a robbery with a sawed-off shotgun. Like other younger robbers, this man has been raised in a succession of institutions, starting

with special schools in which he must be placed after he fails kindergarten. He does not do well in such special schools, from which he is mostly suspended for temper tantrums in which he attacks teachers and fellow-students.

Some settings will not accept the man because he is explosive, and others discharge him after they discover they cannot accommodate his explosions. The man is also a problem because he is badly retarded (his IQ is 63) and has emotional instability which yields imperfectly to medication.

The man has been twice arrested for criminal assaults, and has served time in a youth institution for robbing an elderly woman at knifepoint. After he is released from this placement, the man pistol-whips an acquaintance and commits the shotgun robbery for which he is incarcerated. He arrives in prison announcing that he has enemies among fellow-inmates, though he refuses to tell staff who they are.

A second offender stands convicted of a mugging in which the victim is knocked down before he is divested of his possessions.

The man has spent eight years in psychiatric settings, first as a young child, with the notation that "(his) hospitalization has been made necessary as a result of hyperactivity, unmanageable behavior, assaultiveness and aggressiveness toward smaller children." He is thereafter diagnosed as suffering from childhood schizophrenia and

organic brain damage with impaired intellectual functioning and he does not do well on a trial release, during which he assaults members of his family.

The man's last conviction involves a car theft, for which he earns nine months in jail. In prison, the man is deemed victim prone because he is retarded, but he sees himself as tough and fights other inmates.

The combination of aggressivity and vulnerability of young explosive robbers creates a problem for prisons, exacerbated by the fact the offenders (none of who have graduated from high school) have remedial programming needs.

5. The Mature Mugger:

Mature muggers are offenders of median age who commit robberies involving nonserious violence - typically the sort of crimes committed by offenders younger in age.

One example is a thirty-five year-old man who has mugged a lady and is cornered by her neighbors. He explains that he has "had more than his two drink limit," has discovered he is "feeling very hungry" and that he "knew there was no food at home." He also testifies that he "saw the victim who was nicely dressed and thought she would have some money and that 'it wouldn't hurt her if I took a couple of dollars.'" He explains that he has once attempted a similar offense under similar circumstances, and "some men saw what happened and chased me and beat me up."

The man has been hospitalized on thirteen occasions, for periods from one week to one month, diagnosed as

suffering from paranoia and depression. When he feels the onsets of such episodes, he walks to the hospital and commits himself. A probation officer suggests that "the defendant seems to need the hospital at times for a complete rest and the security and the extra care it gives him. He also likes their food."

Hospital staff write that the man is "generally non-violent and extremely passive dependent . . . is respectful of authority figures and trusting of them and is very cooperative in our program." They also testify that the man "recompensates quickly while in the hospital and usually responds well to medication and milieu therapy."

The offender is childlike. He has made no effort to earn a living; he has no plans to work. When questioned about his future, he "says he feels there is 'starvation ahead.'"

A second mugger uses an unloaded gun to threaten pedestrians explaining he "didn't know how to load it." The man's IQ ranges between 43 to 59, depending on who tests him. He has been treated for brain damage in childhood. He has also been treated for "a tendency toward explosive, rather bizarre behavior" which consists of setting his mother's bed on fire and threatening to shoot other relatives.

In prison the man is placed in a special program. Here he does well, and staff report that "inmates on the block

appeared to like (him) and made special efforts to protect him." Later, staff write:

> He carries out simple tasks well . . . He has developed a cooperative attitude and a willingness to please those in authority. He has made lesser progress in the area of personal hygiene and grooming skills and needs reminders to wash his clothes.

The man manages prison as a result of the tender care he is afforded. Prison staff explain that "he gets around by following the person in front of him; new situations can't be handled." Staff conclude that "it is unlikely that he would be able to manage without assistance," which means that "he will always need a sheltered, supervised program and may prove unable to function in an unsupervised living situation."

6. Acute Disturbed Exploders:

The types we have designated "disturbed exploders" are dangerous offenders, and perpetrate extreme--and often bizarre--violence. The first of the groups (acute disturbed exploders) contains inmates who are often diagnosed psychotic, are viewed as disturbed at the time of arrest, and commit eccentric offenses. Two thirds of these inmates, however, have low arrest records, and half no histories of violence, despite the fact that the group tends to be relatively old.

Fairly typical of exploders is a twenty-six year-old schizophrenic convicted of manslaughter. The man has no offense history but as a youth he becomes fearful and leads a reclusive life. His relatives report that he "even had

tar put on the roof, thinking that if someone wanted to get him they would get stuck in the tar."

Before he commits his last crime the man reexperiences the onset of his delusions:

> He started talking about drug dealers, big crime and the communists taking over . . . . A few days before the shooting his mother stated that he asked her if she had heard a van pulling into the driveway at about 3AM, claiming that some people in the van wanted him to come outside so that they could shoot him . . . He used to hide . . . putting pillows on his bed so that people would think that he was there.

The man's delusions focus on gangs of drug dealers, and he decides to kill a person he suspects of such membership. He cannot find his intended victim, however, and shoots one of the man's associates. Thereafter he attempts suicide in the jail, must be hospitalized, and assaults a nurse in the hospital. In prison, he continues fearful and complains of psychosomatic problems. Staff report:

> He became suspicious, thought the "Mafia was after him," and that his father was going to kill him with a gun. He became inappropriate, tense, unable to sleep and had little appetite, as he felt someone was trying to poison his food.

At other times the man's delusions take a more ethereal form. He writes a letter to the victim he has killed to express his remorse, and he becomes concerned about space invaders:

> In discussing his delusions he indicates that FBI agents and drug dealers are no longer the source of his difficulties, but that through the assistance of another inmate he has been able to see that certain human beings are, in fact, space creatures who have been placed on the earth and have assumed human form

for the purpose of harassing and controlling certain people, of which he is one.

Throughout his tenure in prison, the man functions as a mental health client, who commutes fearfully between prison clinic and hospital settings.

Another offender, also in his mid-twenties, has earned no criminal record to date. However, he is a drug addict who has led a nomadic life, centered on residence on flop houses. In one such transient establishment he kills a neighbor by stuffing clothing down his throat, after he becomes convinced the man is conspiring against him. He is subsequently hospitalized from the jail, refuses to eat and must be fed through a tube. He also attempts suicide by hanging.

Released on probation, the man attacks members of his family and is resentenced to prison. He arrives in prison confused and withdrawn, refuses to eat and walks into walls, but recovers under medication. He must later be hospitalized. Between hospitalizations he "was not interested in any programs . . . but only liked to read magazines, newspapers and then would sit back and sleep in his chair." This pattern is a nonviolent pattern, but violence-related concerns are raised about the future, because the man blames his mother for his imprisonment, and has threatneed to kill her.

7. Chronic Disturbed Exploders:

Chronic exploders are the largest cluster of disturbed offenders. They are also a distinctly violent group, both

because their offenses are serious and because they have histories of violence. The offenders often have substantial arrest records and long-term mental health problems.

Some chronic exploders show consistency in their crimes. One offender is imprisoned for injuring four persons in a knife attack. One of the man's victims is his former spouse, who is also a victim in a previous incident, in which he slashes her face. Before the man is sentenced for his second offense he declares that he intends someday to kill the victim (and himself), and "insists that (his probation officer) include such statements in his report."

The man is institutionalized at age eleven, after he is adjudicated a neglected child. At the time he is seen as a problem client, and maintains the reputation in the army, from which he receives an undesirable discharge. He serves prison time for forgery, then graduates to kidnapping. At this juncture he is adjudged disturbed, and is twice declared incompetent to stand trial. After he is imprisoned, he spends time in the prison hospital, where he is diagnosed "schizoid." However, he views himself as nondisturbed, and insists that he has no mental health problems as he reenters prison, though he demands to be medicated.

A second exploder is involved in a sadistic episode in which an elderly victim is stomped, beaten, sexually abused and robbed. The man has a history of prior arrests, yielding five convictions. One of his arrests involves

sexual abuse, which the man describes as consensual sex with an underage girl.

The man starts life in foster child placement, and is hospitalized at age eight after foster parents cannot control him. He spends five years in a hospital, where staff write that

> he has not been able to transcend his traumatic and extremely deprived childhood . . . At this time, the prognosis for reintegration into the community is poor."

Thereafter, the man spends twenty years leading a transient existence interspersed with crimes, ranging from burglary to robbery and assault.

8. Disturbed Sex Offenders:

This cluster contains sex offenders, who are by definition responsible for serious violence. These offenders are also disturbed. They are often seen by mental health staff at the time of their offense, and one of four (28%) have been diagnosed as psychotic. They are older offenders, mostly Causcasian, and usually have no history of violence.

One sex offender in our sample is a man in his late thirties who has victimized his daughter and infant son. He describes these predations as "hug therapy" to prevent misconceptions about sexuality. He also claims that he was sexually abused as a child, and describes himself as a practitioner of satanism.

The man has no prior contacts with the system. However, he has been caught smuggling marijuana in the Navy and admits to drug and alcohol abuse. His arrest upsets him. He goes on a protracted hunger strike in the jail, not out of guilt but because he fears prison, where he knows child molesters are unpopular. He complains that "if he had been a 'murderer or airport bomber' he would be a prison hero but due to the nature of his actions he would not do well in prison."

The man arrives at prison reception depressed and in tears and is placed in a protective setting, where he does well. He is not deemed disturbed, but staff write that "he has a strange outlook on life." They later revise their views after the man attempts sucide. He has become depressed because he has been turned down by the Parole Board, and his wife has divorced him. The Parole Board has suggested that the man undergo therapy, and he follows their recommendation. He is adjudged to make progress, and no longer announces that he will kill himself after he is released. He also resolves his religious conflict (between Christianity and Satanism) by professing that "he tends to lean toward God."

A second sex offender resembles the first. He is imprisoned for sodomizing his daughter, attempts suicide in confinement, and must be hospitalized from the prison. The man is in his thirties, and has longstanding problems. He has been sent to a boarding school as a child because he

cannot manage at home. In this institution he "alleges that during his first week he was sodomized by another boy who repeatedly sodomized him over the next five years." After leaving the institution the man is hospitalized for "nervous breakdowns." He later marries, but does not do well. (A social worker records that "his attempts at leading a semblance of a normal life were unsuccessful.")

The man is arrested while on probation for another sex offense involving an underage victim. He then tries to hang himself in jail, where other inmates try to strangle him and scald him with boiling water. He also professes guilt, and says that his offenses "will torture me for the rest of my life."

In prison, the man has to commute between protective and mental health settings, including the prison hospital. In the hospital he is again assaulted by a fellow inmate, who also attacks him in the prison. After two serious psychotic relapses, prison staff write that "it appears that (this inmate) for the time being at least will continue to experience difficulties maintaining himself within the correctional system, and may well require extended psychiatric intervention."

9. Composite Career Offenders:

The "composite" group contains older offenders with long-term mental health histories and longstanding records of violent involvements. The crimes these offenders commit are diverse, and most have been previously imprisoned.

The hallmark of the group (like that of long-term disturbed exploders) is that the offenders have long histories of mental health problems and records of offenses, and are career criminals and career patients. An illustrative career is that of an offender serving a life sentence for an armed robbery. The man is in his thirties, but he is a veteran offender who has been convicted of a burglary at age ten. His first adult offense (at 16) is one in which he assaults and injures a police officer. He is subsequently convicted of rape, robberies, assaults, escapes and weapon offenses.

After the man's arrest for robbery he is declared incompetent to stand trial and diagnosed as suffering from paranoid schizophrenia. He has also been declared incompetenet and hospitalized nine years earlier. Thereafter he has been sent to prison, where staff have noted that he "is severely suicidal and can act out violently when he doesn't get his way." At the time the man describes his occupation as "hustling," which is accurate since he has never worked and is a multi-drug user.

In prison the man must be committed and tries to hang himself in the prison hospital. Psychiatrists there describe him as psychotic. They report that he

> experiences auditory hallucinations, hears his mother's voice calling him different names, feels there are spies out to kill him, was autistic and withdrawn, appeared slovenly and dirty.

Yet the man makes a recovery, leaves prison and reembarks on his criminal career.

The man has reentered prison denying his criminal history and "claim(ing) he is the victim of racial prejudice." He also declares that he will not participate in programs since he has been unjustly incarcerated. He nonetheless does well in prison programs, is well regarded by staff and appears to have found a long-term home.

10. Compensatory Offenders

This small cluster of very disturbed persons comprises chronically disadvantaged offenders, over half of who (10 of 19) have been diagnosed psychotic. These offenders tend to have clearcut intellectual deficiencies, yet they mostly commit serious violence, and have histories of violence. They tend to be intoxicated and ineffectual at the time of their offense and they lead a rootless existence, as exemplified by the fact that 18 of 19 are unmarried, though few of them are young.

The crimes of this group reflect the multiple inadequacies of its members. A typical incident is described as follows:

> The instant offense finds (the offender) under the influence of alcohol and drugs, cutting the purse strap of a seventy-one (71) year-old female, knocking her to the ground and stealing the purse.

The offender is described at prison entry as

> a high school graduate with no work history due to a psychiatric disability (who) has been diagnosed as a paranoid schizophrenic, which has been somewhat exacerbated by alcohol abuse.

The man is hospitalized in his teens and is maintained on medication. Prison staff diagnose him as a schizophrenic

in remission with a "passive aggressive personality" and learning problems. They suggest counseling and remedial education.

A parallel offender assaults a seventy year-old man, returns to the scene and is caught. Before the offender is sentenced he undergoes a competency examination because he is severely retarded. He is also a school dropout, has been hospitalized (diagnosed as manifesting "schizophrenia, latent type") and is an alcohol and drug addict. He has not been in prison before, but has an offense history consisting of aborted muggings.

A third offender sets fires which "appear to be an attention-getting device." He does so when he is intoxicated, which is often. After his last fire, he gives himself up to the police. The offender is retarded and he has hallucinations, for which he has been hospitalized. He has committed offenses other than arson (none, major) which he also attributes to intoxication.

Reconstituting Humpty Dumpty:

The vignettes illustrate differences among clusters, but also highlight the continuum of which the clusters form part. This is so because violent offenders often have multiple problems, and present similar dilemmas to service providers. Among features which these individuals--irrespective of type--seem to share, are (1) the advent of symptoms and/or behavior problems at early ages leading to (2) early institutional placement followed by (3) ad

seriatem institutionalization and (4) an unproductive, marginal, migratory existence, which includes (5) brushes with the law. The offenders often (6) have combinations of deficits, such as emotional problems exacerbated by substance abuse, which (7) color some of their offenses, raising questions of competence, and (8) impair the ability of the offenders to manage in prison and profit from prison programs, which (9) decreases their prospects of successful community adjustment, thus (10) increasing their chances of recidivism, including (11) violent recidivism.

Other links between the clusters are more specific. One such link has to do with the fact that age-specific clusters can be career junctures which follow each other in time. Impulsive robbers can thus become long-term robbers, and impulsive burglars can turn into composite career offenders, given time. Levels of violence and pathology can also change, separately or in tandem. Acute exploders, for example, are typically late bloomers, both as offenders and patients. Long-term robbers, by contrast, often deescalate one or both elements of their checkered careers.

Chapter 6:

Offenders with Substance Abuse Histories

Our last chapter surveyed violent offenders with histories of mental health problems, and this chapter extends the review. We again examine offenders who have received services in the community, but we now view persons for whom services include treatment for substance abuse problems. We later turn (below, in the second half of this chapter) to clients of exclusively specialized services.

The difference between offenders who receive substance abuse services and the offenders we have already discussed is admittedly one of degree, since emotionally disturbed offenders often report abusing drugs or alcohol. The substance abuse histories we review in the present chapter, however, are more salient. They also contain more detail, thus permitting disaggregation by type of substance abuse. More important, the data we have about alcohol or drug addiction can be used as a disaggregating criterion, so that types can be based on the offender's long-term and short-term history of substance abuse.

A. The Mental Health-Substance Abuse Sample

Our first (compound) sample contains recipients of both specialized and non-specialized services. The sample, as noted in our summary typology, yielded five clusters.

1. Dependent Burglars:

As with all our inmate samples, the compound sample includes a group of burglars, whose offenses are invariably nonviolent. Burglars with mental health and substance abuse problems are a distinctive group. For one, they tend to be older persons, and they have substantial arrest records. Most of the offenders also have long-term histories of violent involvements and of mental health contacts, they have been treated for drug addiction, and more than half (13 of 20) are intoxicated when they commit their burglaries.

An offender who provides an illustrative case is a twenty-eight year-old man who burglarizes a neighbor. He commits this visible offense, according to a person who interviews him, because "at the time he was high after taking three quaaludes and smoking PCP, (and) because of his intoxicated state he got an urge to get up and steal." The man claims complete lack of premeditation. In further exoneration, he points out that his performance was clearly substandard, and argues that "if this was planned, I would have used gloves."

The man has never used gloves. His difficulties begin in early childhood (where his recorded IQ is 67 though he later tests at 102), and he takes up drugs at age 12. He ambivalently boasts that he averages ten marijuana cigarettes daily, that he has used angel dust for a decade and "has taken over one hundred LSD trips." These facts matter to us because the man engages in circular reasoning, in which he attributes his problems to his addiction and his

addiction to his problems. He reports that he fails parole because "I can't do it on my own . . . the pressures are unbelievable." He absconds from drug treatment, he says, because "weekly contacts are not enough" and he engages in group offenses because of an "inability to separate himself from a negative peer group."

