PROCEEDINGS

CONFERENCE ON THE MENTALLY ILL: A PROBLEM FOR THE CRIMINAL JUSTICE PROFESSIONAL

March 6 and 7, 1975

University of South Florida

Tampa, Florida

Final Report

PRESENTED BY: THE CRIMINAL JUSTICE DEPARTMENT
UNIVERSITY OF SOUTH FLORIDA
Tampa, Florida 33620

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CONFERENCE ON THE MENTALLY ILL:
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BIOGRAPHICAL SKETCHES

DR. HERBERT C. QUAY is Professor of Psychology, Applied Social Science Program, University of Miami, Florida. He received his Ph. D. in Psychology from the University of Illinois in 1958. Since that time, he has served on the faculty of Vanderbilt University, Northwestern University, University of Illinois, and Temple University. At the University of Illinois he was Director of Research at the Child Research Center. Selected items from his Vita include: "Psychopathic personality as pathological stimulation-seeking," AMERICAN JOURNAL OF PSYCHIATRY, 1965; "Personality factors related to juvenile delinquency," CHILD DEVELOPMENT, 1961; and Psychotherapy; neuroticism, and verbal conditioning: A replication and extension," JOURNAL OF CONSULTING PSYCHOLOGY, 1965.

MR. GEORGE H. SHEPARD is Program Manager/Operations, Office of Youth Development, Department of Health, Education, and Welfare in Washington, D. C. A New York policeman for 23 years, he received his Master's degree from the University of Rochester. Active in the training of police personnel, he developed the first pre-service Police Science Program in the State of New York. He has worked extensively with juveniles and has coauthored the chapter on "Juvenile Delinquency" in MUNICIPAL POLICE ADMINISTRATION, and INTAKE SCREENING GUIDES: IMPROVING JUSTICE FOR JUVENILES.

DR. HARRY E. ALLEN is Director of the Program for the Study of Crime and Delinquency at the Ohio State University, Columbus, Ohio, and holds the faculty rank of Associate Professor in the School of Public Administration. He received his Ph. D. in sociology from the Ohio State University in 1969. His dissertation, "Some Biosocial Correlates of Two Types of Anti-Social Sociopaths," has been widely recognized as a significant contribution to criminological research. Dr. Allen is a member of the executive board of the American Society of Criminology. In addition to his many publications in professional journals in criminal justice, criminology, and sociology, he is the co-author (with Dr. Clifford E. Simonsen) of CORRECTIONS IN AMERICA: AN INTRODUCTION (Beverly Hills: Glencoe Press, 1975).

DR. HAROLD J. VETTER, Professor of Criminal Justice at the University of South Florida, received his Ph. D. in Psychology from SUNY at Buffalo in 1955. He has served as a staff psychologist at the Psychiatric Clinic of Erie County Court, Buffalo, New York, as a lecturer in the Overseas Program of the University of Maryland, and as a visiting professor, International Division of Sophia University in Tokyo. Before joining the faculty of the University of South Florida he was on the faculty at the University of Maryland, Florida State University, and Loyola University of New Orleans. His recent publications include INTRODUCTION TO CRIMINOLOGY, 1974; THEORETICAL APPROACHES TO PERSONALITY, in press, and PSYCHOLOGY OF ABNORMAL BEHAVIOR, in press.

PREFACE

Some of the most complex and perplexing situations in which criminal justice personnel find themselves are the encounters with individuals who have technically committed criminal acts while at the same time exhibiting signs of severe emotional disturbance. In numerous cases, criminal justice professionals encountering individuals exhibiting signs of emotional problems are inadequately equipped to handle such encounters.

Therefore, the purpose of the University of South Florida conference on Mental Illness and the Criminal Justice System was to provide some insight into the problems encountered daily by line personnel in criminal justice agencies when coming into contact with emotionally disturbed clients. In order to achieve this task, the following goals were established for the conference: 1) to provide a detailed overview of the nature and characteristics of emotional abnormality frequently encountered within the criminal justice field; 2) to specifically define the types of mental illness problems faced by criminal justice personnel; 3) to review some of the ideological and situational bases that contribute to emotional stress; 4) to survey the dispositional problems encountered by the criminal justice system in handling individuals with severe emotional problems.

The contents of the following manuscript are the edited presentations of the conference speakers with reactions from panel members and the audience to each presenter. Each speaker was selected because of his expertise related to one of the goals given above. Speakers were not only selected because of their academic renown, but also because they each possessed extensive practical experience in the areas they were assigned to address.

Mitchell Silverman
Carnot E. Nelson

THE MENTALLY ILL: A PROBLEM FOR THE CRIMINAL JUSTICE PROFESSIONAL

Introductory Remarks: Dr. Carnot E. Nelson, Associate Professor
Department of Psychology

First, I would like to welcome all of you to the conference -- The Mentally Ill: A Problem for the Criminal Justice Professional, which is sponsored by the University of South Florida under a grant from LEAA.

It is my pleasure at this time to call upon the dean of the College of Social and Behavioral Sciences of the University of South Florida, Dean Northcutt, who will make some opening remarks.

THE MENTALLY ILL: A PROBLEM FOR THE
CRIMINAL JUSTICE PROFESSIONAL

Welcome: Dean Travis J. Northcutt, Jr.
College of Social and Behavioral Sciences

On behalf of the College of Social and Behavioral Sciences and the University of South Florida, I would like to welcome you to this conference concerning mental illness and the criminal justice system.

Normally, a dean serves as a ceremonial figure who welcomes people to conferences again and again, often without even knowing what they are really about. This conference, I assure you, is quite different. I know what it's about and recognize the importance of the problems you will be discussing for the next several days. I wrote the proposal to LEAA that initiated the research that has gone into the planning of this conference, and had planned to be personally involved in it all the way until they appointed me as Dean. When this was no longer possible, Mitch Silverman, Carnot Nelson, Mort Brown, and others took over for me. Since that time, I have only been able to be marginally involved in the research and planning.

Nevertheless, for a number of reasons, I have maintained my interest in it. I was for several years the director of community mental health research for the State of Florida. During that time, I tried to promote dialogue between the criminal justice and the mental health systems. In an effort to do so, we held a training conference at the South Florida State Hospital at Hollywood. One of our most able resource persons was Captain Cataro of the New Orleans Police Department who developed a training film entitled "Booked for Safe Keeping" for the National Association for Mental Health. Unfortunately, we did not follow up on the conference and extend the training to criminal justice personnel throughout the State.

As you can tell by the daily papers, the problems are still with us. Hopefully, through your deliberations in this conference and our continuing work with the Florida Mental Health Institute, we will be able to make a significant contribution to the solutions this time.

THE MENTALLY ILL: A PROBLEM FOR THE
CRIMINAL JUSTICE PROFESSIONAL

Presentation Made at Session I, Thursday Morning.

Chairperson: Dr. Carnot E. Nelson, Associate Professor, Department of Psychology

Introduction of Dr. Harold J. Vetter

Our first speaker, Dr. Harold J. Vetter, is a professor at the University of South Florida in the Department of Criminal Justice and is also the Director of their graduate program. He received his Ph. D. in psychology at the University of Buffalo, now the State University of New York at Buffalo, and has served in a variety of capacities as a staff psychologist in Erie County, as a lecturer in the Overseas Program at the University of Maryland, also as a guest lecturer and visiting professor in the International Division of Sophia University in Tokyo. Before joining the staff at the University of South Florida, he served on the faculty of the University of Maryland, Florida State, and was chairman of the psychology department of Loyola University in New Orleans. He is the author of many books and articles including, INTRODUCTION TO CRIMINOLOGY, which appeared last year.

Dr. Vetter will present an overview of the problems of criminal justice in the mentally ill. Dr. Vetter.

Speaker: Dr. Harold J. Vetter.

I should like to announce that the sign downstairs, reading "Mentally Ill Conference," was merely a case of awkward wording--not an implied psychodiagnostic assessment of either the guests or the speakers at this conference.

The comment by the Dean about the case that was aired in the newspapers is a graphic example of just what this conference is all about. It poses in capsule form some of the basic issues we are going to be talking about this morning. I have the advantage over my distinguished colleagues on the panel, as the person charged with presenting an introduction and overview. It gives me the opportunity to air all of my prejudices and bring up all of my pet peeves and do it in a cursory fashion, leaving the job of filling in all the details to the people who follow me on the panel. By the way, Dr. Allen's new book, CORRECTIONS IN AMERICA, is just recently out, and he has authorized me to announce that the people who are attending the conference can buy it for the same price as anyone else. There will be no extra charge.

I think your presence here this morning is an impressive testimonial to how far we have come in a relatively short period of time since 1967, which is the year, some of you may remember, when Congress discovered that there was crime in the United States. I reflect on the fact that it was merely a short decade ago that you could get all of the psychologists in the country, who identified themselves as forensic psychologists, into a Volkswagen and have

room left over for their dates. Many of us who toil in the groves of Academe in the name of higher education in criminal justice, have come to our particular institutional affiliations in a rather roundabout way; and I am no exception to that generalization. After I had attended school long enough in my family's opinion to acquire more degrees than a thermometer, my first gainful employment was as a staff psychologist at a clinic which was attached to a series of courts. I joined a number of other psychologists and psychiatrists in an operation which was basically a process of rough-sorting defendants for the courts, and this was a rather radical change from what I had been exposed to in graduate school in psychology. As an experience, it probably had a greater impact on me than about anything that had happened up to that point with the possible exception of learning experiences that I associate with the discovery that girls are different from boys. My training up to that point had been in a completely different kind of vein and here I was in daily contact with the criminal justice system, with what the National Advisory Commission calls Criminal Justice System I: enforcement, prosecution, the courts, and corrections.

I discovered that the people who worked in the criminal justice system employed a different set of concepts, a different vocabulary, a different set of philosophical assumptions and presuppositions, and a completely different way of thinking, talking, and acting with regard to the clients of the system they operate. My initial reaction was something akin to cultural shock when I discovered that these people were talking about concepts like responsibility and competency. As I reflected on some of these initial experiences, it occurred to me that I had to go back and completely ransack my graduate education; and I ended up jettisoning large quantities of it because I found that it was largely irrelevant, particularly those portions of my graduate instruction that I had received from people with an essentially psychiatric or psychodynamic orientation. I found myself (as a lot of psychologists have done) going back and examining what we had learned about psychology, as opposed to what we had learned about psychiatry. By the time I got finished, I realized that these two systems--and I'll give them the terms clinical perspective, on the one hand, and legal perspective, on the other hand--really come to the most intensive dramatic focus around the question of the so-called "mentally ill" offender, because this is an individual who is in the intersection between two systems of categorization, classification, and social response. That is the problem I should like to discuss and examine today.

The criminal justice system, consisting of law enforcement, prosecution, the courts, and correction, as the title of this conference suggests, deals with the mentally ill offender and deals with him in a way that, on some occasions, brings the criminal justice system into cooperative arrangements with the clinical perspective and, on a number of other occasions, into rather abrasive and disharmonious contact. I would like to talk very briefly about what I think are some of the problems posed by the so-called mentally ill offender in those four major components or subsections of the criminal justice system. In other words, what are some of the problems of the mentally ill as seen from the perspective of the policeman, as seen from the perspective of a prosecutor in the courts, and as seen from the perspective of corrections?

Urban Americans have a technique for dealing with a lot of different kinds of problems. It is called "calling the cops." There is a whole spectrum

of problems that people deal with by calling the cops. They call the cops to abate a nuisance, they call the cops to ward off a suspicious-looking prowler, they call the cops to resolve a domestic tiff, and I might point out that this is a fairly chancey operation if you're a police officer. Intervening in family tiffs costs, in an average year, the lives of a number of police officers and also produces a large number of police casualties.

As a member of the psychiatric clinic which was attached to the court that I mentioned, I was once approached by a police administrator who asked would I, as a clinical psychologist, give a kind of short, informal series of instructional seminars to the members of his department for purposes of orienting them as to what to look for in mentally ill individuals that they might be called upon to deal with in the course of their activities. I answered, "Sure, I would be happy to." I discovered almost immediately that the police officers who ended up as my students did a much more capable job, in many cases, with little or no training in how to deal with the disturbed individual than did many of my clinical colleagues. This was many years before Dr. Mort Bard, in New York, initiated a program of training with police officers, whereby some of the insights and some of the experiences amassed by psychologists and psychiatrists, in dealing with crisis situations and disturbed individuals, are pooled in an attempt to establish some guidelines for dealing with crisis intervention. (Later on Geoge Shepard is going to talk about some of the results of that particular program of instruction.) The policeman is uniquely charged in our society with the delivery of situationally justified force. From time to time, various well-meaning and well-intentioned people would like to deprive him of that capability, on the grounds that the job of the police officer should be law enforcement, period. Such people believe that he should not be called upon or required to perform all these activities which, in many police departments, are looked upon as irksome, annoying, distracting, and an ancillary area of activity. While it is true that policemen often aid sick and troubled people because physicians and social workers are unable to or unwilling to take their services where they are needed, this is not the only, or even the main reason, for police involvement. In fact, physicians and social workers themselves quite often "call the cops." As Egon Bittner has observed, "on the periphery of the rationally ordered procedures of medical and social work practice lurk exigencies that call for the exercise of coercion. Since neither physicians or social workers are authorized or equipped to use force to attain desired objectives, the total disengagement of the police would mean allowing many a problem to move unhampered in the direction of diaster." If this is a fair statement of the case, and I believe it is, then the problem is not to take the police officer out of the area of contact with the potentially or actually disturbed individual. With what kind of person would he be replaced? A mobile social worker, a mobile psychiatrist? What does one do when confronted by an individual who is not only disturbed, but is disturbed in such a way that the consequence may be, and too tragically often is, inflicting bodily injury or harm on somebody else or possibly on himself? If this individual is apprehended, taken into custody, and moves into the next phase of the criminal justice system in the process, we begin to get an indication of the potential areas of conflict between what I identified earlier as the clinical and legal perspectives. A lot of these generalizations or observations that have been made by other people, most notably by people like Thomas Szasz, a psychiatrist who has pointed out that "mental illness" poses us with some real problems of definition and conceptualization. I very often get accused of over-stressing the importance of definitions. I get accused on occasion of haggling over terms. There was the

couple that approached the marriage license clerk at the window and in the process of filling out their application for a marriage license, the guy asked him for his full name. "Tom Smith," he said. "No, that's not a full name. That's a nickname. I want you to go downstairs to the Bureau of Vital Statistics and check to see what your full name is," said the clerk. So the fellow came back and said that his name was Thomas E. Smith. The clerk wrote it down and turned to the girl and asked her what her name was. She said, "Jackie Jones." "No, No. You had better go downstairs, too." She came back and said that her name was Jacqueline Jones. So the clerk filled out the application and handed it to them all completed and said, "If I had gone ahead and filled out that marriage license application with the nicknames you gave me and you two subsequently got married and had a child, that child would be a technical bastard." The guy started to laugh and said, "That's what the guy downstairs in the Bureau of Vital Statistics said you were."

Let me be a technical bastard for a while and raise some technical questions about some of the procedures that one finds characteristic of the clinical perspective, then take a look at how they compare with some of the procedures employed in the legal perspective. One can deduce a number of principles about the clinical approach and how they refer to the conceptualization of the problems with which they deal. This is by no means an original series of conclusions. It has been expressed with great vigor and great vitality by Dr. Simon Dinitz of Ohio State University and with a proper observance of my indebtedness to Dr. Dinitz let me point out some of the features which characterize the approach to "mental illness" within the clinical perspective. The term, "mental illness" has a number of built-in assumptions. How does one characterize particular patterns of behavior? Basically, that is what we all work with. How do these things get categorized? Obviously, somebody has to do something and somebody else has to observe them doing it and make an interpretation about the meaning, significance, and possible determinants of that behavior in order to arrive at a categorization like "mental illness." As soon as we invoke a term like mental illness, we make the automatic assumption that we are dealing with a disease process that is somehow or other comparable or analogous to the physical illness process. Once one has made that assumption, then a number of consequences flow almost automatically. One tends to conceptualize behavior as being not particularly important in and of itself, but rather only to the extent that it is symptomatic of some presumably underlying pathological process. If the pathological process is not specific and organic in nature, and is therefore, identifiable by some fairly objective criteria, we are immediately ushered into an area of perennial controversy among clinicians themselves. What behavior gets categorized in this particular way? The very best I have been able to determine after studying the matter for some 20 years or so, is that, potentially almost any kind of behavior can get labeled "mentally ill," depending on a number of factors that include the circumstances under which it occurred, who does it, where it takes place, and so forth. For instance, the term mental illness is used to describe or label a variety of deviant behaviors--those which diverge sufficiently from certain commonly accepted norms of behavior that one does not have to be a psychiatrist, a clinical psychologist, or a psychiatric social worker to arrive at the conclusion that they are peculiar, atypical, or abnormal. But, apart from gross categories of deviant behavior, we have lots of other possibilities. The term "mental illness" has been applied to

psycho-social problems such as criminal behavior, promiscuity, marital infidelity, political fanaticism, general unhappiness and discontent, and sometimes to people we do not like. We used to call a son of a bitch a son of a bitch. Now, we refer to him as alienated. He suffers from anomie--from normlessness, from rootlessness, from meaninglessness, from existential neurosis. Finally, within this category of "mental illness," we find behavior that looks irrational from one or another set of perspectives on what consists of rationality, behavior that reveals no clear or understandable motivation (at least that can be discerned by the person doing the observing) or that merely disturbs our sensibilities. All of those are potential categories that one finds lumped under the common group name of "mental illness."

Without particularly emphasizing the labeling and stigmatization aspects of this, I merely would like to point out that once the labeling has taken place, it is almost impossible to get an individual unlabeled. That is not specifically true, or exclusively true, of the clinical perspective, because once the labeling process has occurred within the legal perspective and an individual is labeled as a convict, he is forever an ex-convict, just as a mental patient is an ex-mental patient from now till kingdom come. Senator Thomas Eagleton was dumped from the McGovern ticket a number of years ago in the national election when he was categorized as an ex-mental patient. I don't think it did Tom Eagleton any particular harm; because to be dumped from the McGovern ticket was kind of like being given a kayak or a canoe to escape from the Titanic which went down, at least in McGovern's case, with all hands, exclusive of Tom Eagleton, that is. We do not have in our system any kind of process for de-stigmatization. We have no way of eventually restoring the individual to his pristine former status. And I submit that one of the problems we have in dealing with the mentally ill offender is that this person is subject to a kind of double jeopardy process. When the courts and the clinical perspective come into interaction with an individual, there are a number of differences in perspective that immediately emerge. Let me briefly enumerate these.

I should like to tell you some of the things that I think are characteristic of the clinical perspective, then we can look at them against the legal perspective. First is what one might call the principle of adjustment. Principle of adjustment--adjustment to what? The Greeks talked about harmonious adjustment to the cosmos, Chinese talked about Ying and Yang, and Karl Menninger talked about adjustment to conditions of social living that lead to harmony and happiness. When you are in an institution, you are posed with an adjustment problem that takes on some interesting properties. For instance, in one institution where I worked, in one ward the individual in charge was what is referred to as eclectic in his approach, which means that he used a variety of things. He used chropromazine, librium, and valium. In so far as I could see, the eclecticism largely consisted of a kind of pharmacological catholicism. In another adjacent ward, operated by an individual who was very heavily into behavior modification and token economies, the adjustment was a matter of manipulating reinforcement contingencies, so if the individual stopped writing his monogram on the wall with his feces, he received ten blue tokens which could be turned in for one white token, which in turn could be used to operate the color TV set to see the 387th rerun of an "I Love Lucy" episode, number 4622. A little further on, was a guy who

was very heavily into the therapeutic community (not Maxwell Jones' therapeutic community, but his own therapeutic community). He was very big on democratic self-government for patients, which largely consisted of endless discussions and debates centering on the question of the democratic rights of the patients to get pizza late at night. Now, I should point out that the problem of adjustment takes on some particularly poignant characteristics in an institution, because one of the things you have got to do to get out of the instiution, is to adjust. If you are talking about adjustment to the conditions of confinement, you are referring to conditions that have to satisfy the parole board. The parole commission looks at the man's folder and says, "He had a drinking problem when he arrived, but since he came here, he has joined AAA and Seven Steps. He's got a good work record and he's had very few cell changes, etc. Let him out." So here is your adjustment problem: If you're in a "funny farm" and you're in the first ward, adjustment is a matter of better living through chemistry. In the second case, adjustment is learning how to operate the equivalent (psychologically speaking) of the Skinner box lever. And, if you're in the third situation, you demonstrate how beautifully you can interact democratically in the discussion of the pizza problem. In the case of the individual who is in the joint, in order to get out of the institution, he has to demonstrate that he has managed to adjust to the criteria established by the institution, which are to make a person passive, dependent, acquiescent, malleable, and tractable. All of these are kinds of behavior which have little or no relevance to the problems a person is going to face as soon as he walks out the door.

We also have what we might call the principle of rationality. But whose rationality? When we characterize behavior from an operational standpoint, we are imposing a set of interpretive criteria which may be highly idiosyncratic in nature on the part of the person doing the interpreting. A friend of mine, who is a psychiatric social worker, was on duty at the intake desk in an out-patient psychiatric clinic. She looked up and here was this guy standing in front of her who said, "Wie gehts." She looked him up and down and said, "Wie gehts." He looked kind of blank and repeated "Wie gehts." She said, "Ziemlich gut, danke schön. Wie geht es Ihnen?" He said, "Lady, I don't know what the hell you're talking about. My name is Vernon Gates and they sent me over here to see you."

I posed my students with an interesting problem. Suppose you are visiting someone in a mental hospital and you overstay your visit, and all of a sudden everything begins to lock up, how would you go about demonstrating to the nurses, the attendants, the psychiatrist, the psychologist that you are not cuckoo and that you are not a resident member? By throwing a tantrum, by getting quite agitated? Think about it.

There is also the principle of work which is part of our Judeo-Christian heritage. The idea is that everybody is supposed to work. It was the original hang-up we acquired for being booted out of the Garden of Eden. Now everybody has to work in our society except people who are sick. If you are sick, then you don't have to work. You are allowed to be passive, dependent, and helpless, and have someone else do the work. One of the things that the label "sick" bestows is an option not to labor in the mines, not to hew wood, not to draw water, but to kind of lean back and take it easy while everybody else hews wood and draws water. It also absolves you

from a certain amount of responsibility for cleaning your person or cleaning the area where you live. When you are sick, you cannot be expected to fulfill these responsibilities.

Then we have the principle of sociability. In one institution I used to visit as a consultant, it was a routine practice to lock the doors of the patients' rooms during the day so that they could not go back to their rooms and be alone. They had to interact socially. Which meant that there were about 30 or 40 people in the day room, all sitting around morose. They were not interacting with one another, they were sitting around wrapped in their own particular thoughts and solitude. Before the advent of phenothiazines, they would sit around in straightjackets and babble at the top of their voices. After the phenothiazines came into use, the noise level was significantly reduced. But to get them out there and have them interact was one of the essentials. Now, I don't want to put this down because sociability or the capacity to interact socially is a very important characteristic especially in a society as gregarious as ours. There are times (they usually coincide with the immediate period following visits from relatives or in-laws) that I feel I could do with about two weeks in a sensory deprivation chamber to recover.

Another principle that I think is important is the principle of moderation, the notion that things done in excess are categorically suspect and, if done in sufficient excess, they constitute potential "mental illness."

Sixth, there is the principle of illness or disease. According to the mental illness model, which we inherited from the area of physical medicine, everything is analogized in relation to its presumed relationship or similarity to a physical disease process. We don't talk about behavior, we talk about symptoms. We don't talk about determinants, we talk about the pathological basis for the symptoms. This leads to the last principle, which one might call the therapeutic principle. The task of the clinician is to treat ill behavior. There is a series of so-called sexual psychopath laws in the statute books of various states according to which an individual who commits certain categories of criminal activity is put into an institution, not on the basis of a criminal proceeding, but by a civil commitment process. He is not sentenced to serve a particular period of time, but is placed into the custody of the institution for the purpose of receiving treatment. Now, in this indeterminate commitment process, the implication is that he is to be given various kinds of treatment and when the institutional authorities decide that he has been treated sufficiently he is released. But, he is not released until or unless he reaches that category. There is only one thing wrong with this particular approach. I've been looking at the results of various kinds of psychotherapeutic approaches for a long time and my conclusion is that the state of the art at this particular juncture is very much like the Scotch verdict--not proven. I am not sure what constitutes an effective treatment, what constitutes a set of explicit criteria for determining in fact, if treatment is actually taking place. I do know this. After having looked at about 30 or 35 different approaches to psychotherapy, I find that about the major difference between them is the nomenclature. My students, currently, for instance, are debating whether there is essentially any major difference between guided group interaction and

reality therapy, other than the fact that the former is associated with McCorkle and the latter is associated with William Glasser. We seem to be unable to come up with anything that really constitutes a major difference between the two. So we have these treatment approaches. They range from tender, loving care for juveniles to some fairly Machiavelian kinds of behavioral manipulation, up to and including, the implantation of resistors according to which people at a distance can be "beeped," which will result in various kinds of brain stimulation, which will, in turn, produce some salubrious behavioral changes. We are on the threshold of leaving the age of psychodynamics after having spent a brief period of time with the behavioral technology of Skinner. We are shortly, I suspect, moving into the era of electronic manipulation. I saw a patent on a piece of equipment whereby an individual can have an electrode implanted, and his activity can be monitored by an operator/observer. You can determine where he is at any given time during the day and when he is doing something he shouldn't be doing, you can zap him with an electric current. After 1984, what?