The offender is a penny ante recidivist. He serves an earlier prison sentence after he commits an aborted burglary in which he is intoxicated. He later has problems in prison which include being caught in the act of injecting himself with drugs. Prison staff complain about the man's "supercilious attitude and perceived macho/gangster type image" but protect the man from his peers, who fill him with anxiety. The dilemma faced by the staff is that the man is a shamelessly dependent person who relies on outside support (which is unhealthy), but that one has to reinforce his pattern whether one like it or not because he cannot manage without support. The same dilemma is faced by the man's parents, who "on numerous occasions bailed him out of jail, paid his legal fees and allowed him to remain in their house", nevertheless earning his undying ingratitude.

A similar dependency problem pattern is that of a second burglar who takes little responsibility for his acts. The man is a substantial recidivist who has committed a rape, which he loudly disclaims. He also minimizes his last offense--he is caught burglarizing--by maintaining "he was really only a bystander." After this burglary offense the

man attempts suicide in the jail, and is hospitalized (in installments) for close to a year.

The man's criminal career is continuous and begins in grade school, where he steals from purses, mailboxes and desks, and urinates in classrooms. He also deploys more blatant attention-getting measures, such as having intercourse with an inflatable dummy used as a demonstration device in health classes.

The man is an addict who ingests a variety of drugs (he even inhales gasoline fumes.) He does not care to have anyone deal with this problem, however. According to the record he "absconded from a drug program because the stress of facing issues relating to his drug use and emotional problems was too much." Mental health staff also class the man as treatment-resistant and report that he "had a problem keeping appointments."

The offender's entry into prison is inauspicious because he takes the view that he "can't do a maximum security sentence, as he would be killed." He spends much of his time in protection cells when he gets to prison, and invests most of his effort arranging transfers between prisons. He sets fire to his cell in one setting and assaults a guard in another, while depending on guards to extricate him from environments he fears.

2. Skid Row Robbers:

The second cluster contains few (only nine) offenders, who are all middle-aged alcoholics who commit robberies. The men have long offense histories, including violent offense histories, and tend to be drunk at the time of their offenses.

A typical group member "states that he has been drinking for twenty years and drinks a couple of six packs of beer per day and a fifth of Scotch." On the day of his last offense (an armed robbery of a cab driver) the man consumes five bottles of wine, and the arresting officer describes him as "very, very flushed." The probation officer notes that

> it is possible that the defendant really was so drunk that he didn't know what he was doing, since the arresting officer concurs with the idea that the defendant was highly intoxicated. In that case, a lifestyle of intoxication on the part of the defendant may be a primary source of his continuing criminality.

The man's extensive offense history includes an arrest for assault (dismissed), two convictions for driving under the influence of alcohol, several burglaries and an insurance violation. The man's alcohol problems are attended to at a VA hospital (he is a Vietnam veteran), where he is detoxified "once every other year." The offender also is past president of a local chapter of Alcoholics Anonymous.

A second offender robs a gas station, then embarks on a high speed chase in which he throws several objects--including the proceeds of the robbery--from his car window.

He is drunk, and reports steady drinking for some seven years, averaging a quart of alcohol a day. The offender is also a discharged veteran. Before becoming an alcoholic he has been a drug addict and minor dealer, and many of his (eighteen) arrests are drug-related, though he has also been convicted of larceny, burglary, possession of weapons and driving while intoxicated.

The man is diagnosed as a very serious alcoholic who suffers from "bouts of blackouts, liver and pancreatic damage." He has been treated for these conditions in a variety of programs, but the ministrations are less-than-successful because the man insists he has no alcohol problem he cannot handle. The man is a success in prison, however, where he functions nicely as a skilled carpenter.

3. Skid Row Exploders:

A contrasting pattern to that of skid row robbers is that of alcoholics whose violence is diversified and explosive. These offenders are individuals whose arrest record is often low, but the offenders tend to be seriously emotionally disturbed, and tend to be drunk when they commit their crimes.

An example of such an offender is a middle-aged woman whose difficulty (as assessed by others) consists of the fact that "when intoxicated (she) becomes extremely hostile, abusive and profane." In a past incident this lady has become embroiled in an argument after an all-night drinking

session. She is dissatisfied with the resolution of the dispute and burns down her apartment building, killing a guest (a drinking companion) whose presence she has forgotten.

The last offense she commits is similar, in that she is intoxicated (she claims she has "blacked out") and holds a grudge against her victim. The victim--a female neighbor--reports that

> she (the victim) came home from work and noticed (the offender) was talking very strangely, as though in a trance. (The victim) stated (the offender) left, and she was in bed just going to sleep when there was a knock of the door. (The offender) entered with a knife in her hand and began yelling at her and calling her names . . . . (The offender) then proceeded to stab (the victim) six times.

The offender in turn blames alcohol, and testifies that she "only remembers standing in the hall with a knife in her hand and (the victim) bleeding."

There have been incidents in the lady's life involving diverse brushes with the law. She has been arrested for arson, assaults, and impulsive property offenses. She has also attempted suicide, and has been hospitalized for alcohol abuse and for chronic schizophrenia, for which she is medicated. She participates in treatment willingly, though she assaults a nurse in the prison because "she does not want (her dose of thorazine) diluted with water." She also has other disciplinary problems in confinement, which have to do with "temper tantrums and arguments."

Since the offender is not intoxicated when she is in the prison, her outbursts suggest that her readiness to take offense and to respond with retaliatory rage transcend her drinking episodes. Alcohol adds obliviousness to her indifference to consequences of her acts. Intoxication also adds to her rage, and emotional problems play an aggravating role because they distort (and steeply escalate) grievances grounded in miniscule disputes.

4. Composite Career Offenders:

Composite career offenders are the most disturbed of the offenders who have substance abuse and mental health problems. These offenders have long-term histories of contacts with service providers; they also have serious criminal histories, including histories of violence. In addition, the offenders suffer from long-term drug addiction.

The pattern is highlighted by a violent robber who hurts his victim, choking her and pushing her into a wall. The man goes on a mystifying rampage in which he destroys the victim's apartment, wildly scattering her possessions as the police arrive. He plays this scene after being released from prison, where he has served time for a similar offense. In this period he is also involved in a rape.

The man is in his mid-thirties, but his crime and mental health problems date to an early age. He first sees a psychiatrist at fifteen; three years later he is

hospitalized, diagnosed as a chronic schizophrenic and certified as a drug addict. He is also involved in weapons offenses, and convicted of robbery.

Service providers describe the man's double (or triple) problem. Juvenile workers record that he "impresses as a disturbed youth who relates in a hostile and withdrawn fashion." Hospital staff report that he has to be "treated with psychotropics and was a management problem." Detention officials note that "he had to be transported in a straight jacket from the jail to the hospital." Staff of community drug programs complain that the offender "states his interests are 'partying, basketball, getting high and fooling around.'"

The man arrives in prison "extremely surly" and "exhibited a hostile and negative attitude." Two years later, a progress report reads:

> His horrendous custodial adjustment continues this six-month period with four reports that resulted in 225 days sentenced to keeplock. (He is) a confrontative individual who has little regard for rules and regulations and who has poor rapport with staff and is only marginally acceptable with peers.

This assessment parallels that of an earlier prison stay in which officials complain that "the inmate's behavior constitutes a real and constant physical threat to both peers and staff in spite of 'tailor-made' programs." Though the man's eccentricity is recognized, the impression he makes is that of a dangerous, embittered, angry and irritable person with a gigantic chip on his shoulder.

5. Multi Problem Robbers:

The last group is contrasting, in that the offenders commit little serious violence, have low arrest records, and are apt to be seen as disturbed. The offenders, moreover, are likely to have problems involving alcohol and/or drugs.

A case in point is that of a man who is imprisoned for several robberies he has attempted while he is on probation. In these crimes the man uses a threatening extortion note which sometimes produces money but is often disregarded. The man, unfortunately, has this note in his possession when he encounters the police.

The offender has been arrested in the past for minor offenses, but he has violated probation by discontinuing drug treatment. He has undergone drug treatment repeatedly, but without success. He has also been hospitalized suffering from depression, and has been diagnosed as a paranoid schizophrenic. Such difficulties continue to manifest themselves when the man is in the prison, where he must be hospitalized. He is otherwise a despondent inmate, and is described as "having some difficulty coping" with various stresses of confinement.

A second offender tries to rob a bank after drinking a good deal and taking drugs. He is not only unsuccessful but himself points out that "he has no recall of the offense." He regretfully notes that his "substance abuse usage had

snowballed (since) he was abusing alcohol, pills and cocaine."

The offender has held respectable civilian jobs, but has destroyed his career by attempting white collar offenses. He has been depressed (possibly by self-induced failure) and has attempted suicide. He has also been involved in therapy, including in hospitals, since adolescence. His drinking begins at twelve, and his drug addiction at fifteen. At the time of his arrest, the man combines use of vodka, barbiturates and cocaine, which he uses daily.

The offender is a man who approaches prison as a structured treatment environment, hoping for drug rehabilitation, as well as a belated college education.

Postscript:

The offenders in this second sample diverge on many counts, but also differ from the prison population, in that the majority of these individuals are white offenders.

Our third sample, the second substance abuse sample (which we turn to next), also differs from the typical state prisoner, but to a lesser degree. The sample is heterogeneous, older than average (though less so than the disturbed inmates), overrepresents white inmates (to a somewhat lesser degree), and shows the influence of alcohol or drugs in the commission of crimes.

B. Clients of Substance abuse Services:

Inmates in the specialized sample have only received services for drug and/or alcohol problems. As noted, the sample contains two small clusters and two larger ones. The small clusters comprise inmates who are engaged in nonserious violence and have no violence histories. The larger clusters contain more violence-involved inmates, who mostly tend to be intoxicated while committing their crimes.

1. Addicted Burglars:

The first cluster consists of burglars some of who are on probation at the time of their offenses. These offenders are drug addicts, and three of eleven have problems of retardation.

The histories of these offenders are unremarkable, except for testimonials they offer to the obduracy of addiction, and to the unregeneracy of otherwise unimpressive criminal careers. A case in point is that of a thirty year-old man who has broken into homes. The man is intoxicated at the time of his crimes and testifies against his crime partner, whom he then regards (correctly) as a prospective enemy.

The man is a heroin addict, but also indulges in cocaine, valium, qualudes and marijuana. He has been a substantial addict since age 16. His sixteenth birthday also marks the beginning of his crime record, which includes six arrests for criminal possession of drugs, six burglary

arrests, and a conviction for driving while intoxicated. During most of the man's life he has been (unsuccessfully) treated in outpatient drug programs, as well as in a veteran's hospital. The man cooperates eagerly in such treatment, and expects more of the same. He tells prison authorities, for example, that he'd like drug therapy and that he wants to become a drug counselor when he is parolled.

A second addicted offender is somewhat older, and is convicted of offenses he has committed while on probation. In one incident the man enters a store that someone else has broken into and steals a television set. In a second offense he sells drugs to an undercover officer, and in a third incident he burglarizes an acquaintance and neighbor.

This ill-starred offender has started life in a reformatory, to which he is committed at age 11 (at his mother's request). Here he spends his adolescence. He then becomes a career addict who has a substantial habit ($100 a day) but absconds from rehabilitation programs because he sees no point in abstinence from drugs.

2. Addicted Robbers:

The second cluster consists of addicts who commit nonserious violence, have no records of violence and very modest criminal histories. One offender in this cluster reports that he has "a $400 to $500 a day cocaine/heroin habit." To sustain this redoubtable habit, the man

participates in an attempted robbery of an oriental health club. He has also sold counterfeit money, which has earned him a federal prison sentence. The man's arrest record is otherwise modest (a fine for driving while intoxicated and an incident involving unlawful possession of marijuana), and he has owned a business, which he has lost.

The offender has participated in several drug treatment programs, and one such program medicates him for "atypical depression" after he loses his mother. The man adduces his mother's death as a contributing factor to his crime, and also points out that "he needed money for Christmas" and had no way to earn it.

The man's capacity for deception (and for self deception) stands him in good stead. For a time, he becomes a model inmate. His deportment earns him membership in a temporary release program, where he works as a jack hammer operator for a construction company, but the privilege is promptly rescinded after he takes unauthorized vacations and submits false pay receipts.

A second, younger offender commits a street robbery while "high on marijuana and beer." The offender fails after doing well in prison. He is parolled and returns the confidence by mugging an eighty-three year-old pedestrian. Drug programs find the man similarly uncooperative, but on other occasions he requests treatment as a way out of difficulties.

The man has been a precocious delinquent. After placement in a juvenile facility, he graduates to a career as an addict and burglar. (Along the way he tries other ways of sustaining his drug habit, such as stealing from his family.) The man's last probation officer comments on his prospects. He concludes that the man's "degree of maladjustment, particularly along the lines of changed social attitudes, is such as to warrant a reasonable belief and expectation that (he) cannot get along without further conflict with the law."

3. Alcohol Exploders:

Addicted offenders are unreliable persons, while exploders are volatile. The alcohol cluster contains violent offenders who tend to be drunk at the time of their offenses, and often don't remember what they have done. Many of the offenders are middle aged, two-thirds are caucasian, and all have histories of alcoholism.

Prison intake staff write about one such offender that "intellectual limitations combined with his alcohol abuse and social instability appear to account for his criminal involvement." The man's career shows a penchant for driving while intoxicated, but also includes arrests in which the man is charged with carrying guns. This propensity culminates in a bloody incident in which the man gets drunk and tries to kill a drinking companion--with whom he has had an argument--by shooting him in the head.

Another alcohol offender attacks a whole family over a traffic dispute, lacerating the father with a car antenna. The man is badly drunk at the time, and has a redundant history of offenses involving intoxication. One such incident is described as follows:

> A statement by (the victim) indicates that she was entertaining some friends at her home when (the offender and two companions) came to her house and insisted they were going to have a party there and drink beer that they had brought. She told them no. They got mad and started slamming and kicking at her front door causing it to break. They then started throwing her kids' toy wagon around the front yard yelling very loudly and throwing items at vehicles in her driveway. (The offender) then broke a window out by hitting it with his fist.

There is evidence that the offender has assaulted his own daughter and has been subjected to child abuse charges based on the physical damage he has done her.

The man is an undisputed alcoholic. A disgruntled probation officer complains that "(the offender's) life style has been a continuous saga of alcohol abuse and alcohol-related criminal activity. His alcoholism has interfered with every area of his life." The officer points out that the offender has "consistently refused to continue alcohol treatment." The man is once placed in a halfway house for alcoholics, but is soon expelled "for using marijuana." He is later terminated from a hospital program for noncooperation and leaves a third program because he "does not feel that he has a drinking problem."

4. Drug Exploders:

A fourth cluster consists of drug addicts with histories of violence and of criminal involvements. The offenders are inveterate recidivists, and they tend to be high on drugs at the time of their crimes.

A case in point is an offender who is in his thirties and "recently specialized in armed robberies of cab drivers." The man attacks his victims at knife point while he is under the influence of drugs. He is also intoxicated in offenses in which he resists arrests, and on one occasion "gunned a car toward a police officer, hitting him, causing injury to his back."

The man is a career criminal, with a dossier of arrests dating to his adolescence. He sees this criminal career as subservient to his drug career, which a prison psychiatrist describes as follows:

> At the age of fourteen (14) he was initiated to the drug culture--he started with smoking marijuana and later experimented with other narcotic drugs, using LSD, cocaine and amphetamines and finally became an addict to heroin. He was spending $50 a day and the funds were provided by illicit activities like stealing, burglary and robbery. He said that under the influence of heroin he felt carefree and nothing bothered him.

The man has participated in several drug programs, and claims that some have occasioned respites in his habit. He also does well in prison, where he holds responsible jobs and participates in therapy. Despite such involvements the man invariably recidivates, graduating from less serious to more serious offenses.

Another drug offender commits robberies in which he holds a knife at his victims' throats. He victimizes acquaintances, and one of them notes that "he looked like he was on drugs, with his eyes glassy and red." Police who arrest the man confirm this condition and discover a hypodermic needle in his pocket.

The offender has been apprehended on eighteen occasions since his seventeenth birthday. Most of his arrests are for felonies, including some he has committed after he leaves prison. The man has participated in methadone maintenance programs in the community. He is also involved in drug therapy while he is in prison, without impact on his postgraduate career.

Accounts such as these vignettes are typical of careers in which offenders who are seriously addicted to alcohol and/or drugs reach middle age with violence-cum-addiction patterns which are intertwined, chronic, and discouragingly recalcitrant.

Chapter 7:

Offenders with no Mental Health-related Histories:

In this chapter we disaggregate our comparison sample, which contains offenders who have no records of mental health services--at least, in the data sources available to us. Cluster analysis subdivides the sample into eight types. Five of these types contain larger numbers of inmates; of these five types, four comprise robbers. The sample contains two groups of relatively non-violent offenders (mostly burglars) and three groups of offenders whose violence is serious.

1. Inexperienced Burglars:

The least violence-related group in our sample is that of burglars who have low arrest histories (60%) and no past violent involvements (68%). The inexperience of these burglars surprises us because we expect non-violent offenders to be imprisoned only as a last resort, on the strength of past feloneous conduct. We infer that there must be special reasons why these offenders may appear recidivistic, such as short-term trends in their offenses or cumulative impressions that include chronic delinquency.

An example is that of an offender who has earned one adult arrest (which has been dismissed) but whose conviction covers three incidents in which he has broken into homes. More important, the man has a juvenile history proving to the court that low order deterrence has never impressed him. On several occasions he has been arrested for burglaries

while on probation, and a disgruntled probation officer observes that

> The defendant, a school dropout, with a history of excessive truancy, and an unstable work record, has run away from home on at least ten separate occasions, and has a pattern of hanging out with negative companions . . . (He) appears to have a pattern of anti-social criminal behavior.

The other side of the coin is the man's lack of aggressivity. This illustrated by the fact that the man signs himself into protective custody when he arrives in prison, which confirms the impression that he is not a hardened criminal.