These are some clinical perspectives. I can deal with the legal perspectives in about five minutes or so. One principle of the legal perspective is what one might call the principle of binary judgment. Things have a tendency to be either/or, at least, until recently. Guilty or not guilty? Shall we institutionalize him or let him go? Right or wrong? Yes or no? When was the last time you heard a clinical psychologist or psychiatrist say yes or no in direct response to a direct question? If he did, he would be drummed out of the APA and stripped of his certification. If you ask a question, you get a very strong maybe, or you get a very, very firm possibly, or you get an absolutely categorical probably. Was it Harry Truman who said after he had listened to so many economists justify this on one hand and that on the other hand, that he wished he could get a one-armed economist. I've heard people in criminal justice express very similar feelings about one-armed psychologists and psychiatrists.

We also have what one might call the principle of the reasonable man. The "reasonable man" doctrine is a basic conception in criminal law. It uses as a criterion: How would a person in full possession of his faculties, presumably engaging in fairly normal or reasonable circumstances, judge this particular situation? I assume you are all pretty reasonable people. Well, I'm not so sure about you. I know I'm reasonable. Anybody who thinks I'm not reasonable is unreasonable, I think. But where do we go from there? We are back to where we started. We are back to this egocentric predicament: namely, that one man's reasonableness is another man's unreasonableness.

My neighbor, when he moved in two months ago, installed a Hammond organ against the wall that we share between our two apartments. You have no conception what a Hammond organ, playing nostalgic favorites from the 50's, like Rock Around the Clock, with rhythm attachments, sounds like at 1:30 in the morning, when you are trying to figure out how much you owe the Internal Revenue Service. So, I approached my next door neighbor with sweet reasonableness and suggested that he lower the volume to something under 200 decibels and he told me to go and perform a certain procreative function, which is extremely difficult to do by oneself even when equipped with contortionist skills. I responded with equally sweet reasonableness by asking if he wished to remain in the same room with his teeth. If this were taken

to court and adjudicated, the judge might very easily say, "A plague on both of your houses."

That brings me to the matter of the principle of punishment. As the Mikado in Gilbert and Sullivan would have preferred, "Let it fit the crime." The punishment perspective comes into a collision with the principle of adjustment when one is talking about the "mentally ill" offender. How does one punish an individual for whom, presumably, there is no responsibility present? One of the essential criteria of the principle of punishment is the principle of mens rea, or guilty intention. So, we find ourselves in a very interesting sort of "catch twenty-two" situation. We apprehend an individual for committing criminal homicide and we accept the plea of not guilty by reason of temporary insanity. On the basis of that plea, we put him into an institution and treat him, and let us assume that the treatment works. After he is treated, we take him back and hang the son-of-a-bitch. How does one reconcile the two objectives of punishment and treatment? I strongly suspect that in much of our correctional practice, what we do is really punish, and if the individual gets any treatment or rehabilitation along the way, well, goody! Two of my favorite prisoners in Angola State Prison in Louisiana used to say, "I got two to five rehabilitation" or "I'm serving a mandatory five to ten for rehabilitation." I asked them whether they preferred to be called convicts or inmates. They said "we've been called both and treated exactly the same."

It is an interesting theoretical question to discover when in the course of human events penology became corrections. I suspect it became that when someone was running for a political office.

Last, but not the least, we (and this is my favorite characteristic of the legal perspective) we have the principle of limited cause. The principle of limited cause asserts that if you ask the question, "What produced this particular action?" there are at least two sets of causes involved. One is a kind of general, extended, long-range predisposing cause; the other a kind of precipitating cause. The law is primarily interested in the proximate cause of the behavior. If you say to the individual, to the juvenile court judge, or to the county or city judge that this individual had a broken home, that he grew up under conditions of minimal supervision, that he got early involved in peer activities of a delinquent type, etc., all this does not really cut any ice. He wants to know what produced the particular act that is under consideration at this given time. One of the things that drives people in the criminal justice system up the wall with regard to practitioners of mental health is the fact that when they ask a question with the intent of eliciting from the individual something about the proximate cause of the behavior, they get a description in a case history that takes them all the way back to the fertilized ovum. How does one reconcile these two particular perspectives? How does one look at the mentally ill offender, an individual who is in effect categorized in two systems of approach and nomenclature, two different sets of philosophy, two different sets of procedures? How does one reconcile such questions as: "Was this individual responsible?" versus "What was his motivation?" Should this individual be subjected to some kind of correctional process, that results among other things, in punitive action or should he be subjected to the procedures of a very quesionable kind of treatment process? These are the problems involving (at least in my view) the mentally ill as seen within the areas where the criminal justice system, on the one hand, and the clinical perspective, on the other, intersect and interact with one another, sometimes cooperatively

and sometimes in a conflicting fashion. I think my colleagues in the conference are going to take up both aspects. They are going to talk about the cooperative elements of this joint enterprise as well as the identity of some of the problem areas. Thank you.

Discussion from Panelists.

Mr. George Shepard:

Harold mentioned in passing, that it was very difficult to pin down someone in the field who was trying to describe a diagnosis or prognosis for somebody mentally ill. You see, I come from law enforcement in the days when psycho was and probably still is, spelled "s i k o," and I suppose I have seen hundreds of thousands of police reports that simply stated diagnosis, "siko." What bothers me is that we are really missing out on a wonderful learning situation. If we could communicate law enforcement with the people who are charged with responsibilities of making diagnoses and reporting to us the preliminary findings of a mentally ill patient or person we succeeded in getting off the streets into a so-called safe environment, right there and then, the learning process could begin. And I hope the day will come when that process takes over, so that the people who are charged with keeping the streets safe can understand the responsibility that the people in mental health, who are charged with the cure process, and they can learn to talk with each other in a simple language. When that day comes, I think we can work a hell of a lot better together. Because, like it or not, your law enforcement person is the mental health and social worker after 5 o'clock and on Saturdays and Sundays.

Dr. Herbert Quay:

I'll have to admit that Dr. Vetter's presentation engendered in me a feeling of depression, and while I have recognized that there is conceptual mismatch between mental health and criminal justice, I have preferred to repress this recognition.

I think the only solution to this mismatch is a reconceptualization on both sides. The mental health professionals are going to realize that they deal with behavior rather than the behavior of a manifestation of some hypothetical, underlying disease that has never been discovered.

I hope the people on the correctional side of the criminal justice system (the side I am most familiar with) are recognizing that whatever the cause of this criminal behavior may be, the correction administrator has to deal with an individual who is unfunctional. So, I think the only possible solution to this conceptual mismatch is for both sides to become more behavioral in their conceptualizations and their approaches to dealing with the problem.

Dr. Harold J. Vetter:

Well, I can only make the general observation that I disagree with what you say, but defend your right to say it.

You are all familiar with the work of Dr. Harry Allen and his associates at Ohio State, carried out over a span of years going back to 1967, a kind of work that was described by Franco Ferracuti as "operational leaps and bounds," which I think is deserved praise for the originality and the significance of the research. The most recent aspect of the research involves going beyond the experimental exploration of the possibility that there are two quite differently constituted types of individual organism involved, which has been blurred and confounded in most of the research done in sociology and psychology. The most recent phase is to make some kind of an experimental pharmacological intervention, more for the sake of investigating further the original hypothesis than to establish something that can immediately be transferred as a treatment modality into the community correctional setting. The conceptual break-through that this kind of research represents to me outweights in actual importance the particular demonstration in any context, that it is possible to produce this sort of modification. It certainly raises all kinds of research questions about some of our most cherished psychodiagnostic stereotypes and encourages me to believe that the task that faces researchers in the immediate future is a merciless, relentless re-examination of some of our most cherished stereotypes and hypotheses, in very much the manner that Harry Allen and Simon Dinitz and their associates in Ohio State questioned stereotypes of the sociopath. I agree with Harry that there are some bright promises involved. Secondly, I couldn't agree more with George Shepard that we need the participation of mental health specialists in something other than a magnified setting. The kinds of behavior a police officer encounters in the delivery of his "justified coercion" adds a dimension of meaningfulness to abnormal or atypical behavior that the average clinical psychologist or psychiatrist, who works in the more restricted setting of an out-patient clinic or institution, is not yet in direct contact with. The policeman sees the mentally ill individual under a very different set of circumstances than, say, one sees as a psychologist or psychiatrist in an institutional setting. This is more than merely saying that there are ranges and types of behavior that are situationally specific. It involves the whole matter of existential context of the mentally ill behavior and how one goes about dealing with this representative of society. There are control as well as treatment problems involved here. And we have a tendency to make this kind of myopic observation. We have a tendency to look at things in terms of our immediate situation or perspective; and it isn't until you see behavior in a different context that you realize that you have built up a very circumscribed perception and some stereotyped sets toward behavior. The policeman's perspective is really dominated by the responsibilities of his job. His job is essentially routine work. If he can do that and at the same time respect integrity in the individual and safeguard his civil rights, etc., then all of these things are additional benefits. But, basically, he has the task of coping with abnormal or atypical behavior which may very easily constitute a threat and that has to be dealt with in the most expeditious terms. I don't know exactly what George has in mind, but I would like to see, for instance, something like a team approach to taking people out of the telephone booth and the clothes closet or out of the office of an institution--if for no other reason than to give them a slice of the kind of problems that the policeman encounters as the purveyor or conveyor of "situationally justified coercion." And, that of course goes along with Dr. Quay's suggestion that we need meaningful re-examination and reconceptualization on both sides. We need clinicians who can begin to restructure some of their ideas in line with

the problems that are confronted daily by the criminal justice professional. Similarly, the criminal justice professional--whether he is in law enforcement, prosecution, or courts, or corrections--can benefit considerably by exposure to some of the viewpoints of the clinicians, which is one of the reasons for conferences of this sort. But, what I would like to see is something other than I have seen in the past. Harry and I attended a two-day conference last year in Ohio on forensic psychiatry, during which we heard psychiatrists, on the one hand, and judges and prosecutors, on the other hand, spend two days discussing essentially the same hypothetical case. The reaction I had when I left recalled the quotation from Omar Khayyam's Rubaiyat, "I left by the same door wherein I went..." I exited by the same door I entered after two days of very intense discussion which resulted in what could properly be described as an impasse. There was no real communication. I'm not sure it can happen that way. I think it takes a different kind of meaningful dialogue. What I found, unfortunately, was the tendency for both sides to present their case in an adversary fashion. I have no particular axe to grind. I think my credentials in clinical psychology permit me to speak with a certain amount of informed judgment with regard to the clinical side of the perspective. And also, I think my experiences in various phases of criminology in the criminal justice system have provided me with respect for the problems faced by the criminal justice professional, which up until recently were not only not addressed, they were not even, in fact, recognized by the mental health specialist. Now, this is where I think we must mercilessly re-examine our presuppositions or philosophical assumption, our biases, idiosyncrasies, and prejudices. I would like to volunteer by throwing mine out for immediate consideration.

THE MENTALLY ILL: A PROBLEM FOR THE CRIMINAL JUSTICE PROFESSIONAL

Presentation Made at Session II, Thursday Morning.

Chairperson: Mr. Leonard Territo, Associate Professor
Criminal Justice Program

Introduction of Mr. George H. Shepard

I am Associate Professor Territo with the Criminal Justice Program. I will be your moderator for the balance of the afternoon. Your first speaker is Mr. George Shepard, who is Program Manager-Operations, Office of Youth Development, Department of Health, Education, and Welfare in Washington, D. C. He will discuss Types of Mental Illness Problems Faced by Criminal Justice Personnel. I will give you a little background about this gentleman before we start. He was a New York policeman for 23 years, he received his Master's degree from the University of Rochester. Active in the training of police personnel, he developed the first pre-service Police Program in the State of New York. He has worked extensively with juveniles and has co-authored the chapter on "Juvenile Delinquency" in Municipal Police Administration, and Intake Screening Guides: Improving Justice for Juveniles.