A second burglar is older (twenty-two), but appears equally non-sturdy. The man has a low IQ (77) and is perfunctorily diagnosed as having "severe emotional problems." He has spent much of his life in reformatories, and grows up to "a rather transient existence, sleeping in cars, home-made tents, with friends and in emergency housing."

Sturdier companions involve the man in burglaries in an ancillary capacity. On his own, he steals cars, files false fire alarms and commits nuisance offenses. The man also gives the impression of being nondeterrable. When he is placed on probation, he is rearrested a week later; he is sent to jail (probation revoked), and reoffends when parolled.

Imprisonment of such offenders responds to the perceived need for a backup option where all else has failed. It may also embody the hope that incipient careers

can be short circuited through shock effects when lesser discomforts have made an insufficient impression.

2. Experienced Burglars

Our second group contains burglars who are older, recidivistic and violence-experienced. A typical member of the group is a thirty-five year-old man who has been caught breaking into a store. The man's prison sentence is disproportionate to his crime because he is on parole at the time of his burglary, and because one of his prior offenses is a rape. His record lists nineteen other arrests and twelve convictions. Though the latter are mostly for burglary, the police view the man as a menace to the community.

The man has been in the army, where he has spent time combatting fellow soldiers. He receives an undesirable discharge, but proudly recalls that he has "fought an officer and threw him through a window." After the army the man settles into a routine in which he commits crimes to support a drug habit. He continues to commit crimes thereafter, despite the fact that he has discontinued drug use.

In prison the man is placed in lower-security settings, attends college classes and undergoes vocational training. The man is in his thirties and may have matured out, but so far he has perservered in his chosen career, which is that of a burglar, despite the occasional lapses into more

serious violence that characterize this group of mixed career offenders.

3. Acute Exploders:

The third cluster is more important to us because it comprises offenders who commit very serious violence, though they have limited arrest records and no histories of past violence. These offenders are often intoxicated when they are violent, or show other signs of eccentricity. Some members of the group (30%) are intellectually limited, and predominant violence categories are retaliatory violence and sex offenses against children.

A somewhat typical example is a first-time felon who has been convicted of arson. The man burns down three buildings in tandem. One of the buildings is occupied, and the police discover that the man has a grudge against a young lady who lives in the building:

> The officers learned that the girlfriend of (the offender) lived in one of the buildings and that the fire marshall was informed that (the offender) had threatened to kill her and she had an Order of Protection against him.

This explosive offender is a twenty-one year-old man of borderline intelligence (his IQ is 76), and he has no criminal record other than two minor drug-related arrests.

A second member of the cluster is an illegal alien whose credentials are otherwise unblemished. The man's offense is a series of explosions which starts with a minor altercation. He argues with a passenger in a van and pursues the van and tries to stop it, displaying a

counterfeit police shield. The real police appear, however, at which point the man becomes helplessly enraged, and the following sequence ensues:

> (The offender) sped away, but shortly thereafter was observed deliberately driving into the side of an occupied stationary police vehicle, causing injury to two officers. The arresting officer observed (the offender) reach for a .22 caliber handgun. (The offender) was pulled out of the car through the window and arrested after a struggle . . . (The offender) also attempted to run down the arresting officer following a court hearing.

Paradoxically, the man seeks protection in prison after other inmates threaten him, which suggests that his capacity for rage is evoked by specific (and very predictable) stimuli, while other threats and affronts inspire fear and/or flight.

4. Patterned Exploders:

The fourth cluster is relatively small, but the offenders who comprise it are responsible for the most extreme acts of violence, chiefly crimes of revenge. More than half commit their violence while intoxicated; almost all have violence histories, though few (13%) have been imprisoned. The offenders are mostly middle-aged and respectably employed.

These offenders show consistencies, but not in the sense that they replay violent offenses. What happens is that their records often describe lesser violence which in retrospect foreshadows more serious violence. By reviewing past incidents we can describe violence-related predispositions, but such inferences must be cautiously

held, given that postdiction is cheap where we know the outcome of the story. What is safe to note is that patterned explosive offenders have violence histories which make their offenses less atypical than those of other explosive offenders.

A representative offender from this group is a fifty year-old man who knifes another man during a drunken argument. The man describes his violence as "self-defense" though the police report that "he stabbed (the victim) repeatedly in the back, under his arm, and in the stomach near the heart, thereby attempting to cause said complainant's death." Other indications of the man's violence-proneness are that his past arrests include assaults and a warrant for "violence and battery of a law enforcement officer."

The man is a foreign migrant who has moved around the country for two decades. He does not speak English and is "functionally illiterate" in his native language. Combined with these educational deficits is the fact that the man's intelligence is substandard (his IQ is 76).

The man may be invoking violence to resolve debates where his language skills prove deficient but his more general pattern is described by prison classification analysts, who conclude that "his criminal pattern is one of assault and serious violence against persons, reportedly when under the influence of alcohol."

A second exploder has a more specialized pattern. He describes his offense as "a crime of passion," though he has gone out of his way to ambush his mistress and a male friend, and has shot them to death. He also tries to kill a police officer, who returns the fire and injures the man. The offender's past difficulties with the law are few but include an arrest for assault and a sentence for attempted murder, which is revealingly attributed to "personal domestic problems."

A third patterned exploder is younger, and on probation for assault. His incident is preceded by convivial drinking and a ball game, during which an argument breaks out. In the course of the argument someone punches the offender, who responds by knifing the person who has punched him, who narrowly misses bleeding to death.

Police point out that the offender and his peer group "have a long established pattern of settling arguments with violence." This pattern starts early, in that the offender (whose intelligence is "dull normal") is suspended from school because he constantly fights.

The probation officer's summary of the man's career is that "the defendant has a predisposition toward violence which in this case nearly resulted in a tragedy." The statement is similar to what can be said about other members of this same cluster.

5. Pre-career Robbers:

The sample contains three groups of offenders largely convicted of robberies. The first differs from the other two groups in that its members have no histories of violence or of imprisonment, and nonserious records of arrests.

Despite their unblemished dossiers, pre-career robbers are often seen by the system as problem persons whose prospects are grim, as illustrated by the following assessment:

> A first felony offender, the defendant's actions herein would appear to demonstrate his capacity for aggressive and reckless behavior. Accordingly the prognosis for his future societal adjustment at this time necessarily is extremely guarded.

The man about whom this is written has participated in a mugging in which the victim (who refuses to part with his money) is kicked onto the tracks of a subway. This offense is obviously serious but the man's prior offenses (trespass, criminal mischief, delinquency) are unimpressive, and his mother feels that her son is disturbed rather than delinquent. The man's peers take him more seriously. They see him as a threat and assault him with a knife, injuring him. The man reacts by trying to hang himself, and personnel in jail must move him to protect him.

Similar profiles describe other offenders. One man (age nineteen) is involved in ad seriatem muggings, in one of which the victim is injured. The man is seen as disadvantaged by some ("the product of a broken home who displays immaturity, poor self-control, lacking in skills") but as unregenerate by others ("has not responded to

discipline, therapy or probation supervision in the past . . . future prognosis in sentencing this individual is poor"). He is also described as violence-embued, such as in prison, where the record tells us that the man expresses "anger and aggression toward either staff or peers."

Novice robbers are individuals who have arrived at a critical juncture of their careers. This is a threshold in which they have not been violent offenders but impress some observers as having become violent offenders, who are slated for a career of serious crime.

6. Early Career Robbers:

Members of the second robbery cluster are uniformly young, but have entered upon a robbery career and been arrested for violent offenses. One out of five of the offenders have been imprisoned in the past, and many (42%) are on probation or parole at the time of their arrest.

The offense histories of these robbers start early, and the descriptions of their offenses are redundant. One adult criminal record, for instance, starts with the account of a team mugging in which the offender's partner "did grab the victim by the neck" while the offender (age 15), "displaying a broken beer bottle, pointed it at the victim's face and indicated that they wanted the victim's money". Month's earlier, the record describes the same offender "acting in concert with three others, allegedly removed $35 in a gold chain and gold watch from an individual."

The man enters prison for the second time for an offense in which "acting alone, he forcibly snatched two gold chains from a female victim . . . . The victim's neck and chest were scraped as a result of this offense." Prison staff ask the man about this offense, and he explains that he uses angel dust every day, and that this is an expensive habit.

Like other members of the early career cluster, the man has spent much time in institutions, and has been a recalcitrant client. The first juvenile setting to which he has been sent (after stealing from his mother) complains that "the resident exhibited a negative pattern . . . many conflicts with both staff and residents, abusive language, destructive behavior, and frequent indulgences in marijuana." A second setting reports that "he began stealing from other residents, fighting with residents and staff, truanting from school and involving himself in illegal activity. He finally absconded from this facility."

When the man comes to prison he boasts to staff that he "had many disciplinary reports during his last (prison) sentence, including several fights resulting in keeplock." He also announces that "if he has any problems with other inmates he will not go to the 'police' but will handle it himself." The man later proves as good as his word, and is transferred to an adult prison. Here he rejects treatment, insisting he has no drug problem.

The man's status as an established career offender is cemented. His chances are assessed by a probation officer after his last robbery. The probation officer writes:

> The defendant's actions in the instant offense reflect the defendant's desire to remain active in a criminally deviant subculture involved in both drugs and strong-arm robbery . . . . Furthermore, the defendant's prior legal history and his actions in the instant offense are almost identical in that his actions were crimes perpetrated on the city streets aimed at unassuming and innocent individuals . . . While on parole supervision, the defendant managed to be arrested on two separate occcasions . . . The defendant's actions in the instant offense are relevant to his past criminal behavior, and despite the defendant's youth, reflect behavior consistent with that of a habitual offender.

7. Late Career Robbers:

Our third robbery cluster contains older robbers who have long-term violence experience and extensive criminal histories. Most of the group have prison records, and many (44%) are nominally under supervision when they reoffend. However, the violence the offenders commit late in life is often less serious than that of young robbers, including themselves when young.

The members of the group often have long-term difficulties. One offender's career is summarized at prison intake as "a long history from childhood of social maladjustment, fighting and violent criminal offenses that are following him to adulthood." The criminal career referred to begins at age ten, when the offender participates in his first recorded robbery. Prior to this time, the man's mother is subject to a neglect petition, to

which she responds that her son is "the most maladjusted and disruptive child in the neighborhood."

The man absconds from the juvenile facility in which he is placed, incurs thirteen arrests before he becomes an adult (including for burglary, robbery and larcency), and graduates to a reformatory. Later the man specializes in stickups in which he threatens his victims with a gun. In his last offense he robs a cab driver, evicts him from his cab, and leads the police in a high speed chase.

The man's third prison sentence is a long one. After an inauspicious start the man--who has left school reading at second grade level--graduates from junior college, applies to a drug program and cements his relationship with his son, suggesting that there has been a possible turnabout in his career.

Another late maturing career is that of a man whose first offense is a serious assault on a female victim. The man later becomes involved in rapes, robberies and combinations of rape and robbery. In one incident he, and a fellow-sadist, place a bag over a lady's head, and rape and rob her. One another occasion the man threatens, beats, rapes and robs a neighbor, ostensibly because of money she owes him.

The man's last offense is a more conventional robbery in which he carries a gun. His prison term is long because he is also convicted of having jumped bail, and he decides to enroll in a prison program designed to rehabilitate

violence-prone persons. He also takes a vocational course, in which he does well.

The cluster heading under which these men fall describes offenders in the late stages of career. This means that violence deescalation may occur, and career desistance is possible.

8. Violence Generalists:

Our last category consists of offenders who engage in variegated serious violence. They have dense arrest histories and long-term violence problems. Some (25%) are mentally deficient, and others (32%) are intoxicated when they commit crimes.

The group combines attributes of exploders and robbers. Its violent offenses are often felony-related but at the same time, or at other times, are irrational and impulse-ridden.

Some members of the group have substance abuse problems. A case in point is that of an offender who is an alcoholic, who is also a drug addict and mentally retarded. A psychiatrist in the prison speculates about the link between the man's problems. He writes,

> He probably had difficulties coping with the environmental requirements and as a result, he was seeking refuge in alcohol and cocaine in order to overcome his insecurity and anxieties.

In turn, alcohol creates more problems. The man has a penchant for drunk driving, which includes running over police in an effort to escape. He has also attempted a

robbery in which he assaults his victim. In a third incident, he shoots at a school full of children and explains that "I had nothing better to do at the time." The police to whom he delivers this account conclude that "the defendant was under the influence of alcohol at arrest," and that he is dangerous.

Another alcohol-involved offender has a barroom argument and slashes a woman in the abdomen, causing very serious injuries. The man has a long criminal record, including convictions for assault, burglary, robbery, larceny, resisting arrest and ringing false fire alarms. At prison entry, he is described as " a predicate felon, if not a persistent felon." He in turn tells prison staff that he wants "individual counseling in order to better understand himself with the hope of not returning to prison."

Members of the generalist cluster are often candidates for services--such as substance abuse services--which they have not received. The omission makes the offenders "nondisturbed" (because mental health status hinges on services received) and draws attention to other attributes they share. Unfortunately these attributes are chronicity and a penchant for violence, which evoke images of predatory careers, though the offenders are fringe figures whose "careers" are haphazard collages of frequently impulse-ridden involvements.

Chapter 8:

The Disturbed Violent Offense

The study of offenders who have emotional problems differs from the description of offenses that are affected by such problems. Like other behavior, a violent crime can be contaminated by a person's psychological difficulties, but disturbed persons are often capable of committing offenses that are indistinguishable from those perpetrated by nondisturbed offenders. The other side of the coin is that many offenses of ostensibly sturdy offenders can reflect nonsturdy motives such as loss of control or impulsivity.

Both of these facts are compatible with contemporary thinking which (1) rejects the notion that violence and irrationality are the monopoly of a group of people who are different from the rest of us, and that (2) illness/normalcy and crime/law abidingness represent dichotomous behavior. The first point is emphasized by a report to the Violence Commission task force, which notes,

> A popular view of psychoanalytic and psychiatric theories is that they explain why "crazy" people behave as they do. While specialists in these fields do work most often with disturbed people, they also have a general view of life in which antisocial behavior is always present, either in potential or actual form. At the same time, they seek to understand the special role that violent behavior may serve for people who are deeply sick-or at least sicker than others.(1)

The second point is underlined by--among others--Seymour Halleck, who writes that

> Most modern psychiatrists look upon mental illness as a process. Mental health and mental illness are both viewed on the same continuum. The behavior of some individuals may at times become so ineffective, so self-punitive or so irrational that the psychiatrist deems it advisiable to define them as ill.(2)

Halleck himself suggests that crimes and symptoms may be variations on maladaptive behavior, so that

> The same individual may show symptoms of schizophrenia on one day and of obsessive preoccupation on the next. On the third day he might commit a crime, and on the fourth he might be entirely docile and comfortable.(3)

The point that is implied in such statements is that any piece of behavior can be examined independently of the judgments we make about the behaving person, though once we have enough of a person's conduct to assess we can describe behavioral trends involving change or consistency. Halleck further tells us that the labelling of behavior as disturbed behavior does not require exotic expertise, in that "ultimately, most of our decisions to call people mentally ill are based upon judgments of reasonableness."(4) An offender who commits a professional robbery, for example, is mostly viewed as a "reasonable" offender, because "it is assumed that the criminal is seeking goals that everyone can understand and accept, goals such as financial profit or status."(5) If the same person attempts to commit robberies while he is drunk, our assessment may become different, on the grounds that

> A reasonable man would not undertake a difficult criminal task while intoxicated. If he must depend upon crime to earn his living, he is behaving no more reasonably than a surgeon who would try to operate while inebriated.(6)

Such ratings of specific crimes need not imply, of course, that offenders are uniformly reasonable or unreasonable. But it should be obvious that offenses can be revealing acts, shaped by the goals and concerns of individual offenders, reflecting their skills and deficits, including intellectual, emotional and social deficits. Where deficits are substantial, one expects that crimes will be contaminated by them, sometimes subtly, and sometimes dramatically and blatantly. Should this occur, the sum of many "unreasonable" offenses approximates a diagnosis of mental illness:

> When the criminal fails to pursue acceptable goals in a logical, consistent or effective manner, we must assume either that he is inept at solving ordinary problems, that he has met with environmental circumstances which he cannot master, or that he is driven by motivations which are not apparent and which deviate from those which society would consider reasonable. These are all qualities that could just as easily describe the mentally ill. We, therefore, must return to our earlier assertion that if the judgments by which we designate unreasonable behavior were consistently applied to the law violator, we would have to agree that many criminals behave in a manner that is not too dissimilar to that of the mentally ill.(7)

As it happens, our data permit us to explore the strategy of behavior-ratings that Halleck suggests. We can do so because we have concise descriptions of most offenses for which members of our samples were convicted. We also have an eccentricity code (which we describe in Chapter 2),

which approximates Halleck's conception of "unreasonableness" in crime. This code lets us describe the range and quality of offenses that for us raise questions about the offender's mental state at the time of offending. The point of our review is not to document the extent to which criminals are mentally disturbed, because statements about the prevalence of mental illness cannot be based on impressionistic judgments. The point, rather, is to venture hypotheses about the ways in which specialized dispositions of violent offenders (psychological problems) can affect some of the offenses they commit.

Random Violence:

The most uncontaminated relationship between violence and emotional disorders exists in incidents where strangers are assaulted without provocation, and seemingly at random. Random violence has repercussions that transcend its numerical importance, because (1) victims have no way of predicting or preventing victimization by offenders who strike out of the blue and offer no cue to their impending resolve, and (2) such violence makes disturbed persons in general objects of fear, since random violence is in fact characteristic (though unrepresentative) of pathologically tinged violence.