Mr. Shepard and I found out that we had something in common when we were talking prior to the conference. He served as a juvenile officer in the 23rd Precinct and at the same time he was serving as juvenile officer, I was serving as a juvenile delinquent.

I would like to turn the program over to him now.

Speaker: Mr. George H. Shepard.

When Mr. Territo first asked me to come to this conference I was delighted to go to Tampa in mid-winter. It was 16 degrees when I left yesterday. But, I will have to admit that I was a little skeptical about my role. He told me about the theme of this workshop and asked me to draw upon my own experiences in law enforcement as a prelude to the kinds of problems faced by the police in the front line. He said he wanted pragmatic situations calling for pragmatic responses. Of course, it reminded me very much of something that took place in 64 as an aftermath of all the civil rights riots we had in some of our major cities. Harvard University received a grant to bring in 30 police chiefs and orient them with business administration so as to prepare them for better management in order to cope with some of these riots. Various police chiefs were brought in and for the first few days they were stunned to hear professors getting up and talking about a prune factory and about the growing of prunes, the processing of prunes, and how the management of a prune factory was so similar to, of course, the operations of a law enforcement agency. After a few days, they caught on and indeed, there were tremendous similarities because the management of a prune factory is very much like the management of a police department, a middle line, staff, and the feedback of information. After two weeks, they saw that there was a tremendous similarity between the prune and the policeman, in that people never think about prunes or policemen until they need them. When they need them, they need them to be effective. Well, being somewhat of a ham, I thought

that I could run with this assignment. However, because I had a little teacher training in me, I thought I would be remiss if I did not do some research into the whole issue. I'll have to admit that I learned a hell of a lot. Especially when I relived some of my experiences as a copy for 23 years in New York. But I did read a lot of reports and publications and I came across one on Issues and Human Relations which was edited by my late friend, Dr. Nelson Watson, who was director of the Professional Standards Division of the Chiefs of Police Association. I was amused by some of the eleven attributes listed in one of the articles in that reading. Let me recite them to you; some of them are gems.

1. The policeman has to endure long periods of monotony on routine patrol yet react quickly and effectively like prunes.

2. Demonstrate mature judgment on the use of force.

3. Exhibit interpersonal relations defined by friendliness and persuasion on one side and firmness and force on the other.

4. Able to endure verbal and physical abuse.

5. Exhibit professional self-assurance and confidence when dealing with offenders.

6. Capable of restoring equilibrium to a social group, family fights, neighborhood brawls, and rival youth gang fights.

7. Ability not to unduly alienate participants or bystanders at scenes of police action.

8. Tolerate stress and cope with pressures under fire. (Did you know that peptic ulcers are an occupational hazard for police officers? I have one.)

9. Exhibit personal courage in dangerous situations.

10. Maintain objectivity while dealing with special interest groups of all varieties.

11. Maintain a balanced perspective in the constant exposure to the worst side of human nature. (Friends, believe me, rarely does a police officer see any other side.)

That's quite a tall order, I think, for a superman who in some parts of this country still draws $500 a month, who is still mostly a high school graduate, who comes from a low-middle class environment with a low tolerance for different groups and different value systems. What is there about a police officer that automatically makes him the recipient of all of society's dirty work? Has he been selected on the basis of those eleven attributes I mentioned? The answer, of course, is no. Has he been trained and readied for work which is thrust upon him in every instance? And, of course, the answer is emphatically no. Do his superiors, who are generally behind the

firing lines, consistently go on record opposing roles and tasks for him which should be handled by others and for which he is not equipped? The answer is most probably, no.

The President's Commission on Law Enforcement Administration of Justice very wisely pointed out that the police did not create and cannot resolve the social conditions that stimulate crime. They did not start and cannot stop the convulsive social changes that are taking place in America. Yet, in today's society, the role of the policeman includes dealing with people when they are most threatening, most vulnerable, when they are angry, when they are frightened, when they are sick, or drunk, or desperate, or just ashamed. Well, I'm not going to ask that you not burden the police department with the mentally, the emotionally disturbed, and the other segments of our society that are beset by crises of all kinds. No, I am still enough of a cop to recognize and really firmly believe that if the police don't do the job, then nobody will. Louis Radelet, very famous in police community relations, once said that the police are, to their own dismay and belief, the community's social workers after 5 o'clock at night when the doors of the other agencies are closed.

Incidentally, unless you are looking for trouble, I wouldn't repeat that to a policeman. I don't know why it is, but there exists an awful lot of animosity between law enforcers and social workers. You call the law enforcement officer a social worker and you get a punch in the nose. Of course, its ridiculous. I feel that both groups are mutually responsible for this condition. I've met too many cops who believe social workers are fags, queers, and far too many social workers who should know better, who believe policemen are brutal Cossacks. The truth is that nothing could be farther from the truth.

The fact remains that policemen <u>are</u> in an unusual and unique position for the early identification of human behavioral pathology. Unfortunately, they have to learn the hard way what has to be done. Too many officers have been bled and too many people needing help have been battered and arrested because symptoms were ignored, because training was inadequate, and because the community was unresponsive. In short, nobody really gave a damn.

I remember once responding to a flop house in New York on Skid Row in the Bowery, where a young police sargeant trying to subdue an alcoholic with delirium tremors was stabbed to death by this guy, who subsequently was killed by the policeman's partner. I also remember one very early Sunday morning about two o'clock, having one of my radio cars respond to a call for assistance in a family fight. I responded and when I got there, the need for the call was immediately apparent. The man of the house was a gargantuan, 250 pounds and over six feet tall who simply refused to leave his wife's apartment though that lady insisted on his being ejected. Well, all of us knew from very hard experience that any arrest served no purpose, because in 95 percent of these kinds of cases, the distraught wife would refuse to sign the court complaint after we made the arrest. Which, of course, meant that some poor cop would have to complete his night shift, deliver his prisoner to court the next morning, prepare the complaint form, kill two or three hours waiting for the case to be called, only to be informed that the wife had had a change of heart. So, you know, we smarten up a lot, and with

family fights we learned to take the quick and easy route. Getting the guy out of the house as a cooling off device. Of course, I have to admit that this method was only another step in the revolving door process, which has been mentioned time and again. For very evidently, the guy would return before too long and the whole thing would begin again. Well, in this particular case, I quickly surmised from the atmosphere that ejecting this guy was going to cost blood. It was obvious that he was not going to leave willingly and what was even more obvious, was that unless we shot him or beat him with out sticks, he was going to make mincemeat out of two or three of us. So, I decided then and there that discretion was the better part of valor, and I quickly announced in as loud a voice as I could to my men, "All right you guys, take off; there's no trouble. This guy and I are going to sit down and have a little talk and a smoke and talk things over like two sensible human beings." They left. Well, to make a long story short, it worked. After about 15 or 20 minutes, he agreed that a sensible man should not lose control; that he should not get into trouble because of an unappreciative broad, and he should not jeopardize his kids by losing his job and getting arrested.

In the process, I found out that he was living in a furnished room downtown so I gave him a ride in my police car to the subway station. Case closed. I have to admit that I violated about 16 rules in the process, but nobody went to the hospital or the morgue that night as a result. That's what counted as far as I was concerned.

At the risk of sounding self-complimentary, I hold experiences like that as, well, probably fore-runners of what is now called family crisis intervention. Lest you think I invented it, let me tell you now, that thousands of cops have used the same process over and over again. The pity of it is that we were really never trained. We just, like Topsy, grew into our roles. And, even more to be pitied, is the fact that the mental health professionals in my city never really took enough time or solicitude to try to teach us better ways. All of us were asleep at the switch. The handling of the mentally ill is a common, everyday occurrence for policemen. Not all the stories I can tell you have happy endings. Even now, 20 years later, I have pangs of conscious about some of the things I did that I thought were right at the time I did them. I particularly remember, with great pain, of having to suppress an old woman, a mother who had just gotten a telegram from the Defense Department that her son had been killed in World War II. She went completely berzerk. It was my job to get her manacled and into the cycle bus for the trip to the city hospital. Well, can you imagine her grief, the reaction of her friends, neighbors, and relatives as were were struggling with this poor woman to prevent her from jumping out of the window, banging her head against the wall, yet all the time screaming that the Nazies were killing her just like they killed her son. Rest assured that there were people in the crowd that gathered who loudly condemned us for what we were doing to this poor woman.

I remember particularly one serious family incident I responded to with a very young officer with only a couple of months on the job, where a berzerk husband had plunged a knife into his wife's breast. When I got there the knife was still embedded in her flesh, but she was walking around and nonchantly smoking a cigarette. Well, of course, I became enraged with what I saw; my family was middle class, family oriented, respectful toward father, mother, husband, wife, the whole bit. So, I quickly grabbed the guy and

shoved him up against the wall to search him. He was like an eel and swerved about and grabbed the stove poker and commenced to clobber me with it. I had the presence of mind to knock the poker from his hand with my night stick, whereupon the lady with the knife in her breast picked up a kettle from the stove and started to bash me with it for trying to subdue her assailant. I soon learned, all policemen do, that he who goes to placate a family fight does so at his own risk and quickly becomes the victim of those he is trying to help.

We said this at lunch, but it is worth repeating. While the first lesson all police officers must learn in handling crisis situations involving the mentally and emotionally disturbed, is self-preservation, the second lesson has to be the protection of lives and property, particularly the lives of all people including your case subjects. Policemen get these jobs mainly because they are there. They are not doctors who enjoy the luxury of professional consultation before they diagnose, nor are they as lucky as judges who ponder legal issues after the fact and can take the matter under consideration before they make a decision. We have to make decisions on the spot. And, by golly, they had better be right, because there are a lot of Monday morning quarterbacks who will gladly tell us what we should have done and not what we did.

My plea before you is not concerned as I said before, with taking these tasks out of the police jurisdiction. The help I am concerned with is the help of the mental health professionals, their expertise. In far too many communities across this country, the police task of helping the mentally ill is encumbered by the lack of facilities for handling these people after we get them off the streets. Now, I'm not talking simply just about residential facilities. I have in mind community-based 24-hour-a-day diagnostic centers, 24-hour-a-day crisis hot lines, 24-hour-a-day counseling centers, and above all, I have in mind, direction and assistance for the police on how to cope with the problems that we, ourselves, cannot manage or prevent. The point is that when police handle disturbed people and succeed in temporarily restoring peace and order, they must have some outside agency to which they may refer and where assistance is available.

This brings us back to the argument this morning about accountability and responsibility. When I was a young juvenile officer, I referred hundreds of vulnerable youth at risk (notice, I did not call them delinquents) whose actions indicated a cry for help. I referred them to social agencies for guidance and counseling. Ninety-nine times out of 100, in those days, for obvious reasons, help never materialized. Either the kids wouldn't go or their parents wouldn't take them, or they didn't have the wherewithal to pay for the services and it boiled down to who was going to pay? That was the kiss of death. Mind you, I'm not faulting the agencies. Workers and programs are expensive. So, in those days, the net result was too frequently, one sick kid and one frustrated cop.

We cannot and we should not have to go through the same frustrations with the emotionally and mentally disturbed. Too frequently, because of a community unconcern, the police role becomes the catalyst for the whole revolving door philosophy. We get them off the streets, we refer them for help, and they are right back in a few days because there is no help. We

have done this for years with Skid Row people and the alcoholics. We lock them up, dry them out, and shove them right back out again. That is why so many of our Skid Rows have a never-ending stream of steady customers.

Most of you here, I am sure, are familiar with Dr. Morton Bard's "Study on Training Police Specialists in Family Crisis Intervention." As Harold Vetter told you, I am going to tell you a little bit about it. Incidentally, those of you who would like to obtain a copy can write to the National Institute on Law Enforcement, LEAA, Washington, D. C. 20530. I am sure you will be able to obtain a copy, free of charge on a single copy basis.

Dr. Bard documented what we in law enforcement knew for many years. That at least 90 percent of the calls for assistance in urban cities involve complaints unrelated to crime control or law enforcement. Bard was aware that most police department training methods generally ignore these non-crime functions, so he set up a federally sponsored training program in two New York police precincts. They were to become operative within the existing organizational framework of the department. One precinct became the demonstration area and the other precinct adjacent to it became the control area. Three teams of six men each, working around the clock in two's, with at least one team available at all time. The teams operated as generalists and specialists depending upon the need. Performing police functions, but in addition, available as task forces in family crisis situations if and when they arose. The men selected were exposed to an intensive four week training program which included innovative techniques such as role playing, sensitivity training, case studies, and attitude management. Incidentally, they also received three college credits from John Jay in Advanced Social Science Research for this experiment. A special faculty including college psychologists, research assistants, doctoral candidates, a clinician, and a social worker were hired. The social worker, by the way, had the responsibility for developing a community resource file for use by the unit and for arranging for field trips to health and welfare agencies during the last week of that four week training period. A de-briefing form was developed so that information on cases handled could be studied in depth and corrections and procedures could be made if warranted. The training was really intensive, full-time attendance for all unit teams. The teams were then selected by a sociogram to show compatibility with one another and also to enable the establishment of ratio units in keeping with the precinct population. The operational phase of the project from July 1, 1967 to May 30, 1969, 22 months in all, was then evaluated. One of the student consultants to the project, when reviewing action reports exclaimed, "A clinician would take days of tests and interviews to make the kinds of judgments that these guys have to make under pressures and often at the risk of their own skins."

One of the aims of the experiment was to reduce injuries to police responding to family disputes. The training methods stressed listening, thinking, and moderation, and helped team members to improvise new methods to help keep the "cool." Most importantly, members learned to look at issues from both sides of the family crisis. This helped them to react in ways geared to a peaceful mediation and resolution. Mind you, I can tell you from experience, that most of the time we tended to side with the poor woman, even though quite often she was the cause of it all. The evaluation also disclosed one of the most consistent frustrations (and this is so

typical); the lack of service to families after referral by the units. It was found that agencies could not adapt their policies and practices to the demands made by police for services to clients. Interestingly, while homicide did not decrease in the experiemental area, it was noticed that not one of five families with homocide incidents had been previously handled by a family crisis intervention unit. I don't really know what that means except you could perhaps guess that if they had gotten there, it could have been prevented, but I am not prepared to say that. During the project's duration, there occurred three and a half times more assaults in the demonstration precinct than in the comparative precinct. Anybody want to guess why? Reporting, reporting. The cops in the comparative area did not think it important enough to report, but the control area, the experimental area reported every incident. That's why I suspect there was a three and a half times difference. I know the physical area and the population of both precincts and I don't think there should have been that kind of difference. In the demonstration area, no injuries were sustained (and this is important) by team members, who you will remember, were more vulnerable because of their specific exposure. This, of course, you will have to attribute to the skills acquired in moderating family disputes. In New York City, an estimated 135 officers would have been injured during any similar 22-month period in the handling of these kinds of cases. That comes from the record. Incidentally, the increases in the demonstration area can probably be attributed to the fact that FCIU members were quite trained and ready to fully report every incident. And I suspect, if my experience serves me right, that some of them should not have been listed as family crisis.

At the end of the experiment, it was indeed significant that team members were more frequently approached by young officers who showed the greatest interest in their methods. Which proves to me, of course, that this kind of training is best given at the entrance level of law enforcement, the police academy, when you have the police recruits as a captive audience. The project succeeded in highlighting what well may be a most significant factor regarding traditional police training. That was the need for developing skills in order maintenance as well as law enforcement. Police, as I said earlier, are in an unusual position for early identification of human behavioral pathology. If they are trained, they can play a critical role in crime prevention as well as preventive mental health. Their success, however, points up a critical need. Something that only communities can help with. Communities have to provide the services. Communities have to provide the services that pick up when the police drop off their referral. These services should not be relegated to just the traditional insane asylums. We feel that there is a great deal more that has to be provided at the community level if the fires are to be extinguished. We need help in establishing training programs for police officers which will give them insights in handling mental cases humanely and effectively. But, keep in mind, that if you go along with lip service or critical observations alone, you will just merely extend the revolving door practices so prevalent in mental health approaches and law enforcement.

As a "street wisened" cop, I would hate to believe that communities are doing the best they can. I would hate to believe that anti-socialwork and anti-police work syndromes still exist in both organizations. One of the best ways, I think, of breaking this barrier is getting help and establishing numerous community-based mental health facilities in every single

neighborhood. I know this is a hell of a lot easier said than done, but a start has to be made. These facilities need not be elaborate. They can start off very simply as drop-in centers for all the neighborhood people. They could expand to 24-hour mental health "hot-lines," they could add a desk or two for counseling and referral, they could make inroads to the police station, and eventually, to the police academy. They could find a psychologist or psychiatrist or two with connections to more sophisticated facilities to devote a couple of hours a week for neighborhood clients and even to act as a backup for other professional or paraprofessional indigenous workers.

Just think of the numbers of young people that can be helped to get started in public service careers if we had something like I just described. My feelings are that the horizons are almost unlimited in the numbers of residents that can be helped in small but effective ways. One of the most important things we need in law enforcement to help us is the establishment of community-based foster facilities where the mentally or emotionally disturbed can be temporarily housed and treated without the need for long transport to state institutions. Even in those communities where they can boast of asylum facilities, more frequently than not, those facilities are filled to overflowing and cannot accomodate emergency cases without undue red tape. All of us know that many cases handled by police are short-term acute type cases which do not require extensive periods of residential treatment. These are the kind of cases police need help with. Just getting the case off the street is often the most difficult job of all.

Maybe what I am suggesting is over simplified, perhaps it is wishful thinking, but I would like to relate to you the experiences of a community, the River Region Mental Retardation Port in a seven-county area in Kentucky. This I took from a current issue of The Criminal Justice Digest. It will only take a few minutes and with your indulgence, I will read it.

> "One of the basic tenets of community mental health philosophy is that services must be made available to those persons most in need--where they are in need and when they are in need. Correction specialists, law enforcement personnel, mental health personnel, and concerned citizens all have at one time or another taken note of the need of mental health counseling and services to clients of the criminal justice system. That's what this is all about. By definition, these individuals are psychologically a high-risk population. They are experiencing serious problems in living, are in need of mental help and other services."

It is for this reason that the River Region people felt responsible for providing services to the agencies of the criminal justice system in the seven counties of Kentucky, which their project is serving.

The River Region Mental Retardation Port consists of a seven county mental health retardation system with sixteen comprehensive centers, a crisis center 24 hours a day seven days a week, several half-way houses, and inpatient facilities, as well as a number of other speciality centers, and an organized criminal justice liaison unit to work directly with the various agencies needing such services. Here were some of the services they offered.

1. Information screening and referral for the clients of the criminal justice system (I can't tell you how important this is just to prevent people from getting lost between the cracks) which meet and serve the needs of each individual requiring service with the resources of the River Region and/or the community agency most likely to meet those needs. The River Region information screening and referral function also provides follow-up to see that the individual received the necessary services and treatment.

2. There is coordination with jail medical staffs. Regional physicians, psychiatrists, nurses were brought in for consultation with the medical staff of the county jails when it was felt that a particular case so warranted.

3. There is coordination with jail counseling staffs and probation and parole officers so that River Region psychologists and social workers are available to provide assessment, treatment, and follow-up where required.

4. In treatment programs there were both a drug offender and an alcoholic offender program, there were other mental health groups started, and individual treatment programs were instituted as required.

5. There was coordination with a Louisville general hospital, whereby River Region physicians and psychiatrists obtained assistance in expediting admissions when the situation warranted. The crisis and information center staff members assigned to the emergency room on weekends, and from 4:00 PM until midnight during the week served as contact persons at the hospital.

6. Coordination with forensic psychiatry units because River Region could not admit prisoners to the forensic psychiatry units, professional staff assisted in that process. When necessary, River Region social workers and mental health specialists provided community follow-up with families and/or prisoners upon release.

7. There was a crisis and information center with the usual services you find there.

8. Inmate evaluation. When requested by the public defender of correctional officials, River Region provided psychological or psychiatric evaluation for inmates and the service also provided for any other prisoners lacking the ability or resources to seek private consultation.

9. There were services for jail and prison personnel. I'm not talking about chapel services, I am talking about real services because River Region was able in many instances to provide help in developing training programs and consultation on a regular basis when required.

If I have succeeded in some way in making you aware that professionals in law enforcement and in mental health can, must, and should cooperate, and that each group should realize that their missions are mutually dependent, I think we have gone a long way in getting something off the ground. Thank you very much.

Discussion from Panelists.

Dr. Herbert Quay. (Dr. Quay's comments were inaudible and, thus, was lost in transcription. The burden of his remarks, however, was that the public has acquired an exaggerated idea of the effectiveness of the techniques in behavior change which are available to the mental health specialist.)

Dr. Harold Vetter.

I would merely like to emphasize what Dr. Quay has crystallized in a few well chosen sentences. What's the real problem we face in this area? There are a lot of promises that have been made and never kept. Not through bad faith, but through absolute lack of confidence in the exceedingly urgent task of behavior change. People who have not worked actively and directly in the field of behavioral change are not aware of exactly how difficult it is to change behavior.

Joseph Wolpe, the founder of psychotherapy by reciprocal inhibition, pointed out that there are three long established patterns of change: growth, lesions, and learning. So, if an individual is not involved in a maturational change process, or is not affected by some process that alters the organic structure, the remaining possibility is that the behavior change occurs through the process of learning, or as it is translated in various conditioning approaches, behavior modification or behavior therapy. This is a relatively recent arrival on the scene and it is already under very heavy attack in a number of class action law suits. In an article by Dr. David Wexler, an attorney, which appeared in the University of Arizona Law Review a year or so ago, reviewed some of the recent litigation involving behavior modification programs and approaches that have been used in a variety of institutions. Questions of the rights of patients in mental hospitals and rights of prisoners in penal institutions to be subjected to behavioral modification procedures have been the target of some severe scrutiny by the courts. Apart from that, one of my longstanding concerns has been the fact that the mental health area (more specifically, psychiatry) has given the public to understand or assume that behind its lexicon of ponderous terminology and impressive jargon there is some arcane knowledge, some expertise, which can be applied to people in institutions, out-patient clinics, or in the physician's office, that somehow or other produces substantial and significant behavioral change. That's boloney! This particular brand of boloney has been sold for a long, long time and periodically someone exposes it as boloney. Sooner or later, we are going to have to stop slicing that kind of boloney and face up to the fact that any expression of faith in any particular therapeutic approach is exactly that--an expression of faith to accept, in the absence of good hard evidence, that a particular therapeutic intervention technique works to produce some kind of effective behavior change. This is essentially the product that the mental health program has to give to the rest of society. I agree implicitly with Dr. Quay's observations that this is absolutely unfounded.

George, you talked about the family intervention program in New York City, I would like to know if any efforts have been made by the New York City police to incorporate some of the elements of that program into the recruit training program?

Mr. George Shepard:

I wish I could answer that truthfully, but I don't know because I have been removed from it. If my past experiences are any indicator, the Police Academy of New York City is a really professional organization and I would not be at all surprised, though I cannot truthfully say, that some of the elements have been instituted. I certainly hope so.

Dr. Mitchell Silverman:

I agree very much on many of Dr. Vetter's comments, but I think he paints the picture a little too black. I think there is a certain amount of technology that is available that can be used judiciously. I think that one of the problems my colleagues and I encounter, is that there is never enough knowledge.

Dr. Harold Vetter:

If one is called upon for the kind of hard evidence required in a court of law, it is impossible to make your case. Now, if you talk to me about my own therapy, I will tell you with great relish about all the wonderful and successful things I've done in psychotherapy. I have forgotten all the failures. I forgot them while they were happening. If you ask me to make a case in a certain therapeutic approach, I can make you a very substantial case until you ask me to present you some hard data. I fully agree with George, this can become a cop out. If we can't do it with 100 percent efficiency, we won't do it at all. I agree that that often becomes the case. All I am saying is that I would like to see some halt to the constant iteration of claims for the efficacy of this approach and that approach in the almost total absence of any kind of believable evidence. If, for instance, you are both poor and "mentally ill" and if you get custodial treatment and chemotherapy, you largely get warehoused and zapped with one of the phenothiazines. What these produce is a kind of a quiescent tractability. It reduces the noise level and the activity level, and if in a period of time, some of the circumstances change where the individual usually lived and you send the individual home and the tension level has subsided, and there has been a change in the configuration of family relations, and if a number of other things have happened, with luck, the individual won't be back. But, if these things happen, I think it is necessary to recognize that its happening has very little to do with some kind of treatment intervention. We all know that. I have worked in institutions where the staff, 75 percent of it, could not speak English. But, they have an M.D. in psychiatry from some foreign country and they can prescribe and they can vary the dosage up or down. That's clinical psychiatry.