The reason why random violence can be ascribed to mental disorders is that its inception is invariably associated with psychotic delusions or hallucinations. The offense may appear motiveless, but the offender usually

assigns private, symbolic attributes to victims who happen to be available at the time the offender's delusions or hallucinations reach climactic junctures. To the extent to which external stimuli play a role in provoking the offender's violenct act, the role is always a bizarre and improbable role, in which the victim become a repository of grievances the offender derives elsewhere. An illustration of this sequence is provided by the following scenario:

> The offender--a man in his mid-thirties--feverishly paces a subway platform mouthing the words "push, push, push," scanning his surroundings in what is described as "a nervous manner." The offender than approaches a young oriental woman waiting for a train and pushes her under an incoming engine, which crushes and decapitates her. The man is overheard saying, "Now we're even. I did it. Now they'll see at school." After being arrested, the man has a telephone conversation with his sister in which he explains, "This is not my fault. It is the Board of Education."

It develops that the offender has been a teacher placed on medical leave after experiencing the onset of a schizophrenic condition. He is hospitalized and treated as an outpatient, but discontinues his therapy and medication against the advice of his physicians. He then returns to his job, his performance proves substandard, and he receives letters of admonition from his principal. The resulting anxiety contributes to a resurgence of the man's difficulties, which now center on a delusional system which makes him the target of a conspiracy. On the day of his offense the man has lunch at a Chinese restaurant, where the waiter has asked him what he does for a living. This question leads the man to conclude that the Chinese

communitiy is in league with his superiors, who are the source of his difficulties. He also concludes that the Chinese as a group are "interfering with his mind and poisoning him to make him homosexual."

Another offender who (unsuccessfully) attempts to throw a stranger onto an incoming subway train has spent "ninety per cent of twenty years" in psychiatric settings. In this instance, psychological difficulties have a remote origin and date to the man's military service decades previously. The man's condition includes angry outbursts and reactions that are irrationally impulsive. He can offer no reason for committing his offense, and after he is incarcerated, the prison intake analyst observes that "in every way he is an institutionalized psychiatric patient who belongs in a hospital rather than a prison."

Personal experiences that precipitate random violence can generalize from one target to another in psychological chain reactions. A case inpoint is that of a female patient who has been living on the street. One month previously, the patient has been raped, and she has acquired a screwdriver to "defend herself." She has also become obsessed with birth and maternity concerns, which culminate in a random attack on an infant in a stroller. The child's mother fights off the incursion, but in the curse of the melee the patient turns her attention to an elderly bystander, whom she stabs with her screwdriver.

Another chronic outpatient becomes involved in the following sequence:

> The patient walks the streets in an agitated state, mumbling to himself. A pedestrian asks him whether anything is the matter, and in response he pulls a knife and stabs the pedestrian in the face. By this time a crowd gathers and the offender slashes two bystanders. The police arrive, and the man menaces an officer with a knife and is shot in the leg.

In another example,

> The offender walks up to a stranger on the street, grabs him and cuts his throat and chin with a knife. He subsequently explains that "his friend, with whom he had worked, had died of cancer. He felt that two other people would die. He was suspicious that he was being attacked."

Elsewhere incidents arise in which the offender's concerns have more focus, in that they attach to a particular individual who triggers a specific obsession. Examples are the following:

> The offender enters a laundromat armed with a knife and encounters a stranger. The stranger leaves the laundromat and is followed by the offender, who stabs him in the back and throws bottles at him. The offender tells the victim, "I'll kill you if I see you (again) on this street."

The offender peeks through a window and sees a woman taking a shower. He enters the house, picks up a knife and knives the victim in the arm, neck and back, subsequently indicating he has "no idea why" he committed the offense.

There are instances in which delusional concerns focus on victim behavior and the violence is "quasi random" rather than random. This means that the victim has dealt with the

offender, but that the connotations the offender assigns to the victim's acts are improbable and bizarre, and are thus unpredictable. An example is the following chain of events:

> Two days prior to his violent crime the offender has gone to a welfare office to inquire about his check. The case worker is not in the office and the offender leaves a mesage. On the day of the offense the offender returns and wordlessly stabs his case worker with an icepick. He explains, "I had to get my rent paid. I was afriad I would be thrown out of my place. (If I had used my hands instead of the weapon) I would probably have to go back there over and over again to see about my check."

Another example involves a disturbed female parolee who knives a woman in a washroom, explaining that "the victim bumped into me and didn't apologize."

Most random violence one encounters is an uncontaminated product of mental disorder, but some random violence (though not an appreciable proportion) includes involvement with alcohol and/or drugs. The following examples are cases in point:

> The offender runs up to a woman who is waiting for a bus, and hits her in the face with a tree limb, breaking her nose; the woman falls, and the offender continues to assault her. He then "vigorously resists: arrest and police conclude that he "is high on angel dust."

> The offender has been drinking heavily in a tavern, exits and points a crossbow at passerbys, two off-duty police officers intercede, and the offender stabs them.

Unsurprisingly, offenders who commit random violence often hypothesize that motives for their behavior are unascertainable. The offenders' inability to "explain" their violence relates to the specialized state of mind at

the time of their offenses--which cannot be recaptured in retrospect--but also has to do with the complexity of motives which underlie random violence. We have noted that more than other violence, random violence is a product of pathology. This means that the motives for the violence are related to the dynamics of the offender's emotional difficulties, including their causes and effects. Such relationships must at best inferred, as in our examples in which sex-related anxieties lead to panic which is ascribed (via delusions) to external danger. The instances in which offenders themselves can pinpoint such dynamics are rare. There are exceptions to this rule, however, as in the following incident:

> The offender--who is a transvestite--drives his car through a red light. When he is flagged down by police, he speeds away, and crashes into a wall. Approached by the police he exits his car, swinging a knife, shouting, "I'll kill you. Kill me!" The offender indicates that at the time he is "extremely upset over his masculinity," and has been suffering bouts of depression. He recalls that when his car crashed "he truly hoped the police would kill him."

Arson and Emotional Disturbance:

A second category of violence that is almost always associated with emotional problems is incendiary violence or criminal arson. The dynamics of arson offenses are variegated and are insufficiently understood, but some offenders shed light on prevalent motivational patterns. One such pattern combines impulsivity, impotent range and a sense of lingering resentment. The following examples are cases in point:

While walking by a house in an intoxicated state the offender remembers an altercation with the owner of the house that occurred several years previously. Inspired by this recolection, the offender smashes a bowling ball through the victim's car window, pours gasoline through the window, and sets the automobile on fire.

The offender--whose intelligence is extremely limited--has done work for his landlord in exchange for promised compensation. Instead of a reasonable wage, the landlord pays the offender a very small sum (four dollars). The offender feels resentful, gets drunk, and starts a fire in his closet. He also sets fire to his apartment on another occasion after fortifying himself with alcohol. On this date he has not received a promised food donation and has discovered that a neighbor to whom he feels attached "does not like him."

The offender, who is drunk, sets fire to an apartment building, doing minor damage to the building's garage. The offender reports that the owner has called her "names." She indicates that she has reported the affront to the police, who "refused to do anything."

Another offender has set five fires, resulting in damage of $300,000. One fire destroys the garage in the offender's father's house. The offender reports disagreements with his father. After these acrimonious arguments he testifies that he gets drunk and sets fires.

The offender, while intoxicated, incinerates a bedroom to injure her sleeping husband, with whom she has had an argument.

In incidents such as these one factor we invariably encounter is the offender's feeling that he or she is overwhelmed or resourceless in conflicts with opponents who are powerful. Thus suggests that the offender has a low level of self-esteem and a limited sense of self-efficacy. Another denominator that cuts across the incidents is that

the offender does drinking as a precondition to firesetting to work up his or her resolve.

Though resentment and a sense of impotence is a frequent motive for arson, some more complex patterns are detailed by a few offenders. One amibguous account, for example, emerges in the following incident:

> The offender--who suffers from retardation--has set two fires in a motel that do extensive damage. He is a former employee who has been recently discharged, but claims, "I had nothing against the motel . . . without thinking I would just go and light a fire anywhere." The man explains that he sets fires in response to hallucinations in which he sees the face of an individual who has killed his sister, and that he sets the fires to "get even" and to reduce tension he feels; "then everything builds up and I do it over again."

As it happens, the offender's account is incomplete, in that his fire-setting proves to be a long-term pattern. The offender has set several fires preceding the incident (his sister's death) which he regards as catalytic. This fact is not surprising, however, in that predispositions to arson are often chronic, while specific stimuli (such as feeling rejected) enter as shorter term, reinforcing motives.

It is also not surprising that arsonists attribute their offenses to immediate antecedents, since longer term motives are hard (if not impossible) to characterize. This difficulty also contributes to the fact that arsonists' self-descriptions often include claims to rational, goal-directed or calculated behavior. The following incidents are illustrative:

The offender breaks into a construction office to "look around" and steals a pen from a desk. He decides to "cover up finger prints" to avoid capture by strewing flammable liquid over the office, burning it down and causing several million dollars worth of damage.

The offender has been rejected by a female friend and sets her house on fire. He claims he has done so to "play the hero" by rescuing his friend's children, thereby inspiring her to renew their liaison.

Some offenders react to the difficulty of trying to explain their irrational acts by attributing their offenses to intoxication ("when I drink I set fires") or highlighting the enjoyment they derive from watching fires after they are set. Both observations are relevant, but neither gives adequate weight to longer term motivational states documented by the mental health histories of arsonists.

Mental Health Problems and Retaliatory Violence:

Retaliatory violence is committed by a wide range of people, including persons who have no criminal histories, those who have extensive involvements with violence and those with emotional problems, substance abuse difficulties and cognitive disabilities.

There is no distinguishably different pattern of "crazy retaliation" but some retaliatory violence perpetrated by disturbed offenders resembles quasi-random violence (e.g., a man has a snowball thrown at him and cuts the thrower's face to ribbons); other incidents can combine retaliatory motives with concerns that are symptoms of mental illness (e.g., a man kills his wife after an argument and hears voices which tell him to kill her). There are other instances in which

the motives for the violence are contaminated or are ambiguous, as in the following examples:

> The offender--who has been hospitalized on occasions for treatment of schizophrenia--engages in arguments with her fiance two days before her wedding. During the course of these arguments, she stabs her fiance to death, and later explains that she "was choked to death by light-complected members of the black race who had joined in a conspiracy to destroy her via (the boyfriend's) death." She also claims that the police has substituted the murder weapon for a "dagger" brandished by the victim.

> A man kills his brother-in-law with a twelve-gauge shotgun, calls his sister (the victim's wife) and asks her "to clean up the mess." He claims the victim has sexually molested his two daughters and "taunted him about performing sexual acts with him." He complains that he has shared such concerns with relatives, but "no one would believe him."

Retaliatory offenses are responses to perceived affronts, but it is not uncommon for disturbed offenders to add unusual twists to standard acts of retribution, which include eccentric behavior during or after the offense:

> The offender suspects that his wife is involved in extramarital liaisons. He stabs the sleeping wife in the neck, then chokes her with a telephone cord. The police find the offender "dazed" and describe him as "incoherent."

> The victim is the offender's ex-girlfriend, whom he has harassed "in order to get her back." In the incident the offender takes a shotgun and holds the girl for sixteen hours "trying to get up the courage to kill himself in front of her." He uses the gun, shooting out windows, before giving himself up to the police.

> The offender is a homosexual, and is also retarded. The victim is the man's lover, who has provoked him by becoming attentive to another man. The offender stabs

his lover in the back, eats dinner and asks a neighbor to call the police, who find the vicitm dead.

The irrational extreme among acts of retaliation is behavior involving disinhibited (angry, explosive) overkill, including massive and disproportionate reactions to seemingly minor provocations. This attribute is not confined to any special group of offenders, but can be associated with the catalytic contribution of alcohol or drugs to retaliatory resolves. Examples of alcohol involvement include the following:

> The offender has been "drinking excessively." A police officer finds him blocking the exit to a bus terminal and asks him to move. The offender responds "you're done, mother fucker," and attempts to shoot the officer with his service revolver.
>
> The offender is a supervisor in a rooming house. While intoxicated, he encounters a nonresident using a bathroom without permission. He arms himself with a baseball bat, wiats for the victim to exit, and beats him to death.
>
> The offender assaults a fellow-patron in a bar, kicks and beats two female police officers who try to restrain him, and assaults a male officer, kicking him in the groin. After the man is nominally subdued and taken to a hospital, he assaults doctors and nurses by spitting at them.
>
> The offender is chronic schizophrenic who has been described as a man who "becomes paranoid and wanders aimlessly about." He has been drinking with the victim in the latter's apartment. The victim asks him to leave, and the offender stabs the man in the heart.

Drug disinhibition (notably that of PCP and cocaine) is sometimes associated with acts of retaliatory "overkill."

There are also instances in which, the effects of drug and alcohol disinhibition seem to occur in combination:

> After an argument, the offender kills the victim, striking him with blunt instruments and then strangling him to death. The offender "states he was drinking and smoking angel dust, and does not remember the incident."
>
> The offender has a fight with an elderly drinking companion over a bottle of wine. During the fight, he stabs, punches and chokes the victim in such a frenzy that others cannot stop him. He claims to have been drunk and "high on PCP."

Disinhibition occurs among some disturbed offenders whose violence has a tantrum-like flavor. In such violence the offender appears to run helplessly out of control, as in the following incident:

> The offender injures an acquaintance after an argument. He also injures police officers who try to arrest him, lifting them and "banging them against a wall." A repeat performance occurs in the prison, during which four officers try to subdue the offender and are seriously injured. Prison staff note that "it seems that (the offender's) size and occasional episodes of dull-witted behavior may make him look like an easy target for others to pick on to prove themselves, although, due to his mental state, he is also capable of misinterpreting others' intentions and reacting explosively without real provocation.

The offender reliably inflicts damage because he is large and throws repeat tantrums. The mans size is an unusual and unique attribute but the combination of chronicity and promiscuous explosiveness occurs elsewhere among offenders with mental health histories. The following are some cases in point:

The offender's difficulties include early referrals for "uncontrollable temper tantrums," including breaking a teacher's fingers and "destroying property at school." In the recent incident he shoots at a man he has previously stabbed, against whom he harbors a "grudge." He has also thrown a knife at a sister (puncturing her leg), threatened to kill his brother and grandmother, and "sexually attacked" a female acquaintance.

The offender has spent six years in a psychiatric hospital. He is imprisoned for explosions in which he (1) stabs a former girlfriend's new boyfriend; (2) blinds the girlfriend by stabbing her in the face and (3) beats up the girl's father, threatening to burn down his house. In prison the man remains assaultive, "admits having no control over his explosive nature and does not care what he does to others."

In jail, the offender, who is awaiting trial for an assault, attacks a corrections officer because his shampoo is missing, throws hot water in the face of an inmate with whom he has argued and injures two officers who try to restrain him.

The offenders in these incidents have histories of diagnosed difficulties, but explosive violence also occurs among men and women who have no such histories. A propensity to disinhibition--the tendency to explode under stress--draws attention to the contributing role of disinhibitors, which may be external (alcohol and drugs) and/or internal states. The latter incude emotional lability and congnitive dysfunctions which impair appriasals of threat or assessments of response options.

Vehicular Violence:

Among forms of violence which reflect the influence of disinhibition are extreme violent assaults in which cars are used as weapons. Serious vehicular violence involves destructive impulsivity, panic, and indifference to consequences (including one's personal survival.) Though such violence often features alcohol as a disinhibitor, it also provides a role for other disinhibitors, such as those associated with emotional problems.

Vehicular violence by disturbed offenders includes serious incidents such as the following:

> The offender has tried to break into his inlaw's home. When police arrive, the offender backs a stolen car into three officers, then attempts to escape on foot. One officer sustains a hip and a head injury when the car is backed into him. Another officer is dragged a hundred feet down the street. The offender explains that he has arrived to talk to his wife, who he thinks has died in a plane crash. He is also there to see a friend from Venus, who has returned to help with his problems, and feels the police have interrupted his colloquy with his extraterrestrial friend.
>
> The offender has a history of assaulting police officers and prison guards. Preceding his offense he has been ordered to stop his car. He speeds away but later returns, taps the officer on the shoulder and asks him whether he has a problem. He locks himself in his car, and when ordered to exit drives the car into the officer, into a parked car and a police vehicle that responds to the scene.
>
> The offender is a disturbed juvenile escapee. He steals a pcoketbook and is intercepted by a witness as he steals a van. He drives over the witness and drags him down the street, killing him. He explains that "I got crazy the way things were going."

These incidents show admixtures of confusion, anger and fear. The same ingredients characterize more conventional incidents, but (1) the break with reality may be less drastic than it is among some disturbed offenders, and (2) the role of alcohol as a disinhibitor may make the contribution of psychological problems less salient:

> The offender is a former mental patient who lives in a trailer park. He is intoxicated, announces that he is going shopping, but a neighbor prevents him from driving off. The offender agrees to go to bed, but later changes his mind, threatening his neighbor (offering to burn down his trailer) if he does not relinquish his ignition keys. He drives out of the lot with tires spinning, kills a pedestrian, and talks about leaving town to avoid "going to jail for life this time."
>
> The offender accuses a man of stealing from his girlfriend, drives over the man repeatedly, then aims his car at the girlfriend, who he alleges has been "paying too much attention" to the victim.

One motive which may at some level form part of disinhibiting sequences is indifference to survival, but the role of this factor (which at minimum consists of a cavalier disregard of danger to oneself) is pure subject for speculation, as it is for more conventional DWI offenses.

Sexual Violence:

Persons with mental health or substance abuse histories are overrepresented among offenders who commit sexual assaults against adults or children.

This statistical fact confirms that deep-seated dispositions figure among routine motives for rape and sodomy and that sexual violence is complex in its dynamics.