Dr. Mortimer Brown:

This has to do with George's interesting proposal about having settings on the scene. What about a room or two in the station house for establishing

community-based mental health facilities? From a sheer, bureaucractic, administrative point of view I ask, "Would whoever is in charge be willing to give up space required for such a project?" Where, in the hierarchy of values would a police department put: assigning space, hiring people and providing their time, for that kind of a project as compared with competing for equipment etc.? Furthermore: Who is responsible? Who would pay to set up these things? I know that they did some of this in Los Angeles and Milwaukee several years ago. Whether that is still a mounting, peaking kind of a thing or if it has reached the zenith and is on its way down, I don't know. All the things you mentioned do call for expenditure of resources in one way or another. In the context of responsibility, professionalism, and commitments already made, what kind of priority would that kind of a thing receive?

Mr. George Shepard:

Your answer, of course, depends on so many things. There are police departments and there are police departments. I know this: when special revenue sharing was announced by the former Nixon administration, it was hailed as a great departure in procedure for dispensing with monies without the usual shibboleth. I only know that after several years of operation of Revenue Sharing that social services, on a scale of one to ten, ranked ten. When it comes to spending revenue shares for that kind of thing, I suspect the same kind of thing is true in many police departments.

My first impulse is to ask, "Have you been to a police station recently?" The ones I knew had hardly enough room for men to change clothes in. There's been an institution of new rules where lunch rooms were provided. They didn't want cops to chisel free meals, so they provide meals by machine--hot sandwiches and other junk that comes out of vending machines. The idea is great. You will never get an argument on that score.

I want to tell you about a project that took place in the 60's in the City of Chicago. It was called the JYDC, Joint Youth Development Committee. It was instituted by the Department of Human Relations. A gal I knew was running it. It was the first attempt at what later became known as Youth Service Bureaus, and was espoused in the National Crime Report in 1967. It was an attempt to group all youth-serving agencies in the community into a police station where services could be rendered at the community level. They invented a new name for it. They called it Ergonomics. Feeding services to the clients rather than the other way around.

When I was a cop in Brownsville, and locked a kid up and brought him to juvenile court, the court was always downtown. It was very tough to get parents to take a day off from work to go down to court. Now, the idea is to bring the juvneile court to the community. I'm all for keeping them open 24 hours a day, seven days a week. That's why court judges hate me. But, the idea is not new and it has worked. I'm with you all the way. I'd love to see it established. But, let me point out the experience in Tokyo. Tokyo police have to live in the community where they work. It was tried in London, too. It is a great idea, but how many middle class white cops would you get to live in the ghetto? Not many. When I worked and lived in New York, we had what was called the "Lion's Law," which said that you could not live in any borough outside of the City of New York and retain your job on the city

payroll. It has been voided now and I can safely say that at that time, 90 percent of the men did not live in the city. First of all, housing was too expensive, and what was available the men did not want. They were middle class and low middle class, so they moved to Long Island, upstate, all over.

Dr. Mitchell Silverman:

One of the things going on in Tampa is that a group of sociologists, psychologists, etc. meet and set up a court. It is a panel type of thing working primarily on problems the policemen face. This group is available on a non-fee basis to help the police on family problems, etc. One of the things I have noticed with this is that professionals like everybody else on a volunteer basis tend to be involved as long as there is romaticism. It's like the "Hot-line" phenomenon. Everybody and his brother were starting hot lines doing work with dopers, etc. Ben Casey had a television program with social workers eight years ago. After that, there were at least 20. Every M.D. wanted to get his name in the paper, every psychologist and psychiatrist was involved in this thing. The same is happening with getting involved with police departments. It's very "posh."

Mr. George Shepard:

It's not new, Mitch. Even in the days I was a member of the force in New York City, we had a host of honorary surgeons. We gave them a badge and a card. This allowed them to park in illegal areas. But, when our kids needed corrective surgery or remedial help of any kind, we could get it. If not for free, for very little, by using these surgeons. The policemen's benevolent association, PBA, had a list of the names of all the specialists. If that's what it takes to get them, then I'm all for it! My older boy had some trouble with his hip and needed an orthopedic surgeon. Boy, was it great! I used one of the surgeons on the list. Why not? I'm all for it.

Dr. Mitchell Silverman:

I would like to see some of my colleagues join the ivory tower, and give the police officers some assistance. Especially in community relations. They could serve as advisors or help in a situation that calls for a specialist.

Dr. Harold Vetter:

Let me just address myself to Mort's comment as to whether the police department would provide space, etc. Bard was one of the first social scientists who described himself as not a "getter." I suspect that more and more people in social sciences are going to go into police departments to do research, but also they are going there to leave something behind. The trick is to convince the police administrator that you are there to give information as well as get information. This is what Bard did in New York City. He said to the police administrator, "Let me give you some good information about how to reduce your domestic disputes, handle them more effectively, which in turn will reduce the assaults against police officers, reduce your homicides, and general felony assaults." There are more and more social scientists going into police departments with this attitude. If you go in there with the

understanding that you want to help, that you will leave something behind, you can convince them. What fertile grounds for new knowledge! But, you are going to have to convince them that there is something you can do that will make their job more effective and easier. If you can do that, then there would be no readjustive priorities. But, I don't believe much effort has been made about this around the country.

Mr. George Shepard.

Let me say in the defense of the police department that most of them are patsies. Cops have a very peculiar way of categorizing people as pro-cop or anti-cop. If you are lucky enough to get into the former category, they will give you the place. And it's not hard to do. They have a very wonderful way of discerning what kind of a person you are by what you do. If they trust you, the sky is the limit, and I say this out of experience and certainly out of practibility. I know it's true. Unfortunately, on the other hand, I don't know of any other institution in our society who has, since the end of World War II, suffered as much indignity at the hands of the social scientist as the police department. Any time anyone wanted to write a thesis or a dissertation, good or bad, he chose the police department. The police are getting tired of that, very tired. They have been guinea pigs long enough. If my information is correct, and I'm pretty close to them, you can still get in, but you had damn well be one of the pro guys and not there to hurt them. They will turn you off fast and a good idea may go to pot with it.

Mr. Leonard Territo.

Who has the responsibility to put into effect a program like that? The money the public has is being put into private programs. They are not saying, "Okay, we'll give the police department or the sheriff's office money to see if the plan will work." They have a budget and they are not interested in rehabilitation.

Dr. Harold Vetter.

It's not really necessary to have a full-blown program. As a matter of fact, many of the things they learned in New York City will apply any place in the country. In Bard's book on crisis intervention, there was a series of things about what you should be aware of when interceding for people. Separate the people, give them each an opportunity to tell his side of the story, identify the problem. It would be nice if you could replicate this, but it isn't necessary. The police administrator in a major metropolitan area, with little difficulty, can incorporate major portions of this into his police recruiting program and invite people from the region to instruct the police officers. It is not a very complex system from an administrative standpoint, maybe complex from the human dynamics involved. What it really takes is the willingness on the part of the administrator to incorporate this into his program. It can be done. The information is available and some of it has been done by police officers for many years, but they didn't call it crisis intervention and unfortunately, when they did do it right, the chances are they probably did it wrong 100 times before and caused a lot of anguish and unnecessary grief. Then, there were still some who had not learned the lesson to their own unfortunate experience. But, it can be done without a large amount of money.

Mr. George Shepard:

A lot of these problems are going to be circumvented because of the growth of professional law enforcement criminal justice education. In New York City, where, thank God, John Jay College reigns supreme, out of a 30,000-man police department, some 10,000 are at various stages of education; including doctoral programs. Pretty soon these studies will be "in house." And you are the people, right here, who are the embryos in the criminal justice field. That's the way to get the hard-bitten police chief to listen--right from within.

THE MENTALLY ILL: A PROBLEM FOR THE CRIMINAL JUSTICE PROFESSIONAL

Presentation Made at Session III, Friday Morning.

Chairperson: Dr. Mortimer Brown, Assistant Director for Research and Evaluation Section
Florida Mental Health Institute

Introduction of Dr. Herbert Quay

My name is Mortimer Brown and my role this morning is to give you some introductory remarks about the major speakers and handle your subsequent questions and discussions.

The first speaker is Dr. Herbert Quay who was born in the very cold State of Maine, but had the sense by the age of two to leave Maine and come to Florida. He was persuasive enough to talk his parents into joining him and they came to St. Petersburg where Herb went to school and grew up and then his social conscience was still so strong that by the time he went to college, he went up to Tallahassee where he became a member of the first class that integrated the Florida College for Women to make it the Florida State University. He took his B.S. and M.S. at that University and then went west to The University of Illinois where he got his Ph. D. in 1958. I first came to know Herb Quay when he took his first postdoctoral job at Vanderbilt University in Nashville, Tennessee. When he came on as a young professor, I was there as a graduate student. After I finished my work at Vanderbilt and went to start a Mental Health Center in Illinois, Herb Quay turned up at the University of Illinois and we reestablished contact. Over the years, I followed his career as an interested student will do with regard to a former professor. I flatter myself to think that somewhere along the line we became colleagues rather than merely student and professor.

When I was asked, as a part of the planning group for this conference, if I knew of any people who might have a good background in clinical, social, and applied psychology and also a sensitivity and an awareness of criminal justice problems, Herb came to my mind immediately. Herb, at one time, was a psychologist for the Florida School for Boys. He has been professionally concerned with children, juvenile delinquency, and criminal justice in general over much of his career. At the present time, he is consultant to the Federal Bureau of Prisons; he is a member of the National Advisory Panel for the Federal Bureau of Prisons; and he is on the Editorial Board of Criminal Justice and Behavior. Last year, he received the "Distinguished Contribution Award to A Correctional Psychologist" from the American Association of Correctional Psychology. The award was given in recognition of his work on Studies in Differential Classification and Treatment. He has recently moved to Miami University, where he is developing a Master's program in Criminal Justice and Correctional Management. It is with pride and pleasure that I introduce Dr. Herbert Quay.

Speaker: Dr. Herbert Quay.

Good morning. Thank you, Mort, for the very kind remarks. I must admit that it took me a long time to get back to Florida and I am certainly

glad to be back in this State and away from those cold northern winters.

Dr. Vetter said something the other day about there being two seasons in upstate New York: nine months of winter and three of bad sledding. Well, where I was born there are two seasons also, August and winter, and in many instances that was true of where we were in Illinois. When Mort asked me to talk about the situational and contextual basis of mental illness as these are relevant to the criminal justice system, I had the same sense of panic that George had expressed yesterday morning about how one could summarize two or three textbooks full of research in about 45 minutes to an hour and relate it to the problems in the criminal justice field. I am not sure if I figured how to do that, but I though I would begin with the problematical approach and then simply give you a bit of an overview of some of the factors which one would have to take into consideration when making judgments about the three problems that I will present.

I will present three situations which are typical of those confronted by people working in the criminal justice field.

> In the first, a police officer was called to a tap room to deal with a belligerent patron. When the officer arrived, he found a man bleeding from the head, obviously angry, waving a gun, and shouting incoherently. The question pre-eminent in the officer's head is quite simply: "What is this mad man going to do next?"
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> Situation 2. A police officer is called to a retail store where the manager is holding a shoplifter. The offender is an aged, disheveled man who is clutching a cheap shirt, and either unresponsive or incomprehensible in response to simple questions. Now, the officer's question becomes: "What shall I do with this man?"
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> Situation 3. A police officer responds to a domestic crisis call to find a distraught, weeping father holding a knife to the throat of his 3-year old daughter. The father's comments relate to the futility of life following his estrangement from his family; and the desire not to see his daughter grow up in an evil world. Question for this officer: "How can I stop an impending child homicide?"

These situations are found time after time in police work as well as in probation and correctional work. The scene may differ, the actors may differ, but the question becomes one of assessing the degree of abnormality of behavior and proceeding with some course of action that is likely to result in least harm to the parties involved. Before I discuss the contextual, situational, and psychoanalytic bases, it is necessary to give you, at least briefly, my working model of human behavior.

The working model I am going to give you is a gross over-simplification, but I believe it is necessary to put my subsequent remarks in some kind of a comprehensible framework. In this working model, we begin with a biological organism upon which is superimposed learned behavioral reactions. That is to say, possible responses in various environments. These possible reactions are left at rest, or set into motion by physical and social needs which themselves have been learned. These learned responses which are set in

motion are then under the control of various environmental contingencies, events, or happenings, which the behaviorists call reinforcers. In predicting behavior, which is a very difficult undertaking, we need to have information in four basic areas. First, we need to know the status of the biological organism, because a deranged bioorganism may produce deranged behavior. Second, we need to know the person's repertoire of possible responses or behaviors in a given situation. Whether or not the person is capable of aggression, flight, manipulation, rationally thinking through a situation, etc. Just what kind of behavior is this individual capable of performing? Third, we need to know what motivating events are at work. Is the individual hungry, afraid, in need of social approval, etc.? These are very important when one is dealing with gang phenomena, for example, in the delinquency field. Fourth, we need to know something about the environmental events. We need to know the environmental events which usually control these behaviors. In question form, we would ask: "What are the environmental contingencies which operate to control this individual's behavior in a given situation?" "What serves as an inhibitor, or a releaser?" "What environmental responses make certain behaviors more likely to occur than certain others?"