This observation makes it unsurprising that sexual violence is often recidivistic as well as impervious to deterrence through imprisonment. Adding to the seriousness of this picture is the fact that victims of sexual violence are frequently depersonalized and callously dealt with by offenders whose obsessiveness and incapacity for empathy is extreme. Victims in such offenses are responded to as objects of need-satisfaction, and in the most serious incidents are treated with quasi-sadistic disregard for their physical survival:

> In one incident an offender abducts a twelve year-old girl, rapes and sodomizes her and leaves her zippered in a suitcase.
>
> An offender abducts a woman at a party, rapes and beats her and leaves her under sub-zero conditions in which she narrowly survives.
>
> The offender rapes a mother and beats and kicks her four year-old daughter.
>
> The offender rapes a deaf mute girl who must be hospitalized as a result of serious injuries.
>
> The offender sodomizes a seven year-old boy at knife point, urinates in his mouth, and leaves him covered with abrasions.
>
> The offender attacks a patient suffering from cerebral palsy, abandons him in freezing weather, and steals his wheelchair. His comment to the victim (who almost dies) is, "good bye, sucker."

Offenses such as forcible rapes of infants and assaults on persons of advanced age are predations in which victims are preselected for their helplessness as well as for their implausibility as sexual targets. Additional pathological

nuances sometimes manifest themselves in the details of unfolding incidents, such as in the following examples:

> The offender enters the victims' apartment, knives the husband and tries to rape the wife. When police arrive he throws a bottle at them, and tells them they cannot arrest him without a warrant. The man's blood alcohol is .16, he has convulsions and must be taken to a hospital.
>
> The offender forces his way into an occupied apartment, comlains that it is a pigsty and makes the occupant wash dishes. He then kisses her, watching himself in a mirror, and explains to her that everyone get s raped, including himself in jail. He then rapes the victim and tells her that he will drown her in the bathtub.
>
> The offender abducts a pedestrian and tries to rape her. He explains that (1) he is intoxicated, and (2) has heard voices instructing him to have intercourse with a woman.

Students of abnormal behavior assume that some sexual assaults--particularly of children and other powerless victims--are compensatory efforts by persons who feel (and often are) inadequate. In this view, men who are afraid to approach adult partners can gain sexual satisfaction and forceful dominance against helpless--and therefore nonthreatening--targets. The generality of this explanation is in some dispute,, but illustrative documentation of inadequacy includes incidents such as the following:

> The victim is intoxicated, is sleeping soundly in the subway and remains asleep while the offense takes place. The offender (a mental patient) subjects the victim to oral sex while another man (not associated with the offender) tries to rape her.
>
> The offender exposes himself to an elderly lady, takes off some of her clothes and flees. The next day the victim sees the offender in front of her home, and he is arrested.

The offender is a mentally defective outpatient who partially disrobes a female pedestrian, but is subdued by other pedestrians before he can attempt to rape her.

Evidence of Inadequacy among Other Offenders:

Offenders who are limited or disturbed at the time of their offenses can have their efficacy as crime-perpetrators reduced. Though the proportion of disturbed persons who fail as career criminals is surprisingly small (which suggests that crime is not an occupation calling for sophisticated skills), some persons are clearly too impaired to function effectively in carrying out specific offenses. Among instances of failure due to impairment are robberies in which offenders try to follow standard robbery procedures, but become unconvincing because of their obvious instability or eccentricity:

The offender gives a supermarket cashier the note, "I don't mind dying; you'll go with me if you don't give me a stack of twenties and fifties." The cashier cannot open her register due to nervousness. The offender takes his note and leaves the store. He is promptly overtaken, and is arrested.

The offender approaches a subway booth he has robbed, apologizes to the attendant and tells her he is going to mug someone. He does, and is arrested.

The offender robs a gas station. He is recognized because he has been in the station before and has filled out employment applications listing his name and address. He is described by the victim as "very nervous" at the time of the offense.

The offender enters a station wielding a knife and announces, "This is a stickup." The owner and two sons respond, "You've got to be kidding." As they subdue the offender, he yells, "I am an officer; call the police. I'm a detective." The police arrive and arrest him.

The offender enters a bank claiming to have a bomb, demanding money. The teller laughs at the offender and he flees. A short time later he jumps over the counter, takes money and is arrested. He claims to have no recollection of the incident, since he was under the influence of alcohol and drugs.

The offender tries to rob different banks using deposit slips of other banks and is informed that he is "in the wrong bank." He eventually does rob a bank, and leaves a deposit slip with his name on it.

In incidents such as these, the offender's failure can arise from (1) ambivalence or lack of self-confidence, (2) inappropriate behavior which reduces the credibility of his threats, and/or (3) self-destructive behavior which increases the probability of capture. Similar triats can reduce the efficacy of residential burglaries, as in the following examples:

The offender has spent his paycheck on a drinking binge. He enters an apartment but flees when the occupant wakes up. He enters a second apartment and again wakes up the occupant, who steps on him as he tries to hide. He tries to flee but is grabbed by the occupant of the first apartment, who finds him "in a daze."

The offender talks to an answering machine of a former employer indicating that he is going to burglarize the man. He does, and is arrested.

The offender burglarizes a home and lingers to take a shower. He burglarizes a second house and lies on a lounge chair on the porch, where a neighbor observes him and calls the police.

The offender's IQ is 55. He burglarizes an apartment leaving behind shoes and his wallet, later explaining that he was intoxicated.

The offender breaks into an unoccupied apartment and steals property, but abandons his hat and jacket. He also leaves feces on the floor.

In incidents such as these, the perpetrator shows that he lacks the capacity to complete an offense without risking apprehension. In other instances, offenses are undertaken on the spur of the moment (e.g., the offender drinks and runs out of money, crosses the street to rob a bank and returns to resume drinking). Such actions qualify offenses as expressions of "criminal impulse" rather than as manifestations of "criminal intent."

Violence Overkill in Burglaries and Robberies:

Very different from inadequate offenders are offenders who use gratuitous violence in committing property-related violent offenses. Offenders with mental health histories are less likely than offenders without such histories to use excessive violence in property offenses. This fact is surprising because violence overkill is irrationally motivated, in that it is unnecessary to achieve the ostensible goal (monetary gain) of the offense.

Extreme violence among disturbed offenders can combine long-term traits (chronic mental health problems) with shorter term situational motives (seeking violence as an end). Compounded irrationality can increase the sadistic flavor of violence, such as in the following incidents:

> The offender robs a gas station, then takes the attendant into the woods and stabs him with a machete, breaking his arms and legs and slashing his neck and chest, leaving him for dead. In a previous offense he has locked a cab driver into the trunk of his cab and abandoned the cab, which is not found until four days later. The offender is a mental patient and a member

of a satanic cult who "from adolscence has been a bizarre, violent, warped sadomasochist." He declares that he "is not afraid to die nor eliminate anyone who antagonizes him."

The offender participates in the robbery of a fast food establishment. After the robbery, he goes into the store and shoots the manager in the head. He tells a cab driver he has kidnapped, "I had to shoot that mother fucker . . . twenty-five years don't mean nothin' to me. No one wants me anyway. I'll shoot you too."

The offender robs four stores. In the first, he shoots the owner three times in the head. He shoots his other victims in the chest, killing one of them. He is a chronic outpatient who has no criminal record. he claims no recall of the offenses.

The offender enters the home of a paralyzed veteran, dragging him from room to room and beating him. He keeps beating his victim because he is "infuriated" that the man has no money.

The offender enters a house, steals property, then shoots and kills the family pets--a retriever and a ferret. He claims that "he remembers little of that day as he had been drinking heavily and had taken PCP."

The offender beats an elderly woman with a cane and kicks her in the face while mugging her. He is a disturbed transvestite with a history of robbing older, defenseless women.

The offender throws his victim against a wall and demands money and the victim hands over his wallet. The offender removes money and demands the victim's shoes and jacket. Thereafter he tries to strangle the victim, throws him down a flight of stairs and kicks him in the head. He explains that he is "high on angel dust."

Some offenders mention drugs as contributing to their involvements in violence, but patients with drug histories are underrepresented in felony violence incidents. This suggests that the drug-involved violence-prone offenders are atypical, as are the disturbed offenders who become involved in felony violence. To the extent to which drugs and

emotional problems combine to spark violence overkill, disinhibitors must evoke specialized motives to reinforce violent dispositions.

Felony violence is not a psychotic symptom, in the sense of responding to command hallucinations or delusions. If a common motivational denominator exists, it is an effort to demonstrate power through one's ability to maim or kill. Victims trigger the violence by being helpless which makes them easy, inviting proving grounds for the toughness the offender senses that he lacks. One cue is that cruelty often coexists with self-destructive behavior, including suicide attempts, and periodic despondency. This paradox derives from the offender's view of the world as a dog-eat-dog jungle, in which one is alternatively a victim and a victimizer. The offender is also typically tense, highstrung and irritable, full of bitterness and pent up rage.

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Notes

1. Mulvihill, D. J. and Tumin, M. M., with Curtis, L. A., eds., Crimes of Violence. A Staff Report to the National Commission on the Causes and Prevention of Violence, Washington, D. C.: Government Printing Office, 1969, Volume 12, p. 459.

2. Halleck, S. L. Psychiatry and the Dilemmas of Crime, New York: Harper and Row, 1969, p. 40.

3. Ibid.

4. Op. cit., p. 47

5. Op. cit., p. 48

6. Op. cit., p. 49

7. Ibid.

Chapter 9:

The Extremely Disturbed but Minimally Violent Offender: The Problem of Sentencing

We shall see (in Chapter 10) that some offender subgroups are made up of chronically disturbed and very violent persons who are obvious candidates for imprisonment because they pose serious threats to society. Such persons tax prison resources and are at best warehoused in the prison, but they must be incapacitated for long periods to protect the community from extreme and unpredictably explosive conduct.

Other offenders are also disturbed but they pose lesser risk; more to the point, such offenders lack any "criminal intent" in the conventional sense of the term (1) and suffer from a variety of handicaps which create the adjustment problems under which offense-related behavior can be subsumed. The need for incapacitation is not a pressing goal for such persons, the probability of deterrence is usually negligible (since offenses are at best impulsive) and the concept of equitable punishment seems inapplicable, given that the harm that is done tends to be a corollary of clumsiness and confusion.

The type of disturbed offender who is not a public menace stands out unhappily as a prison inmate, and tends to impress correctional staff as a victim of inappropriate, insensitive or inhumane sentencing.

In a recent legislative hearing the official in charge of New York prisons (Commissioner Coughlin) expressed reservations about the disturbed and retarded offenders who are routinely sentenced to prison despite obvious handicaps.(2) The Commissioner advocated increased attention to this problem at the juncture of sentencing.

Commissioner Coughlin said in part:

> Pre-trial identification of these individuals should be intensified. A number of mentally retarded inmates with abysmal coping skills have been tried, pled or convicted and sentenced to DOCS (the prison system's) custody. In some instances, these individuals were in non-correctional custodial care when the crime of conviction was committed . . . .
>
> As an agency, DOCS is not equipped to deal with these individuals. Although the most severe cases are few in number, they account for a disproportionate amount of staff intervention. Their presence in correctional facilities is highly disruptive to both staff and other inmates.
>
> Although (these offenders) have been adjudicated as being legally responsible for their actions, they function at an intellectual and social level well below that of the general inmate population.
>
> I would recommend that the lack of pre-trial services for developmentally disabled individuals be addressed by this committee. The current lack of such services is probably a contribution factor to the inappropriate incarceration of these individuals.(3)

The Problem of Deadpan Sentencing:

In our review of prison files we confirmed that in many of these dossiers questions about the appropriateness of a prison sentence for the offender can be easily raised. Such questions particularly arise in situations where (1) the offender is clearly not a menace to the public, (2) his or

her offense is irrationally motivated and/or reflects the influence of serious disabilities, (3) the offender remains disturbed in the period following arrest and preceding trial, and (4) he or she continues disturbed at intake into the prison.

Examples of cases that meet these four criteria are not hard to locate, though the number of inmates involved is impossible to determine, given that delicate judgments must be exercised, and that information is often sparse. However, it is the nature of the problem, rather than its magnitude, that must be the first of our concerns.

What is the nature of the problem? It is that some inmates are primarily disturbed and secondarily offenders but have been disposed of as if they were primarily offenders and secondarily (if at all) disturbed. Such actions are not reprehensible because they deprive mentally ill persons of treatment, given that mental health services are available in prisons. The problem is rather that fragile individuals must now receive services in a setting that poses tough challenges to the limited coping capacities of nonresilient personalities.(4) This fact holds even where inmates must be hospitalized on one or more occasions, because hospitalization usually provides only a brief respite from prison life and the commitment process can involve abrupt discontinuities in service levels and environmental demands.(5) Moreover, inmates find peers unsettling, and prison staff often must respond to their

disruptive behavior with punitive sanctions which can exacerbate stress levels, when maladaptation is already a product - or partially a product - of serious coping deficits.(6)

Among disturbed offenders who are sent to prison, we encounter a variety of problems, but consistency of dispositions. Examples of career vignettes illustrate this fact, and may help students of the problem understand the dilemma that faces the system and its clients in concrete and specific instances:

> An offender has broken into his neighbor's house. The police discover that he has stolen a plate of chicken wings, a bottle of wine and a yellow garbage can. The man is hospitalized because he is "grossly psychotic" and is diagnosed as suffering from paranoid schizophrenia. He is released from the hospital, found competent and sentenced to prison.
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> The man commits a burglary, is surprised in the act but does not flee, though he can do so. He is declared incompetent and hospitalized. He is subsequently released with the diagnosis "brief reactive psychosis in remission, adjustment disorder with emotional features, borderline intellectual functioning, possible mild organic brain syndrome, mixed personality disorder with histrionic and borderline features, history of head trauma," and is sent to prison.
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>
> The offender (who has spent most of his life in institutions) snatches the purse of a woman in a subway station. He is hospitalized for two years after his arrest, and diagnosed as suffering from schizophrenia, undifferentiated type, chronic. He is finally found competent to be tried, pleads guilty to attempted robbery and is sentenced to prison. In the prison reception center, staff observe that the man "became increasingly withdrawn . . . sat sideways in a chair and barely talked." Later, they record that "continued deterioration required transfer to (the hospital)."

Some cases do involve more serious offenses, which pose at least the potential for violence at the time they take place. These offenses nonetheless raise the issue of the appropriateness of prison because the offender's motives on the face of it appear to be clear products of his pathology:

> The offender, a mentally disturbed alcoholic, has no history of violence, but throws a bottle at a parked police car which injures a police officer. He cannot account for his offense. While awaiting trial, the man spends three months in hospitals, where he is maintained on thorozine. Prison staff find him "lethargic, monsyllabic . . . preoccupied," and refer him for mental health assistance.
>
> * * *
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> The offender has been a resident of several hospitals. He has been diagnosed as suffering from paranoid schizophrenia and as having drug and alcohol problems. He also has shown a propensity to carry weapons. The offense for which he is imprisoned is one in which the police find him sitting on a curb stuffing a machete down a sewer. The man has a bag with drugs, ammunition and a handgun, and warns the police, "Don't you put any bullets in the gun." Despite the man's strange obsession, he is found competent and convicted, though diagnosed as "probable mixed personality disorder with schizotype features."
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> * * *
>
> The offender walks into a store in which his nephew works, carrying two knives and demanding money. In disarming him, the nephew is wounded. The offender is angry at his nephew, who has complained to the police because his uncle has become convinced that his family is trying to poison him. Unsurprisingly the man is diagnosed as suffering from paranoid schizophrenia and is hospitalized for nine months before he is declared competent and convicted. The man arrives in prison "barely functional but taking his medication," and has to be transferred to the hospital.

The issue that is raised by such cases is not whether prison sentences can be legally justified. The offenders can be legitimately convicted and punished, since their

culpability is usually not at issue(7) and they have been found competent. The question, rather, relates to the nature of constraints that impel judges to consider imprisonment as an option, though the record suggests that the offender who is being sentenced has obvious mental health problems. In this connection, it is necessary to consider that (1) the dispositional options that are available to the judge may be limited, and often (as with offenders who are subject to mandatory sentencing provisions) are nonexistent, and (2) community-based alternatives may be sparse, because agencies can try to select their clients subject to restrictive definitions of eligibility.

Such considerations, however, do not account for the routine use of prison sentences for inmates who are disturbed, which suggests that sentencing rationales or other affirmative considerations must be at work. Closer scrutiny reveals at least two reasons that may inspire judges to consider prison as the milieu of choice for some disturbed persons:

1. The Prison as Backup Structure:

Prison sentences are sometimes invoked for persons whose distinguishing attribute is their demonstrated incapacity to negotiate life. This observation raises the possibility that prisons may be selected on humanitarian grounds because they furnish sustenance, shelter and

supervision.(8) The third attribute (supervision) may be particularly prized because it ensures the availability of supportive assistance around the clock. This fact may become a prime consideration where the person who is being sentenced looks particularly helpless or lost:

> The offender has held up a gas station, has "a blank stare on his face" and is incoherent. He is found incompetent to stand trial, and he shuttles between jail and hospital for three years before he is convicted. He has been raped by fellow-inmates, both in the jail and the hospital. While interviewed in the prison "he felt there was an umbrella with falling rain over his head." The interviewer's impression is that "schizophrenia is draining all of (the man's) energy" and concludes that he "needs protection or state hospitalization."

* * *

> The offender mugs a used car salesman, and is arrested. The victim describes him as a bum "who was not all there." (The offender's history is that of a chronic hospital patient, who otherwise "leads a nomadic existence.") The man is twice declared incompetent to stand trial. After years of hospitalization he is convicted and sent to prison, where he must be committed. Prison staff point out that the man "doesn't know why he is in prison . . . lies in his cell a lot. Finds it hard to get up or get started . . . . Impresses as a man who is content with his psychological condition and has no interest in . . . participating actively in life."

* * *

The use of prisons as a supervised multi-service environment may become attractive where less structured interventions seem to have failed to mobilize the offender, who appears to require more supervision, guidance or support:

> The offender has attempted to commit a burglary. He has been resentenced as a probation violator because he

is not employed and refuses to submit to vocational training. After he arrives in prison, he is referred to mental health classification "due to depression with suicidal ideation."

The probation officer describes the offender as "a young man whose emotional problems have played a role in preventing him from complying with the terms and conditions of probation . . . . Curiously, he cooperated with his obligations such that he never missed a probation appointment and basically kept most of his mental health appointments as well . . . This officer tried repeatedly to discover the source of the defendant's inhibition to look for work or accept vocational training. I can only conclude that the defendant lacks the motivation but also seems to have a genuine fear of academic/training situations which may be difficult for him to overcome . . . He was told that probation did not exist to allow him to remain at home and do nothing with his life. The crux of the matter is that the defendant has been unwilling or unable to accept this basic premise of probation supervision."

* * *

The offender has been diagnosed as suffering from schizophrenia, chronic, undifferentiated, with mental retardation (his IQ is 67). His offense consists of a "tug of war" in which he tries to separate a lady from her handbag, but fails. The offender has been paroled from prison (where he has spent most of his time hospitalized) to a civil hospital, from which he absconds. He is consequently resentenced to prison, where intake analysts point out that he "has a history of being unable to function in the community" and "has requested that the police arrest him simply so he will have somewhere to be cared for." At prison intake the man refuses to take medication, requiring an emergency commitment (the man is "eager" to be transferred to the forensic hospital) with the recommendation that "long term psychiatric residence be provided for him in the facility and upon discharge to the community."

A more direct incentive to imprisoning the offender may exist where he has evaded or rejected community services, whose staff cannot enforce their prescriptions. The prison serves as an inviting backup, particularly where backsliding by the offender makes him a nuisance or raises the presumption (admittedly, remote) that he may reoffend. In

such instances the prison is seen as not only having the virtue of being escapeproof but also as serving to interdict trouble the offender seems headed for if he is left at large:

> The man has grown up in foster homes and has graduated to psychiatric settings. He is arrested for a burglary and placed on probation. Within three months he is violated for absconding from a halfway house and not responding to treatment: He has been dismissed from an alcohol program for showing up drunk and not attending group therapy sessions.
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> * * *
>
> As a child, the offender has been taken to a mental health clinic for punching a teacher in the mouth. He is convicted of stealing a motorcycle. He has done so after running away from his seventh foster home placement. He is put on probation and referred to a youth corrections program, from which he also absconds. He is placed in a residential substance abuse program, from which he again absconds, and is sentenced to prison.
>
> * * *
>
> Six years ago the man has committed a violent sex offense and is declared not guilty by reason of insanity. He has been committed to a hospital, from which he is released subject to conditions that include therapeutic involvements. The man's probation is revoked because he "is said to have not taken his medication on several occasions, to have missed two thirds of his rehabilitation classes and about one third of his therapy appointments." Prison officials find the man "distant, removed, unkempt" and "not always in touch with reality." They commit him to the forensic hospital.
>
> * * *

The man arrives in prison ten years after he has committed his offense. The offense is an assault. The man has been involved in a family fight and ordered (by the police) to sleep in a hallway. He knives a neighbor who

objects to his presence, is placed on probation, but is later hospitalized. He is imprisoned after he rejects the hospital's discharge plan, indicating he would prefer living in men's shelters. He arrives in prison actively psychotic and is transferred to the forensic hospital.

II. Prison as a Secure Hospital:

Some disturbed persons evoke worry about risks that relate to their self-care, including posing a danger to self; others spark concerns about the milieus in which they must function, which they can disrupt with noisy, unseemly or destructive behavior. Such concerns are particularly inspired by offenders whose symptoms include a history of acting out, both in institutions and the community:

The offender is a patient who is given to episodes of bizarre explosive outbursts. He has been hospitalized for behavior such as running through the street nude proclaiming that he is Jesus Christ. He has also been arrested for unprovoked assaults. Jail staff note that "he goes nuts and throws things, sets fires and talks constantly . . . he said he was a voodoo doctor and stood naked in his cell."

> The offense for which the man is convicted is one in which he wakes up residents of a house, shouting at their windows that he needs money for drugs. The victims instruct the man to come to their front door, where the police arrest him. After the man arrives in prison, prison staff complain that he is "hostile, verbally aggressive, and emotionally unstable."

* * *

The man has been convicted for an incident that takes place two years previously in which he sets his apartment on fire. He spends much of the intervening time in a hospital, from which he is gratefully discharged with the diagnosis, schizophrenia, chronic, in remission. As soon as he enters prison, the man proves disruptive, "disturbing the entire block and staff." He cannot be processed because he "shouted throughout the (intake) interview" and refuses to take medication. He must be transferred to the hospital.

* * *

The offender commits a mugging during which he "made stabbing motions to the shoulder of a female victim." The victim describes the offender as "somewhat off." The man has a history of assaulting his mother, which has invited multiple hospital commitments. The diagnosis assigned him is schizophrenia, paranoid type, chronic, with acute exacerbation. In the hospital he engages in disruptive behavior, such as burning holes in sheets and setting his mattress on fire.

After the man arrives in the prison, staff write that "his adjustment is marked by continuous hallucinations with which he dialogues while in his cell, and extreme mood swings." The man sings, sometimes loudly, in his cell. Staff write (half facetiously) that "a significant feature of a positive nature is that he has a beautiful singing voice which impresses all who hear him."

The notion that prisons may be envisioned as secure hospitals, or hospital-equivalents, is in the abstract implausible. Without considering this possibility, however, it becomes hard to explain why hospital offenses with clear psychotic overtones result in imprisonment, instead of in the upgrading of security arrangements within the hospital. The same point holds for disturbed persons who prove troublesome in community settings, but are imprisoned rather than institutionalized in more treatment-relevant settings:

The man is convicted of a robbery after he is declared incompetent on five occasions, but later found competent. He serves six years, mostly in prison hospital settings.

After leaving prison, the man is sent to a civil hospital for a fifteen-day evaluation. He becomes disgruntled when his release is delayed and assaults a fellow patient who "said the wrong thing at the wrong time." He explains that "something snapped." The man is sent back to prison, where staff conclude that "he will need ongoing psychiatric care."

* * *

The offender is a badly retarded young man who sets his bed on fire because he is "angry at his brother." He is charged with committing arson, but is hospitalized. While he is in the hospital, the man fondles a female fellow-patient, and is again arrested. He is found fit to proceed, and convicted of his sex offense.

* * *

The offender is a retarded schizophrenic. He has a long history of hospitalizations and brushes with the law. He has attempted suicide by choking himself and jumping out of a second story window. In the hospital he enters the rooms of fellow-patients looking for money, takes a wallet and is caught. He is declared incompetent but is later sent to prison on a guilty plea for attempted burglary. The prison finds that "obviously, he is a disturbed psychiatric patient," and commits him to the forensic hospital. Staff note that "he prefers the role of patient and is a difficult client whose prognosis is bleak."

* * *

The offender is a mentally retarded man who has been convicted of rape after engaging in intercourse with a fourteen year-old agency client who "apparently (was) a willing participant." The man has sustained brain damage as the result of an accident in which he is involved as a child. He has subsequently experienced "nervous breakdowns," has attempted suicide and been diagnosed as suffering from a schizoid personality disorder.

A final category of imprisoned offenders enhances the plausibility of the "secure hospital" image of the prison,

because the offenders at issue are persons who are imprisoned after becoming destructively refractory in other settings. These offenders are not only difficult to manage, but react violently to efforts to manage them. The other side of the coin is that these persons are not premeditately violent, but are clearly disturbed at the time they pose a danger to their treaters. This second fact, however, recedes as relevant to sentencing authorities, given the safety concerns of treatment staff, which seem to underlie community demands for prison sentences:

> The offender is a severely retarded man who has become convinced that staff of a mental health program are laughing at him. He sets fire to the agency's building and tries to burn down its van. He throws bottles at agency staff, and arrives there with a knife in his pocket announcing he intends to stab someone. He also threatens to rape a social worker attached to the agency.
>
> The man is sent to jail, where he is repeatedly raped. He is declared competent, pleads guilty to Arson 2, and is sent to prison with a long sentence.

* * *

> The man is a former hospital patient who is imprisoned for arson after he sets fire to a group therapy room in an outpatient clinic where he is treated. While he is being arrested the man is described as "rambling continuously." He makes statements such as "it was a political arrest," "there is a question of constitutionality involved here; I didn't want to gain any more weight," "it was all after the fact, and there is defamation involved," "I got lonely and I wanted to be with my people at the clinic," and "I never got over the first hump." The man is subjected to competency examinations, but is declared competent, convicted and imprisoned. In the prison, according to staff, he "suddenly experienced a full psychotic breakdown."

* * *

The offender has been sentenced to probation for assaulting his girlfriend. At the time he is diagnosed as experiencing a "depressive reaction with paranoid features." Six years later the man has a psychotic breakdown after he is fired from his job and evicted from his room for "bizarre" behavior. While disturbed he enters his probation office, and refusing to leave. He ransacks the office, traps the staff behind desks, and threatens to assault them. He is restrained and removed from the premises. His probation is revoked and he is resentenced to prison, where he arrives medicated, and is adjudged "friendly and cooperative."

* * *

The man has a long career as a hospital patient. His offense takes place in the hospital in which he is confined. There he assaults a psychiatrist, breaking a chair over his head. He also destroys windows at the nurses' station before he is subdued. In the past, he has assaulted a social worker and tried to choke an attendant. In jail the man attacks a corrections supervisor, who loses two teeth. In prison, he threatens to "deck" correction officers at the reception center. Staff write that he "impressed as having limited intellect, horizons and mental sophistication."

What is To be Done?

The illustrations we have provided document our impression that disturbed persons are sometimes adjudicated in surprisingly deadpan or routine fashion as they are sentenced to imprisonment. We infer that the probability of such prison sentences is enhanced where (1) offenders have failed to respond to community programs, or (2) have proved disruptive to community settings. In neither case can the concern of sentencing authorities be adjudged misplaced, but it is also not obvious that prison is the most appropriate solution designed to meet these concerns.

The difficulty lies in the fact that the hypothetical type of setting that does address concerns about the need for support and structure for disturbed persons does not at present exist, nor are public pressures currently exerted to create such a setting. This indifference is understandable because [1] the types of persons we have described are rejected individuals who have no constituency, [2] they do not fit neatly into service-related classifications,(9) [3] once offenders are in prison, they are invisible to the public, as are the problems they experience, and [4] prisons are institutions of last resort; they have the obligation to deal with their inmates, even if they have proven to be inhospitable and thankless clients elsewhere. The dilemma is further compounded by the fact that a problem person can become a correctional client for life on the installment plan, because once he has been in prison his chances of being recycled into prison are enhanced.

Considering the problems created for the prison by non-serious disturbed offenders and the unimpressive, checkered careers they demonstrate, should we accept their prevalance as prison inmates? Prison officials do not think so, for their agency's sake and that of their charges. Judges should probably not think so either, because the integrity of their craft is demeaned whenever they send a person to prison by default, rather than because he or she belongs there.

Admittedly it is easier to delineate the current situation than it is to envisage its resolution. The best we can hope for is that the future of forensic psychiatry may come to include more serious input into sentencing, and the creation of programs that can divert offenders after they are sentenced.(10) We can also hope for inter-agency arrangements and hybrid systems in the community that will willingly accomodate persons who now fall between cracks, and most notably those impaired, disabled and disturbed men and women who become correctional clients because we do not know what else to do with them.

Notes

* A modified verison of this chapter was published under the title "The prison as dumping ground: Mainlining disturbed offenders" in the Winter, 1988 issue of The Journal of Psychiatry and Law. In connection with this version of the chapter, we are indebted for comments from Commissioner Thomas Coughlin, Dr. Joel Dvoskin, Dr. Ronald Greene and Scott Christianson.

1. Criminal intent (mens rea) literally means evil or guilty state of mind, and refers to the "mental element" of any offense. Seymour Halleck, a forensic psychiatrist, notes that "in the modern era, our courts have really been concerned with the mental state of an offender as an exculpatory factor unless the state can be characterized as a disability sufficiently severe as to meet the legal standards defining insanity. The mens rea or mental element accompanying a crime has become narrowly defined, so that simple awareness of conduct, or circumstances under which it occurs, and its probably consequences are usually sufficient to assume intent or guilty mind" (S. Halleck, The Mentally Disordered Offender. Washington: National Institute of Mental Health, 1986, p. 54).
2. Throughout this chapter we refer to "disturbed" offenders. Attention to our illustrations will remind us, however, that many of the inmates we discuss have

multiple problems, combining (to varying degrees) serious retardation, learning deficits and manifestations of mental illness.

3. Excerpts from the Testimony of Commissioner Thomas A. Coughlin before the Assembly Standing Committees on Correction and Mental Health, Mental Retardation and Developmental Disabilities, December 9, 1987, Public Hearing on Persons with Developmental Disabilities and the Criminal Justice System.

Commissioner Coughlin advocates expansion of supportive services in the prison, but recognizes that "in the short term, pressure (must) be put at the front end of the system, the courts, the prosecutors and the defense bar. Chronic schizophrenics with IQs of 67 should not be allowed to plead guilty and be sent to prison" (Commissioner Thomas Coughlin, personal communication). The timeliness of Commissioner Coughlin's testimony is illustrated by the fact that on the same date on which his remarks were publicized, a newspaper story appeared in which a county judge is quoted as objecting to provisions in the courts that allow "incapacitated persons to avoid criminal proceedings, (creating) a class of persons immune from the criminal justice system and given carte blanch (sic) to commit crime" (J. Cather, "Judge cites loopholes for mentally disturbed," Albany Knickerbocker News, December 10, 1987.

4. Mental health-related adjustment problems of inmates

are discussed in H. Toch, Men in Crisis: Human Breakdowns in Prison, Chicago; Aldine, 1975.

5. See H. Toch, "The disturbed disruptive inmate: Where does the bus stop? Journal of Psychiatry and Law, Fall, 1982, 327-349.

6. For a study that shows that emotionally disturbed prisoners have relatively high rates of prison infractions, see H. Toch and K. Adams "Pathology and disruptiveness among prison inmates," Journal of Research in Crime and Delinquency, 1986, 23, 7 - 21.

7. We have already noted that the insanity defense does not come into play for the types of offenses with which we are concerned, since the defense is in practice invoked only where serious the offender faces very heavy penalties. Seymour Halleck, writes that "in our current political climate, pressure is actually growing to avoid examining psychological issues related to culpability by narrowing the insanity defense or doing away with practices associated with the diminished capacity doctrine . . .By providing a loophole for dealing with the worst possible cases, the insanity defense allows society to acknowledge that at least some offenders are different. This enables society to avoid the formidable problems that would arise if it were to adopt a more flexible approach in assessing the relationship of psychological disability to liability in the case of all offenders" (S. L. Halleck, Note

1 supra, p. 61).

8. The same issue arises for the parole board when it comes to releasing multiply disadvantaged offenders from prison. William McMahon, Chairman of the New York State Commission of Correction, testified, for example, that developmentally disabled inmates are "less likely to receive parole, and are more likely to serve longer (prison) terms." He points out that "they are perceived as poor candidates, largely because the combination of community-based services considered essential for the success of these individuals are not available in most localities. Thus, the parole board believes that it is protecting the inmate and the community". (W.G. McMahon, Testimony, New York State Assembly Standing Committee on Correction; New York State Assembly Standing Committee on Mental Health, Mental Retardation, and Developmental Disabilities, December 9, 1987).

Commissioner Coughlin notes, for example, that "it is abundantly clear that a person suffering from mental retardation and some form of mental illness is the bain of everyone's existence. The retardation people point to the mental illness and throw their hands up. The mental health people point to the retardation and do the same . . . . The current practice of labelling everything just reinforces this process. I once proposed a State Department of Dual Diagnosis, so that no

one could hide behind a label" (Commissioner Thomas Coughlin, personal communication). Chairman McMahon (Note 8, supra) concurs. He testified that "in the case of the dual diagnosed, it is difficult to access services because (agencies) have difficulty agreeing upon primary responsibility." He cites as an added problem the fact that "residential and treatment programs, in general, avoid persons with a criminal record."

10. In New York State, the Office of Mental Health Bureau of Forensic Services and the Division of Probation and Correctional Alternatives are in process of shaping an "Alternatives to Incarceration" proposal which would "define and make available to the courts alternative sentencing options for cases involving mentally ill non-violent offenders." The proposal suggests refining and evaluating models in two state counties and assisting other interested counties with the development of diversion program (Joel Dvoskin, personal communication). One attribute of such programs which is critical is to enable them to cover gaps between service modalities with hybrid organizational arrangements that make it difficult to reject multi-problem clients because they do not "fit". Chairman McMahon (Note 8, supra) made this point when he testified that "I believe that the problems of the developmentally disabled offender can most effectively be addressed by

utilizing a multidisciplinary, inter-agency approach."

Chapter 10:

The Extremely Disturbed and Extremely Violent Offender: The Problem of Programming

In a sense, the dictum "history is destiny" provides an empirically testable hypothesis. Some persons will behave in patterned, redundant fashion, and others will show the ability to change for the bettter or worse. Recidivism refers to one form of predestination--not escaping from undesirable past conduct.

Whether persons who have a history of emotional problems will remain "disturbed" is a crucial issue for our research. If the answer is a negative one, viewing the past as we have done has limited implications for the future, and at best contributes to increased understanding of the present. Where historically derived measures describe continuing patterns, however, they carry substantial implications, such as for prevention or treatment.