In ordinary circumstances, an individual deals effectively with various situations; meeting his needs and staying in reasonable harmony with the physical environment, the social environment, and the interpersonal environment. When a person is out-of-tune with himself or with his social or physical environment, those processes set in motion the mental health system. Now, to some possible psychodynamic and situational factors which lead to a disruption of the organism's capacity to deal rationally and effectively with situations as they present themselves. We can identify three broad classes of factors which have been linked to mental illness or behavioral disfunction. First, physical factors such as disease, ingestion of toxic substances, and physical injury. Second, psychodynamic factors, anxiety, stress, and conflict. Third, the environmental factors such as economics, social status, physical surroundings. In any given case of deranged behavior, one or more of these sets of background behaviors may be at work; and in any given circumstance it is likely that agents from all three areas will be at work with the relative importance of one or another varying from time to time and from situation to situation. Some of the physical factors which seem to be related to maladaptive or deviant behavior are as follows:

First is the inborn abnormality of physiological functioning. There seems to be an increasing amount of evidence that at least a small proportion of offenders who have been labeled psychopaths or primary psychopaths may have some basic physiological defect which causes them to behave in ways that we find ineffective, at least in the social sense. Another set of characteristics which can produce symptoms is central nervous system syphilis. (Eighty years ago, this set a pattern for research in mental illness to look for 'causes' in the framework of a medical model. There has never been another success in the field that has even closely approximated the success with which mental disorder was linked to psychosis with nervous system syphilis.) But, various physical disorders can produce a mixture of physical and mental symptoms. Another physical cause is brain injury. A person who suddenly behaves irrationally, who exhibits symptoms of overactivity, and diffuseness in thinking and behavior with no prior history of behavioral abnormality and

for whom there is reason to suspect that there has been a physical injury to the brain, may be suffering from an acute brain syndrome due to traumatic origin. There are many disorders of physical organs which occur with senile deterioration, or brain damage due to strokes or cerebral vascular accidents. These frequently afflict older people who may be found wandering disoriented, amnesic, or even out of contact. Very frequently this represents an acute phase of senile deterioration or the aftermath of a cerebral vascular accident. Another set of factors in the physical realm has to do with toxic substance ingestion. Alcohol leads to uninhibited behavior. Sometimes in the form of hostility and aggression which otherwise may be kept under control. Alcohol also produces a decrease in self-evaluation leaving a person less able to see his own behavior as others see it. In the extreme cases, of course, we have the well-known DT's phenomena sometimes accompanied by paranoia, agitation, or loss of contact with reality. The ingestion of drugs is another cause of abnormal behavior. The effect of many drugs is not nearly as well-known as the effect of alcohol, but it appears that different drugs cause different effects from lassitude or dreaminess, on one hand to loss of critical faculties, and paranoia on the other. Perhaps the minimum effect being produced by mild usage of marijuana and the maximum effect being produced by LSD, etc. In any case, the effect may be different for different individuals and the behavior which is released may well be a function of the individual's prior behavioral and mental status.

Now we turn to the psychodynamic causes. Principal among these are anxiety and fear. Anxiety or fear interferes with a person's normal chain of responding to internal or environmental demand, and the attaining of reinforcement or reward from the environment. In other words, the usual pattern of the person's responding either to an internal or an external demand, by a set of usually effective responses which then result in reinforcement or reward from the environment, becomes disrupted. One of the effects of high-level anxiety or fear is that the individual is less likely to use complex responses such as sitting down and thinking through the situation before engaging in some form of action and more likely to use primitive responses such as flight or fight. That is, one of the effects of anxiety and fear seems to be to decrease the likelihood that the individual will deal with the situation in a complex and thoughtful way and will deal with it in a more direct or primitive way either by fighting or running away, or in fact, possibly becoming completely paralyzed. Another effect of anxiety and fear is that they may superenergize the person but leave him poorly directed. One of the classical symptoms of anxiety neurosis is a person with a high level of energy who never seems to rest but who never accomplishes anything either because all of his energies are diffused in nonproductive kinds of activities. On the other hand, a high level anxiety may paralyze the person's response system and leave him immobile. A second psychodynamic contribution has to do with the conflict of needs. When two needs are incompatible, conflict results. Very frequently the basis of family conflict lies in the fact that the family member is loved and hated. The family member in the situation that Mr. Shepard described the other day where the wife refuses to file charges after a Saturday night brawl is a beautiful example of the approach-avoid conflict, which the woman feels in the situation. In the criminal justice system, we also see situations in which basic needs are set against social needs; when hunger or other needs produced by economic deprivation are set against the need of social approval. Here is another situation which produces conflict. Still another source of

conflict is seen with juveniles when peer social approval is set in conflict with the need for parent social approval. This frequently puts adolescents under fear and stress. The third factor is stress. Stress refers to a situation in which a person is expected to make discriminations which are extremely difficult. The classic psychological studies of stress and frustration put an animal into a situation where he is expected to make ever finer discriminations between two visual or auditory stimuli. When he is no longer able to do so, he shows a variety of symptoms similar to human neurosis. The pressure under which many people live, produce stress reactions which have as their outcome a breakdown in the normal need--response satisfaction sequence.

Let me turn now to contextual and environmental factors; according to some people the most influential of all. The environment operates in two spheres in behavior. First, the environment provides the context in which all responses are learned. Environment limits the person or provides a wealth of opportunities to learn different forms of responses. Eric Sorensen says that many delinquent kids are raised in an environment which hasn't permitted them to learn effective non-delinquent ways of dealing with the environment. Not that these kids are somehow perversely evil and choose the delinquent response over the appropriate response; but the environmental context from which they come has never provided the opportunity to learn effective response in dealing with the social environment. So, when making judgments about a person's behavior, knowledge of the environment from which he comes is helpful because it gives you some idea of the kinds of responses he has had a chance to learn. If he has been living all his life in an environmental situation in which the most frequent response to an inner personally frustrating situation is to hit someone over the head, then, by and large, that will be the most probable response which he will emit. If he has been raised in an environment in which he has been given an opportunity to learn other ways to deal with inner personal conflict such as manipulation, or graceful retreat, then compromise may at least be in his repertoire. He may not use it, but at least it is there; whereas in the other situation you can be fairly certain that the more complex behaviors are not going to be there.

A second very important function is that environment provides feedback and control for behavior. It is the source of reinforcing events. It is these reinforcing events that tend to fixate certain kinds of behavior. If we know what the reinforcing contingencies have been in a person's environment, we can make an educated guess as to what behavior he is most likely to exhibit. If running away is the most appropriate form of behavior in the given environmental situation and it has been reinforced in the past, it is most likely to occur. If aggression has been most frequently reinforced by a given set of circumstances, it is most likely to occur. Knowing and understanding the physical environment permits one to make some intelligent guesses as to what this person has learned. He may have been given the opportunity to learn a variety of behaviors, and environmental contexts, but the situation in which he has been living in the immediate past may have reinforced one particular form of behavior as opposed to others. There are many environmental factors which have been linked to deviant behavior. Some are identified as related to causes of mental illness as well as causes of crime. These factors are not general explanations nor are they entirely satisfactory as the explanation for the behavior of a given individual. Let

us consider poverty. As you look at the incidence of mental illness and the incidence of crime, you will find that it is, by and large, related to the economic circumstances of the areas in which people live. That is, if you look at the crime rate as a function of the economic circumstances of any neighborhood, it comes as no surprise that the higher the crime rate the lower the economic circumstances are of that given neighborhood. Essentially, the same results have been demonstrated for some mental illness, for example, schizophrenia. However, there are problems in ascribing criminal behavior and schizophrenia to poverty. In the case of criminal behavior, it is obvious that not all poor people are criminals. Testing the hypothesis with regard to schizophrenia and poverty has never established whether a causal relationship exists. It may be that people who once have functioned at a higher level, simply drift down the social-economic scale as their personal functioning level decreases. When they are finally caught in the net of the mental health system, they have reached the bottom of the barrel in terms of their capacity to provide for themselves economically. So you find more schizophrenics in poorer economic situations. However, if you look at the data and think about poverty and the needs which it engenders in the individual as opposed to the social control needs I spoke of, it is not difficult to see how living in impoverished circumstances could lead to psychological disfunction.

Other environmental causes include racial discrimination and ethnic discrimination, both of which put an individual at a social disadvantage in competing for environmental resources. Ethnicity can also be an important variable in predicting an individual's behavior because ethnic groups teach in-group kinds of behavior.

More recently, there has been an interest in space in the physical environment. Recent studies have suggested that overcrowding produces serious behavioral and physiological dysfunction in animals. It is always risky to argue from rat to man, but there have been enough studies of space and distance among humans to suggest that everyone has a certain need to maintain a physical and psychological distance from other people. The amount of distance, being a function of the degree of relationship between the two people involved, is very interesting data. One observes people in physical reaction with others and one can get a quite good correlation between the physical space which separates two people in the interaction and the degree of the intimacy of the relationship between the two. Studies have been done ranging from lovers, to strangers interacting over a business matter.

Privacy is another important factor which is only recently getting consideration in building institutions. All new Federal institutions are being built so as to provide private rooms, or provide space for an individual which has a great deal more privacy than in traditionally built institutions. This is also the trend in building mental hospitals. In any case, the simple physical factors in the environment, such as space, a degree of privacy, crowding or the lack thereof, can produce behavioral reactions which are not in accord with proper functioning.

In each of the above three situations involving the police officer, he would be in a better position to answer his questions if he: had some knowledge of the state of the organism; were able to make some inferences about anxiety and stress; and had some knowledge of the cultural and

environmental context in which he found himself and from which the other participants got their backgrounds.

In example one, knowledge about the location of the tap room, the characteristics of the neighborhood, the cultural surroundings, the extent to which the bleeding is due to a severe head injury or simply a non-consequential lump are all important in deciding whether the gun waving is merely some threatening gesture or whether the best course of action is to disarm this person.

In the second example, it is obvious that the officer is not dealing primarily with a criminal problem and the wisest course of action is probably to replace the cheap shirt on the shelf and talk the manager out of filing charges. Then to take this senile, deteriorated, elderly gentleman to an appropriate diagnostic facilty and see that he receives physical and psychological care that is necessary because the problem is not primarily one for the criminal justice or legal correctional system.

In the third case, the officer is either dealing with a person in a deep depression or with bizarre thinking, or both. It is likely that a calm and rational approach which recognizes the feelings of the distraught father, an approach which interacts with him in an accepting and a friendly manner may well result in a successful outcome. If the circumstances were not recognized and a forceful action were taken, the death of the child might well ensue. So, while it is not possible to make a complete psychological diagnosis on the spot, simply arming the criminal justice professional with: basic knowledge of the possible state of the organism with respect to physical factors; the possible state of the organism with respect to anxiety, stress, and conflict; knowledte of the cultural context from which the person comes; the setting in which the behavior is occurring; one then may better make some reasonable judgment about what this individual is likely to do next.

Thank you.

Discussion from Panelists.

Mr. George Shepard.

I have absolutely no quarrel with the suggestion that police use discretion in cases involving persons who are emotionally or mentally unstable as far as say, talking a shopkeeper out of pressing charges for shoplifting. I think that that is done every day. What I am concerned with and what I think most police officers are concerned with is the ability to recognize the potential danger they face with an armed, deranged person. I don't know if any kind of training he could receive in a police training academy or anywhere else would have an effect on what he essentially does. I can tell you from experience, on the firing line, that when you are confronted with such a situation your first thought is to take care of number one, yourself. It is a very strong urge that you want to get home that night. By the same token, a police officer has an obligation to safeguard the life and property of even the mentally ill or emotionally disturbed person, and most policemen have, do, and will take that under consideration provided their life is not on the firing line in a very precarious situation. What I would like to see, and I don't know if it is possible, is some kind of assistance from the mental health professionals to enable police officers to recognize potentially dangerous symptoms or, perhaps, recognize a situation that could lead to dire consequences if not given weight. I'm not talking about a man who is holding a gun to a kid's head--these things almost speak for themselves--the action taken is almost dictated by necessity. I am talking about the kinds of insights that we can hopefully give to policemen that would enable them to recognize the incipient danger they face, if that is possible, in the family crisis intervention.