We have followed disturbed offenders into the prison, to ascertain whether they will still need mental health services. Table 10.1 summarizes the results of this inquiry, and shows that four per cent of the inmates who have not received mental health services in the community will require them in prison. This figure compares to forty-three per cent for the inmates with mental health histories, and thirty-six per cent of inmates with "mixed" histories,

Table 10.1 Mental health services required during first two years of incarceration by offenders in our four samples

The offender's mental health history	Mental health service provided			
	Screening by staff	Outpatient services	Hospitalization Single	Hospitalization Multiple
No history (n=544)	16.9%	3.7%	0.02%	0%
Substance abuse (n=83)	18.1%	9.6%	0%	0%
Psychiatric (n=540)	20.4%	29.3%	7.2%	6.3%
Combined substance abuse and psychiatric (n=141)	21.3%	29.8%	4.3%	1.4%

which include substance abuse services. Substance abuse histories alone yield a ten per cent figure.

Commitments to the psychiatric hospital, which presuppose very serious illness, are called for with one of seven members of the psychiatric sample, but only one of twenty inmates with "mixed" histories. One inmate in the comparison sample (out of the total group of 544) required hospitalization.

These results are surprising given that a large number of inmates in the four groups are screened, usually at intake and for the parole board. We also know that guards, who refer most inmates for service by mental health staff have no access to mental health files.

Which are the disturbed inmates who need assistance in prison? Table 10.2 targets this question, and shows that several clusters disproportionately account for mental health clients. Heading the list are the Acute Disturbed Exploders, thirty-nine per cent of who will be hospitalized. The group has (unsurprisingly) extensive mental health involvements, particularly recently. Its violence is often eccentric (See Chapter 8), and is always extreme, though the offenders have no violence histories and low arrest records. In this respect these inmates differ from Chronic Disturbed Exploders, whom they otherwise resemble. This Exploder group--who are extreme violent recidivists with long-term mental health difficulties--has less serious problems in the prison, though half the group (51%) needs mental health

Table 10.2 Mental health services required during the first two years of incarceration by offenders with mental health histories

	Mental health service provided			
			Hospitalization	
Psychiatric history offenders	Screening by staff	Outpatient services	Single	Multiple
Impulsive burglar	36%	21%	5%	0%
Impulsive robber	26	18	5	0
Long-term explosive robber	25	30	0	4
Young explosive robber	38	15	0	0
Mature mugger	9	32	5	5
Acute disturbed exploder	16	25	25	14
Chronic disturbed exploder	13	42	6	3
Disturbed sex offender	17	32	9	17
Composite career offender	17	25	7	8
Compensatory offender	21	37	11	0
Combined substance abuse and psychiatric history offenders				
Dependent burglar	20%	25%	0%	0%
Skid row robber	44	22	0	0
Skid row exploder	14	31	9	3
Composite career offender	14	32	3	0
Multi-problem robber	29	32	7	0

services. The third most violent cluster in the sample are Disturbed Sex Offenders, 26% of who are hospitalized. The group records the third highest rate of eccentric offenses and has a substantial history of mental health involvements, but a limited offense history.

Our findings are dramatic and consistent: Persons who are disturbed after they offend tend to be disturbed before they offend, and when we look at the samples in more detail we discover that the most disturbed inmates have committed the most extreme violence, and mostly the "craziest" violence. This trend continues upon inspection: the fourth most disturbed group (the Compensatory Career Offenders) proves to be the fourth most violent group, and the most disturbed cluster in the mixed sample (Skid Row Exploders) is responsible for the most serious violence in the sample. We conclude that there exists a clearcut type we can call the "disturbed violent offender"--meaning, an offender who is extremely violent when he offends and is chronically disturbed. This chapter will deal with the question of what to do with such offenders.

The Insanity Defense Revisited:

If the insanity defense were more frequently invoked, fewer of our offenders would be in prison, because they could lay claim to being adjudged insane. This is so because their mental health problems are mostly contemporary with their crimes, which at least makes it reasonable for

psychiatric testimony to be invited. The offenses the group commits are also serious, which makes an expensive defense more cost-effective.

If the offenders we are reviewing had offended in continental Europe, many would be acquitted because continental insanity rules are at times broader than those that fall in the McNaghten tradition.[1] The European offenders would not walk free, of course, any more than they would if acquitted in the US. Insanity acquittees everywhere earn terms of hospitalization, which are less determinate than prison sentences. In practice this means that hospital terms may prove longer or shorter than prison terms, but one cannot predict whether they will be longer or shorter. Civil libertarians, therefore, worry that hospital terms can prove longer than the prison sentences offenders would serve. The public, on the other hand, worries that hospitalization may release the offender earlier, with the result that he will be insufficiently punished and will pose danger of renewed predation. The public also does not trust hospital psychiatrists (who are presumed to have offender-centered concerns) to consider the interests of victims.

The fact that the insanity defense is almost never used resolves the argument in favor of both contending parties. It also creates a situation that accomplishes two purposes: It makes the amount of time the offender serves more predictable, and reassures members of the public that offenders will "pay" for crimes. On the other side of the

ledger, the non-use of insanity pleas has consequences that are less easily defended. Among these are (1) the fact that persons are convicted who don't look like coldblooded offenders and are hypothetically nonresponsible for their crimes; (2) the discovery that there are only evanescent differences between prisoners and NGRIs, which raises the specter of discrimination based on the availability of defense funds or other unfair considerations, and (3) the point we have already discussed that the influx of disturbed offenders makes prisons repositories of inmates who are seriously disabled.

Disturbed offenders need mental health services no matter where they are sent, and such services must be provided by mental health staff in one setting or the other. Most mental health staff prefer to work in hospitals, but close reflection would tell them that the prison may be a better place in which to treat disturbed offenders. Among advantages of the prison are: Prisons are unquestionably secure, which means that staff and fellow residents are protected from the violence of explosive inmates, and escape is unlikely, and (2) prison mental health staff need not decide when to release people into the community, which is a "damned if you do, damned if you don't" type of assignment. On the other hand, a mental health staff member who works in the prison is a guest of prison officials, whose concerns must be respected.[2]

Mental health staff may also find the prison discomfitting because prisons are selfconsciously non-rehabilitative, though corrections has not been able to stake out a positive mission other than containment.[3] Given the obvious ambiguity of the prison's goal the mental health staff's member, whose role is uncertain to begin with, has an even harder time defining a defensible mission for himself.

The authors of a recent survey of prison mental health services write that

> strong disagreement still exists in a number of areas regarding what services are proper and appropriate for prisoners who desire or are in need of mental health services. Those with a client-centered perspective operate out of a totally different philosophy from those with an institution-centered perspective. One extreme regards the mentally disordered prisoner as entitled to the care and privacy one would enjoy in the private and civilian sector; the other, focused on maintaining order and discipline in a large correctional setting, desires as little differentiation as possible in the administration of rules and sanctions. If we add to this the bureaucratic infighting endemic within and between agencies, it is hardly surprising that no one has come to total agreement on the subject. Without consensus on policy, however, and without the dollars to back up the policy, major conflicts break out among the personnel actually charged with prisoner management, and the disparity between service levels at different institutions grows.[4]

Mental Health Services in Prison:

The problems associated with mental health services in prisons may be serious, but one must recognize that there are also problems in other agencies--particularly in public

hospitals--to which offenders are sent if they are not imprisoned.

Hospitals, like prisons, are in a state of continuing transition. The transitions of prisons and hospitals, however, are opposite, or at least, disparate. Prisons are expanding their purview, and are holding convicts for longer periods of time. Hospitals are shrinking their clientele, but are releasing patients as quickly as they can, continuing to treat them (or referring them for treatment) on an outpatient basis. Today's hospital population is usually seriously disturbed, and the hospital's aim is to "stabilize" their condition so it can be dealt with--in theory at least--in the community.

The disturbed offender fits uncomfortably into the contemporary hospital's mission. For one, the offender cannot be quickly "stabilized" and released under medication, because the community will not tolerate the risk this entails. As a consequence the disturbed offender has to remain on hospital wards until he is certified as nondisturbed or "cured." In the past, this would have been par for the psychiatric course, but today it means that the offender is surrounded by persons who are more disturbed than himself, while in the prison the offender's peers would be nondisturbed offenders serving sentences as long as (or longer than) his own. In the hospital the offender also carries the stigma of his offense. Mental health staff who work in hospitals are apt to be intimidated by violence and

may approach the offender uneasily and with fear.[5] This creates problems for staff morale, but it can also affect patient care, because staff apprehension leads to overmedication as a reassuring "management" tool.[6]

Medication is a key issue in hospitals because psychotropic drugs are the therapeutic modality of choice in most psychiatric settings. This is not in itself a problem, but becomes a problem if we envisage treatment goals for the offender other than reducing or deleting the symptoms of his psychosis. If we have a subsidiary concern with contributing to socialization, the hospital has few advantages over the prison--it can be more democratic, for instance--but it has particularly serious disadvantages, such as the fact that one cannot rehearse prosocial living where the prevailing concern is with humane storage pending the elimination of florid symptomatology.

The disturbed Offender in Prison:

The other side of the coin we are viewing is that prisons are not designed to accommodate psychotics, who are apt to behave in eccentric ways. Two features of prison pose particular problems for the disturbed inmate: One is that prisons insist on participation in prison routines, which include self-care, following instructions, and involvement in programs. Opting out results in a cumulation of prison disciplinary infractions, which invite

punishment, no matter how "crazily" motivated the inmate's lapses may be.[7]

A second feature of prison is that it means close cohabitation by persons who must depend on each other not to increase discomforts built into the prison situation nor pose risks of harm to others. Eccentricity--especially unpredictable eccentricity--creates discomfort for prison staff and inmates because it makes the environment less dependable. Disturbed offenders also invite predation from peers because they are vulnerable, or pose risks when they unpredictably explode.[8]

Another problem is one of logistics. Disturbed persons are variably disturbed, and require gradations of mental health assistance, ranging from hospitalization to "normalcy." If one is serious about responding to changing needs of clients in any routinized setting this means that one must shuttle them from place to place, so as to adjust their regime and social milieu to accommodate the changes in their condition. This becomes a particularly serious issue when a person needs hospitalization. Hospital commitments must be approved by the courts, and require shifting jurisdiction from corrections to mental health staff. Among the typical squabbles this invites is that hospitals may regard some of the inmates referred to them as insufficiently disturbed, and prisons may view the inmates as insufficiently recovered when they return.[9]

There are also many prison systems that have an insufficient range of options to accommodate offenders whose condition falls short of meeting hospital commitment criteria. Where an inmate is moved from the hospital to a very different setting, the sharp transition can undo whatever benefit hospitalization offers because "stabilization" (the standard goal of inpatient tratment) presupposes aftercare, including outpatient services.[10] In the community the unavailability of lower-order mental health assistance contributes to homelessness, and to vagrancy patterns that include involvement in crime.[11] In the prison, unrecovered patients become disciplinary problems, which creates a vicious cycle if punishment exacerbates their mental health problems even further.

Above all, prisons must determine to what extent they are in the business of providing mental health assistance. Such a determination, however, is not simple, because the line between rehabilitation and mental health services is hard to draw. The courts have determined that inmates have a "right to treatment", but it is not clear how much "mental health" is included in the "health" which must be preserved in the prison. The legal formula implies that the goal of therapy one must provide to inmates is to help them reduce symptoms that disable them and make them suffer.[12] But substandard mental health is a continuum of symptoms or suffering, and lines can be more or less generously drawn. Another problem is that there is an unascertainable

connection between the offenses of inmates and their psychological handicaps, which obfuscates the line between rehabilitation and treatment. More relevantly, emotional problems can affect prison adjustment, which is a concern of prison administrators. Even if a mental health staff member did not wish to assist his or her warden it is hard to envision therapy that would not have to deal with prison behavior, since the inmate's difficulties can only be observed (and addressed) in encounters that arise in the prison.

Putting issues of mental health goals aside, we can specify what some of the choices are for corrections if it wishes to create a program that meets the needs of the disturbed violent inmate, those of the prison, and those of society to which the inmate must return.

A Program for Disturbed Violent Offenders:

Any program for disturbed violent offenders must recognize that the group will contain persons with chronic mental health problems. However, this does not mean that all offenders in high-risk groups have chronic problems nor that chronic problems are problems that remain at the same level of seriousness all of the time. The approach to the offender must, therefore, be open-ended, invoking mental health assistance as it is needed and when it is needed. Beyond this requisite there are some questions that any

program designer must resolve to which the answers are less clearcut:

(1) Homogeneity of the Population: There are advantages in working with a group of offenders who have similar problems, such as the members of any of our clusters. These advantages increase if one's task includes rehabilitative concerns, because homogeneity means that offenses are similar in kind. Other problems one may wish to address can also become more comparable if one's clients have reached a commensurate stage of life and if they share similarities of background. The most noteworthy advantages accrue if one envisages a therapeutic community, in which peer interactions are important and the compatibility of inmates matters.[13]

Homogeneity, however, reduces size, and where prisons are crowded few systems can afford small, specialized programs. A compromise structure involves combining clusters, which can be subdivided for certain purposes (such as treatment), and recombined for others. One advantage of this model is that an offender may be assigned to a group concerned with violence (in which Sex Offender A may be paired with Sex Offenders B, C, and D because they share the same offense background) and to a different group concerned with mental health-related issues (in which Offender A might be paired with Offenders E, F, and G, who are schizophrenics in remission, or have become chronic disciplinary violators).

More heterogeneous groups can also be formed around issues of living in the unit or for helping staff run the program, or around activities such as academic self-study.

(2) Segregation of the Program Population: The inmates we have described resemble hospital patients in sufficient respects to cause problems, and to have problems, in the prison. The fact that the inmates are often disturbed argues for a separate, quasi-hospital setting--even a separate facility--which can both be part of the system and have a measure of autonomy. One advantage of autonomy is that it introduces flexibility, if one want or needs it. Some prison routines--such as the operation of the disciplinary process--could be relaxed if necessary.[14] More importantly, in a special setting one can afford tolerance of deviance, which is difficult in the prison. A special setting, however, must not be too special. If one assigns an inmate to a program known as containing eccentric or dangerous individuals one risks stigmatizing him, or creating a ghetto from which it is difficult to escape.

(3) Ingress and Egress into a Program: The problem of ghetto existence can be partly addressed by regarding program participation as time-bound and as a phase of the inmate's career defined by his progress. An offender can become a program resident at prison intake, or later if staff feel that he can benefit from the program. The presumption would be that the inmate can graduate from the

program or be transferred to some other program, when he is ready to make the transition.[15]

The virtue of this approach is that it expects and accommodates change. It permits "mainstreaming" of inmates whose problems dissipate over time, but also allows for formal mental health assistance, or more specialized services, for inmates who cannot adjust to a midrange program.

(4) Staff teaming: Programs for inmates who are disturbed require involvement of mental health staff. Such staff may be invoked for individual inmates as needed, but this arrangement invites jurisdictional problems between staff and compartmentalizes services. A more integrated solution is to use teams which include mental health workers and correctional officers.[16] Staff benefit from such teaming because it offers cross-fertilization and democratization of roles. The inmate also benefits, because the stigma of labelling him as "sick" is reduced. Where all staff deal with all inmates no lines need be drawn (or emphasized) that differentiate "disturbed" and "nondisturbed" inmates, which is in any event an artificial distinction.

(5) Building in a Research Component: We began by noting that disturbed violent offenders are a badly unexplored entity, and we admit that we have far from exhausted the topic as a subject of research. The concentrated availabilty of a study population provides an opportunity to add to our knowledge about this important subject. A

research mission can enhance the role of a program because staff can see themselves serving a larger cause than the program itself. The mission also underlines the importance of keeping records, such as of interview summaries (or transcripts) or the minutes of group meetings.[17] The research function also has appeal to inmates, who can rationalize that they are providing data (with appropriate assurance of confidentiality) when they share intimate problems and concerns.

(6) Providing Treatment: We have not said much about treatment goals, but we can delineate some options. These options include attending to mental health problems and reducing violence recidivism (which entails studying violence), but one can also try to reach some more general goal--such as enhancing living skills--which encompasses the other objectives.

Recidivism reduction is the riskiest goal to claim, and the hardest to defend. Moreover, mental health problems are not the most plausible selection criterion for inmates if recidivism is one's concern. Monahan and Steadman, for example, write that:

> if the effectiveness of therapeutic techniques is to be measured against the criterion of reduced criminal recidivism, those techniques should be targeted directly against recidivism, not against mental disorder as an intervening variable. There may, for example, be a small group of "psychotic rapists" for whom the cure of their psychosis will result in the cessation of their raping. But there may also be a much larger group of nonpsychotic rapists--or rapists for whom psychosis and criminal tendencies coexist without being causally related--for whom psychological techniques aimed directly at reducing recidivism (e.g.

> training in self-control and socially appropriate forms of making sexual requests) would prove effective. The use of such techniques, of course, would leave any existing mental disorder intact.[18]

One problem with this view is that it implies that offenders can be subdivided into compartments, some of which may be watertight, so that they can be filled or emptied without affecting each other. In practice, rehabilitators try to change people for the better, and hope for outcomes on as many fronts as possible.

The example offered in the quote is also misleading, because the criterion it proposes for the pairing of targets is offense alone. If we pool disturbed and nondisturbed rapists we presuppose that rapists are more similar to each other than are rapists and similarly motivated offenders (such as arsonists) who have comparable backgrounds and dispositions. We also imply that we can address the behavior (rape) without worrying about why it occurs. This presumption would be particularly surprising with rape, which ranges from subcultural gang activity to sadistic, pathologically tinged rage.

While it would be shortsighted to work with offenders without considering the offenses they have committed we must recognize that the prison--where crime opportunities are few--gives us little chance to observe offense behavior directly, or to rehearse its discontinuance. We can talk with offenders about their past predations with an eye to

promoting insight and constructive resolves, but crime is no subject matter we can deal with in vivo in the prison.

Crime, however, expresses broader behavior trends which we can hope to observe in non-offense settings. This holds particularly true of violence, which reflects dispositions such as suspiciousness, explosiveness, egocentricity and limited acumen. When one takes a closer look at violent offenses (as we have done in examples) thematic content can be seen which also emerges--usually in attenuated form--in everyday behavior.

Continuity of motive also operates in the other direction, and we have a right to assume that improvements we can effect (enhanced competence, mental health or interpersonal skill) may modulate offense behavior. This does not justify defending treatment as a way to reduce recidivism. What we can claim is that we can achieve tangible behavioral improvement, which we can document with behavior we can observe. The behavior we must attend to will vary with the person and his level of pathology. It can range from taking showers to respectful demeanor with authority figures to not losing one's cool, being predatory, and posturing toughness in compensatory ways.

Treatment goals that address observable deficits are not mental health-restoration or rehabilitation, but can reach such objectives, depending on the transfer that occurs. Substantial change can be hoped for and worked toward, though one should not depend on achieving it because

the criterion is too remote. The goal we must have in mind in working with disturbed violent persons must be to incrementally improve mental health and/or reduce violence potential. The gains in most instances will be modest. The fact that they can also on occasion be dramatic need not unduly excite us. Such results must be placed in the same hopper as the fact that on other occasions program graduates will revert to mental illness, or to crime. Neither development can be credited to change agents whose jurisdiction ends once the offender is released.

Recidivism would be at issue if aftercare extended into the community, so that newfound behavior could be tested for staying power. Coping abilities in life cannot be challenged in institutions, because the range of challenges institutional settings offer--even of painful challenges--is narrow. What instititions provide is a combination of constraint and support (staff call it "structure") which helps vulnerable persons to survive. Persons without support who need support use freedom to flounder and fail. Freed psychotics develop anxiety when they meet complexity. Absent constraints, they refuse medication and decompensate. Released addicts face choices they cannot handle. Given temptation, they revert to drug use and to crime. Such men need institutions until they evolve the resources to survive outside them.

<u>What Sort of Hybrid?</u>

The uniqueness of a setting of the kind we have prescribed lies in the combination of hospital-features and prison-features it needs in pursuit of its mission.[19] Our inmates (DVOs) belong in prison because they have taken lives or injured people; they belong in hospitals because they have longstanding problems. The latter fact is a reason for not being in prison, and the former, for not being in hospital.

How can a setting be neither prison nor hospital, and yet be both? The answer varies, but comprises requisites such as the following:

(1) We must make sure that clients qualify on all counts. The setting must contain clearly disturbed offenders. The most plausible way to start is to replicate our sampling design, which asks whether offenders of concern have histories of mental health problems. The next step is to find those offenders whose mental health problems are alive, or have resuscitated in prison. Mental health problems should be substantial, but fall short of requiring commitment.

(2) We must make sure the clients match the setting. One matching issue revolves around the severity of mental health problems with which a setting can deal. The more substantial the representation of mental health staff in a setting, the more serious the problems it can address. It does not matter in this connection whether the administrative umbrella of a program is corrections, mental

health, or conjoint, but whether staffing levels are sufficiently rich. (For example, medication must be administered by nurses, under medical supervision). A second matching issue has to do with security concerns. Some disturbed offenders are dangerous, some are victim-prone and others combine predatory and vulnerable features. A setting that contains such persons must be able to separate them so they pose no danger to each other, and provide sufficient coverage to prevent victimization.

(3) We must make sure clients get the benefit of helpful prison features. We have noted that one advantage of prisons over hospitals lies in educational, training and work opportunities they provide. This is a normalizing feature which can be adopted to good effect in hybrid settings. Programming is particularly helpful by providing respectable content around which inmate and staff (and inmates and inmates) can relate to each other.[20]

Another prison feature we have mentioned has to do with the fact that the inmate's release date is, within limits, predetermined. This fact reduces incentives for the inmate to play games to get out, and frees staff to do their best to help the inmate in the time they have available, no matter what shape he is in.

A third feature is that prisons offer settings that can be used as substitutes or supplements in designing a program. During the day the inmate can attend specialized

group, or a regular shop setting. He can also be segregated if he needs time to be alone and regroup.

(4) We must make sure the inmate gets the benefit of hospital components: We have alluded to the fact that prison regimes are rigid. Prisons treat behavior lapses as rule violations. Dispositions--which are punitive--vary with the severity of the infraction, rather than with expected impact on future behavior. Hospital reactions to disruptive conduct are more personalized, and more concerned with anticipated effects on the patient, including iatrogenic effects (which make the patient sicker).[21] This approach can be injected where standard dispositions make the least sense or where they can do the greatest harm. Another practice worth emulating is that of mental health case management, which includes treatment planning, conferences that review progress, and revised moves contingent on observed behavior.

(5) We must make sure the inmate gets the benefit of cross-fertilization. This point is probably most important, though least obvious. DVOs are multi-problem offenders, not because they are disturbed and violent, but because their problems are longstanding and complex. The same circumstance holds for many other offenders (and many patients), but plays a limited role in how we deal with them. If future approaches are to be better, the presumption is that they must be less monothematic than current strategies, using a wider range of interventions and

expertise. The DVO's case is nonoptional, because he demands interdisciplinary confluence, inter-agency collaboration, and teaming in delivering services. The necessity of experimenting with interface arrangements forces us to evolve flexible models for responding to multi-problem clients with multi-service approaches. This is an exciting frontier for experimentation and innovation. For those in corrections who might participate and become parties to extending this frontier, it may be a source of adventure. For many, it may be a way to make a difference, which is a rare experience in prisons.

CHAPTER 10

NOTES

1. In Norway an offender who is known to have been psychotic at the time of his offense is found not guilty even if there is no alleged connection between his psychosis and his offense. Other European countries use standards that approximate the Durham rule (See Roth, M. and Bluglass, R., eds., Psychiatry, Human Rights and the Law, Cambridge, England: Cambridge University Press, 1985).

2. An example of mental health staff's concern with this issue is a prison standard proposed by the American Association of Correctional Psychologists, which reads: "the psychologists, and the staff activities for which these individuals are responsibile, (must) have professional autonomy regarding psychological services, within the constraints of appropriate security regulations applicable to all institutional personnel, such regulations being in conformity with the written directives of institutions and or headquarters." (American Association of Correctional Psychologists, "Standards for psychological services in adult jails and prison," Criminal Justice and Behavior, 1980, 7, 81-127, p. 89.

3. We have mentioned elsewhere that "though nature abhors a vacuum, corrections lives with one in disquietingly unnatural comfort. The rejection of rehabilitative goals has created a reluctance to define a new mission. The

closest approximation we have makes prisons the handmaidens of dispassionately vengeful courts" (Toch, H. "Quo vadis?", Canadian Journal of Criminology, 1984, 26, 511-516, p. 511.

4. Gohlke, K.H. "Executive summary," in National Institute of Corrections, Source Book on the Mentally Disordered Prisoner, Washington, D.C.: Department of Justice, 1985,p.3.

5. Lion, J.R. and Pasternak, S.A. "Countertransference reactions to violent patients," American Journal of Psychiatry, 1973, 130, 207-210. The fears of mental health staff may sometimes be reinforced by the advice that these staff receive from correctional experts. A sample injunction is the following:

> The psychiatrist should be keenly aware of his own safety. When unfamiliar with an inmate who has been recently violent, he should inquire into his present behavior before seeing him. If there is any uncertainty regarding the inmate's present state of control, he should not hesitate to interview the inmate in the doorway of his cell with an officer at arm's length (U.S. Bureau of Prisons: A Handbook of Correctional Psychiatry, Volume 1, Washington, D.C.: Department of Justice, 1968, p. 20).

The same source also tells its readers that

> failure to face his fear and hostility will lead the psychiatrist to reject the violent inmate and withdraw from the focal activity of the prison. Facing these fears partially can lead to an over-identification with the inmate and diatribes against "inhumane" treatment. Facing his fears fully, however, will allow him to help inmate and the staff. (Op. cit., p. 21).

6. The author of a survey of mental health services points out that "many prison medical staff members admit that medication is used as much for custody purposes as for medical purposes" (Wilson, R. "Who will care for the 'mad

and bad'", Corrections Magazine, February, 1980, p. 10). A similar impression prevails in other settings in which psychotropic medication is used. An authority on medication in civil hospitals, for example, records that

> This author has often seen the "snow phenomenon" whereby a patient is viewed as exceedingly dangerous and assaultive, given large amounts of medication, and secluded and put in what is tantamount to sensory deprivation. Fearful of being in a locked room, the patient's behavior escalates and becomes loud and boisterous. Nursing staff become more frightened and ask the doctor to prescribe more medication. The medication is administered parenterally without any verbal discussion, the patient's condition worsens leading to more medication, and a vicious cycle ensues. This situation can be reversed both by taking the patient out of seclusion and lowering his medication (Lion, J.R., "Special aspects of psychopharmacology," in Lion, J.R. and Reid, W.H., Assaults within Psychiatric Facilities, New York, Grune and Stratton, 1963, p. 290).

The same authority mentions that medication can lead to the exacerbation of mental health problems, including depression and suicide:

> Violence in an aggressive patient can be controlled through complete sedation, but that is not an acceptable goal. The goal of drug treatment should be to curb the impulsivity and lability of the patient so that he or she thinks before acting and speaks while thinking, thus allowing for conflict resolution. This is a delicate task. The author has seen a profound depression develop in patients whose aggression was "quenched by drugs," and who were then, for interesting and complex reasons, unable to vent their anger but were forced to channel it inwardly. Op. cit., p. 294).

7. Toch, H. and Adams, K., with Grant, J.D., Coping: Maladaptation in the Prison, New Brunswick, New Jersey: Transaction, In Press.

8. Ibid.; also see Toch, H. Men in Crisis: Human Breakdowns in Prison, Chicago: Aldine, 1975.

9. Wilson (Note 6 supra) writes that "a common criticism by psychiatrists of prison administrators is that they want the doctors to handle the problem cases, which are not always psychiatric problems" (op. cit., p. 14). The other side of the coin is that mental health staff may classify a disturbed offender as "not a psychiatric problem" if he appears overly threatening. Wilson quotes an official of the American Medical Association, for example, who admits that "the mental health administrators don't want to monkey around with acting-out clients, so they send them back" (op. cit., p. 8).

10. Commuting between hospital and prison settings is referred to as "bus therapy," especially by observers who see the practice as detrimental. Freeman, Dinitz and Conrad, for example, write that "until courts can establish rules to govern the disposition of such inmates their programming will be punctuated by bus movements which are clearly not intended for their benefit" (Freeman, R.A., Dinitz, S. and Conrad, J.P. "A look at the dangerous offender and society's effort to control him," American Journal of Correction, January-February 1977, 25-31, p. 30.

11. A recent Newsweek review concluded that an estimated 1.5 million mentally ill persons now live in the community. Newsweek points out that

> In truth, virtually any of those 1.5 million patients can be "homeless" at one time or another, for a chronic disease like schizophrenia tends to be cyclical, and its victims usually veer from periods of fragile stability to intermittent breakdowns all their lives . . . What is missing from their lives is effective community care--and without exception, mental-health professionals say the nation has reneged on that promise . . . the norm in most state or local agencies is a level of care so minimal as to approach official negligence--and in city after city, despairing mental-health workers concede that the system as a whole fails abysmally ("Clearing the hospitals," Newsweek, January 21, 1986)

Newsweek's impression is confirmed by most mental health personnel who work with homeless persons. A psychiatrist who has made the rounds of downtown New York City, for example, observes that

> There were disabilities more florid than I had seen before; people lost in the utter apathy that schizophrenia can breed and others fighting through a paranoid world of delusional villains out to ensnare them. These disorders are found in abundance in mental hospitals, but there medications blunt their full force. On Broadway the diseased mind is free to torment its victim relentlessly (Goleman, D. "To expert eyes, city streets are open mental wards," New York Times, November 4, 1986, p. C1).

12. In discussing the rights of disturbed prison inmates, F. Cohen points out that

> For example, a constitutional right to treatment might be fashioned as a right to the most thorough diagnosis and the most skillful treatment available for the particular condition. A mentally retarded inmate might be entitled to such habilitative efforts as will maximize his human potential. On the other hand, such rights could be constructed to require only that some medical or professional judgment be brought to bear to identify and then to provide minimally acceptable care in order to avoid death or needless suffering.
>
> As the text will make clear, the constitutional right to treatment is much closer to the second construction than the first. The most important point we must make here is that constitutional minima in this

(or any other) area must not be confused with desirable governmental policy, desirable professional practices or standards, or desirable penal practices or standards (F. Cohen, "Legal Issues and the mentally disordered offender" in National Institute of Corrections, Sourcebook on the Mentally Disordered Prisoner, Washington, D.C.: Department of Justice, 1985, p. 33).

13. Toch, H., ed., Therapeutic Communities in Corrections, New York: Praeger, 1980.

14. The administrators of an interdisciplinary program for disturbed offenders in Pennsylvania provide a case in point. They write that

> For example, at one point the Bureau of Corrections wished to implement a procedure whereby hospital staff would be required to formally report any infraction of the rules to the prison for inclusion on the patient's record. Treatment staff felt this procedure would be countertherapeutic in that such infractions, which are often a product of the patient's illness, if reported, would interfere with treatment processes aimed at eventual release via parole. An agreement was eventually reached whereby minor infractions would continue to be handled by the unit disciplinary committee and not entered on the record, while major infractions (serious fights, escapes, etc.) would require formal reporting to Corrections. (Cooke, M.K. and Cooke, G. "An integrated program for mentally ill offenders: Description and evaluation," International Journal of Offender Therapy and Comparative Criminology, 1982, 26, 53-61, p. 53-54).

15. Fairweather and his colleagues emphasize that this requisite is essential to any mental health programs that play a transitional role between the hospital and the streets (Fairweather, G.W., Sanders, D.H., Cressler, D.L. and Maynard, H. Community Life for the Mentally Ill, Chicago: Aldine, 1969).

16. The Pennsylvania program referred to (Note 14 supra) describes its staffing as follows:

> (The program) was administered jointly by the Bureau of Corrections and the Department of Welfare. Correctional personnel included an on-site full-time project coordinator, as well as the security staff (correctional officers). Hospital personnel included psychiatric aides, nurses, psychiatrists, psychologists, social workers and auxiliary treament personnel. Hospital and correctional personnel jointly comprised the treatment team (op. cit., p. 53. Also see Toch, Note 13 supra).

17. Such information can prove useful in extending our knowledge about the causal connections between emotional problems and violent acts. One author concerned with such links, for example, concludes that

> Extensive accounts--both spontaneous and structured--from the subject and as many other sources as possible of a violent act, the mental state around the time of that act and states of both pre-act health and social adjustment are thus all important. Collection and integration of many such accounts, and comparison of these between schizophrenic and non-psychotic groups will clarify ways in which the illness has been important and, I believe, identify subgroups who are particularly violence prone, perhaps improving our predictions about the risks of violence. Only then can the role of psychiatrists and of available treatments in managing the violence, even of a psychotic group, be clarified. (Taylor, P., "Schizophrenia and violence," in Gunn, J. and Farrington, D.P., Abnormal Offenders, Delinquency and the Criminal Justice System, London: Wiley, 1982, p. 281).

18. Monahan, J. and Steadman, H.J. "Crime and mental disorder: An epidemiological approach," in Tonry, M. and Morris, N., Crime and Justice: An Annual Review of Research. Volume 4, Chicago: University of Chicago Press, 1983, p. 183.

19. The art in designing a hybrid setting is to link the most desirable features of component settings. If one links the least admirable features (such as the way medication is used as treatment in hospitals and the emphasis on conformity in prisons) one can harm inmates and damage the system. This principle of designing composites was captured by Bernard Shaw when asked by an actress to father a child that could combine her appearance with his intelligence. "But madam," Shaw said (or words to that effect), "what if the child had my looks and your brains?"

20. In a classic study of federal prisons Glaser found that work supervisors had rehabilitative effects upon inmates far out of proportion to their numbers (Glaser, D., The Effectiveness of a Prison and Parole System, Indianapolis: Bobbs-Merrill, 1964). These findings document a listing of requisites for constructive prison impact, which would include that

1. The place where change occurs has dominant or salient work to be done (such as plumbing, carpentry, running Sunday school, or clerking for a guard) which frames a relationship that is a vehicle for change.

2. If possible, a legitimizing peer ingroup develops which approves of staff/inmate links and/or

3. The staff and inmate(s) are ecologically insulated from pressures that emanate from the prison-at-large.

4. Staff-inmate links shift from instrumental task orientation to links featuring supportiveness, warmth and loyalty, permitting modeling, emulation, and spontaneous influence (Toch, H., "Psychological Treatment of imprisoned offenders," in Hays, J.R., Roberts, T.K. and Solway, K.S.,

eds., Violence and the Violent Individual, New York: Spectrum, 1981, p. 230. See also, Toch, H., "Regenerating prisoners through education," Federal Probation, 1987, 51, 61-66)

In referring to the therapeutic community inmate, Maxwell Jones has observed that

> If his interest can be obtained in some simple and familiar work, and particularly if the occupational therapist can enter into a supportive relationship with him, even the most elementary occupation may be therapeutic; it may bring out and direct constructively a variety of emotions which have been denied outlet, and it may do something to offset the restrictions of the mental-hospital regime . . . (an effectively utilized constructive work group) is capable of leading to better contact with reality, to behavior more in accordance with social standards, and to the foundations of self-esteem (Jones, M., Pomryn, B.A., and Skellern, E. "Work therapy," Lancet, March 31, 1956, 343-344, p. 343).

21. Morgan, R.F. The Iatrogenics Handbook. Toronto, Canada: IPI Publishing, 1983. Glaser, (Note 20 supra) is one of few students who argues that "let the punishment fit the crime" is an excessively rigid criterion for disciplining institutional transgressors.