I think Mort Bard's study was great. It certainly set the stage for handling domestic crisis which could become inflammatory, and it did succeed in proving that with some kind of training you could pacify family situations successfully. This would result in a great decrease in the amount of injuries suffered by policemen in restoring peace and tranquility. That is relatively easier to do, I suppose, than teaching an officer how to recognize the potential of the suspect (sick person) he is facing now, who is or may be, a very dangerous individual. I don't know how you do this, but that is where we need help.

Dr. Herbert Quay.

I think that is a very interesting problem for behavioral science. We had a situation in Miami recently where a routine traffic call turned into a shootout. The question came to my mind: "How can one predict in advance by the circumstances surrounding a number of these kinds of incidents, which would most likely remain routine and which would remain non-routine?" I called the Vehicle Operations Department and was told that all of the officers went through a training which tries to minimize the occurrence of these kinds of things. I was told about some of the things they are taught to do. What was communicated to me was: they did not think they really needed to know any more about these incidents, but that when they did occur, it was because the policeman was not doing what he was supposed to do. Well, I thought about that for a while, and I was not entirely satisfied that that was the case. It seemed

to me that although the injuries to officers and other people involved probably could be minimized by following instructions. There were many other incidents about which we could know a lot more, and perhaps through analysis, the characteristics would alert officers and other criminal justice personnel. The same things happen in correctional institutions. There are things that sometimes start out very simple and all of a sudden magnify to very serious situations. Through analysis of the social and behavioral chacteristics we could help.

Mr. George Shepard.

You know, Herb, you really opened up a can of worms which I was reluctant to go into yesterday. And that is this whole business of law enforcement officers reinforcing belligerant behavior on the part of someone they are handling, and I know that this happens. I also know that work has been done in screening potential candidates for the police department, who were dangerous I suppose, from the view of possible future neurotic behavior. I'm all for this kind of stuff. I wasn't referring to that specifically. I do recognize that very frequently an officer can and does (not very frequently, too frequently) stimulate behavior that another officer might be able to placate. What I am concerned with and what I tried to state here was the training for law enforcement people to enable them to confront a situation that is potentially dangerous. I'm not talking about the ordinary traffic incident where one word leads to another and boom! you have a shootout. I am talking about being called to a situation and being confronted with a potentially dangerous individual or one capable of being one. It doesn't have to be a family dispute, it can be any kind of a situation, and I think that is where we need a lot of help. There may be a correlation between screeing an officer at his inception into the service and the decrease in these kinds of incidents. I don't know. I suspect there may be. I am talking about situations that officers get into where, for the fleeting instant, whether to use force or not crosses his mind and some make the right decision and some do not. I am not going to attribute their actions to improper screening at the entry level. I think everybody has a critical point and I just wondered if there was some way we could engender in law enforcement training and practical experience for police officers the ability to stop, hold on, think a situation out before using a deadly weapon or before someone else uses his. I don't know how you would do this.

Dr. Mortimer Brown.

George, your experience on the line for a long period of time obviously has left you with a real concern about potential danger in an on-the-spot situation. It was strongly apparent in your contributions yesterday and it was one of the things in Bard's work which impressed you most: (the absence of the 135 dangerous incidents among trained men) and it is again apparent this morning. I hope we can get more information on that problem. I would like to ask Harold Vetter if he would be willing, at this point, to respond in part to the question you raised as well as respond to the presentation by Herb.

Dr. Harold Vetter.

Well, obviously Mort Bard must be doing something right. Except when

you ask Bard what it is he is doing right, he gives you some rather anecdotal material. Whether it is possible to subject the whole process to systematic assessment is at this point still open for debate. I will say, however, that if the remarks I made yesterday in general about the art produced an acute depression in anybody, when one looks specifically at the area of dangerous behavior or dangerousness in its prediction, it is enough to precipitate one into a complete state of catatonic withdrawal.

I did a study for a paper to present at a conference on prediction of dangerousness in criminal offenders, and in the process of organizing material, I looked at the professional literature to see how dangerousness had been defined. I came up with about ten definitions. Only the crime for which the insanity defense has been successfully raised, all crimes, only felonious crimes, only a crime for which a maximum sentence is authorized, only crimes characterized as violent, only crimes which include physical or psychological harm to the victim regardless of whether it is reparable or irreparable, any conduct even if it is not labeled as criminal which is characterized as violent, harmful, or threatening, any conduct which may provoke retaliatory action, any physical violence towards oneself, and any combination of the above.

All of these are potentially definitions which can be used to characterize dangerousness. It is interesting to note that in any discussions of the interface between the criminal justice system and the mental health process, we always get back eventually to the question of dangerousness and its prediction. And, if I am occasionally accused of singling out the psychiatrist or people with an intrapsychic orientation, for criticism it is interesting to note that this is done occasionally by the psychiatrists themselves. For instance, in a paper by Dr. Rubin entitled "The Prediction of Dangerousness in the Mentally Ill Criminals" which was published in the Archives of General Psychiatry in 1972, he said, "treatment interventions become independent predictions of the likely consequences of interventions. Such predictions are unavoidable for the psychiatrist, as indeed, they are for anyone who proposes to treat another's illness. There is, however, another type of prediction--the likely dangerousness of a patient's future behavior. This prediction is expected of a psychiatrist and psychiatrists acquiesce daily. This belief in the psychiatrist's capacity to make such a prediction is firmly held and constantly relied upon in spite of a lack of empirical support."

Whenever anyone has done or attempted to do any kind of systematic, controlled study of prediction of dangerousness, they have generally failed to produce any kind of convincing evidence that the psychiatrist, regardless of his experience, orientation, or training, can do a more effective job, a more accurate job, of predicting dangerousness than say, the average New York City policeman.

Dr. Mortimer Brown.

It is unfortunate that the concepts of dangerousness have become so heavy within the mental health system. Recently, it has become even heavier due in part to an artifact that commitment laws are now being rewritten, reviewed, and re-examined in response to the fact that many people humanely or professionally, feel that people should not be committed to a mental hospital,

but that there should be a process of voluntary admission. Nevertheless, there is still sufficient feeling that if a person is dangerous to himself or others, and so out of control, then society needs to commit him whether or not he voluntarily admits to that setting. It is a different situation, of course, than that for an alleged criminal. So, when you write into the statutes that someone may be forcibly taken from his place and personal liberties overridden because he is dangerous to himself and other, the only other worse thing than what Hal read off the list of all these supposed definitions of dangerousness would be that there is no definition whatsoever. And, this is the case. The statutes are silent with regard to a definition of dangerousness. And, because of statutes and traditions, it evolves again on the psychiatrist or other M.D. to make the decision as to whether this person is dangerous enough to himself or others to be sent, without his permission, to a state hospital. The state of the art and the state of the political signs is very bad in that particular area. We will see a lot more litigation from civil libertarians and professionals in the criminal justice and mental health fields about this issue and it may be one approach to resolving some of this with better research, through social science.

THE MENTALLY ILL: A PROBLEM FOR THE CRIMINAL JUSTICE PROFESSIONAL

Presentation Made at Session IV, Friday Afternoon

Chairperson: Dr. Hilary Q. Harper, Assistant Professor
Criminal Justice Department

A funny thing happened to me on the way to the conference. I saw a man out in the hall and I said to myself, "There's Harry Allen." I never met the man, I never saw him before, and I can't believe I am psychic. I started to talk to him and we concluded that I probably knew him from a picture on the jacket of his new book which I received in the mail this week. But Harry, that's not true! Your publishers are cheap. They didn't send the cover. Where I know him from, I do not know. The book is titled, Corrections in America, and is written by Harry Allen and Clifford Simonsen, and as you know from your brochure, Cliff couldn't make it so he sent his boss, Harry Allen.

Unlike some others, Harry did not come to Florida to escape the cold. He was born in Selma, Alabama, so maybe he came down to escape the heat. He has degrees in sociology from Stetson, Vanderbilt, and Ohio State University. He taught at Florida State University's School of Criminology for two years and then in 1971 he went to Ohio as a member of the Governor's Task Force on Corrections. In January 1972, he became the director of a large research center, the Crime and Delinquency Center located in the School of Public Administration at the Ohio State University with a staff of twenty-nine. His main duties consist of raising funds and administering research programs, but he keeps his hand in by teaching a course each year. The School of Public Administration at Ohio State University offers both a master's degree and a doctorate in criminal justice administration. Among Harry's accomplishments are the one book published and two more in press. He is treasurer of the American Society of Criminology. His research interests have been in the area of adult corrections, community-based corrections, and forensic psychiatry. This latter interest leads directly into this afternoon's subject, "Dispositional Problems Encountered from a Legal and Social Point of View."

Speaker: Dr. Harry Allen.

For the past twenty years, there has been very active interest in criminal justice and mental health systems, and a set of deviant behavior which systematically appears over the years, but which is subsumed under different titles. It used to be called psychopathy, then it was called sociopathy; the more current terminology is antisocial personality.

Perhaps the best study of characteristics of sociopaths is by a man named Cleckley who lists sixteen dimensions from which psychopathic behavior can be indicated. He starts out with the classic definition, "They are not psycho-neurotic and they are not psychotic. They are usually fairly bright people with no organized life plan and serious, immature behaviors, which are not appropriate to their age categories, and they get into fantastic and non-violent behavior quickly with or without drink. They seem to be inadequately motivated, and they pursue peculiar and non-organized sex life. They seldom commit suicide or, in fact, attempt it." The American Psychiatric

Society, since 1968, has reserved this definition for persons who are basically unsocialized and whose behavior pattern repeatedly brings them into conflict with society. They are incapable of loyalty to individuals, groups, or social bodies. They are grossly selfish, calloused, irresponsible, impulsive, and unable to feel guilty, or learn from experience and punishment. Frustration tolerance is low, they tend to find others who offer plausible rational reasons for their behavior. I thinks perhaps you are beginning to spot some of your caseload people showing up in this particular diagnostic category. We don't really know why these people are the way they are, but we do know they are frequently in contact with law enforcement agencies, and are placed in correctional and mental health institutions. In the correctional institutions they are estimated to constitute as much as 25 percent of the population in maximum security units to which they tend to gravitate in particular. Their destructive behaviors are deleterious not only within the institution but in the impact they have on criminal justice and mental health systems. They tend to be visible (cause disturbances within prisons), and they tend to condition public thinking about all offenders. If it were not for this category of difficulty, it is possible that we would get more acceptance in American society for community-based correctional and mental health centers. They are, in the real sense, instantaneous trouble makers, though their negativeness allows them to do much more than that. Most jurisdictions have statutes on handling these so-called psychopaths, sometimes delineated as sexual psychopaths. There are a number of definitional management problems, which I will explore with you a bit today, with this deviant syndrome, because the psychopath laws, like the criminal insanity statutes, have legislative decodation that marks the interface between mental health systems and the criminal justice systems. Most of the statutes dealing with categoric deviant persons came in the 30's and 40's when the Goodrich Act of Michigan was hailed as the first full-blown sexual psychopath statute. Many of the statutes fought this primarily on the sexual components of the misbehavioral expressions, and this resulted in a great deal of definitional confusion. They focused on the sexual components because there are some wide-spread and unquestioned assumptions about behavior of these types of people, and they keep showing up in the various state statutes that deal with the so-called sexual psychopaths. One of the assumptions is danger to women and children; the second assumption keeps cropping up, especially in the records of the passage of legislation, that the number of sex crimes is increasing more rapidly than any other type and that such crimes are usually committed by sexual psychopaths with a high degree of luridism. Sexual psychopaths who are so identified should be confined as irresponsible and dangerous persons, and they should not be released until cured of their malady or disturbance as declared by a judge. That was a court decision in criminology by a judge named Sullivan in 1950. In any event, their deviant behavior falls in the confines and special statutes we call sexual psychopathy, where the sexual behaviors are generally defined as one part of the larger population of mentally ill individuals who are called criminally insane. It includes people who are competent to stand trial, or to enter a plea; defendants not guilty by reason of insanity; defective delinquents; convicted and sentenced offenders, who when confined to institutions become ill (stir crazy or prison psychos); and finally another category of persons who could be referred to as defective intellectually, inferior persons who would fall within these statutes. There are, at present, seventy-three institutions

in the United States which are supposed to offer treatment for these types of offenders.

There are some other postulated, but not really tested, assumptions about these types of persons, especially how they should be handled and managed, including prediction of criminal inclination and/or dangerousness. A psychiatrist named Rubin has let us to believe that a psychiatrist's ability to predict dangerousness is unsupported by evidence, but what he failed to suggest, is labeling of deviance as mental illness or predicting dangerousness is just a convenience to get someone to treatment. Once in treatment, the concept of dangerousness is forgotten.

There are serious legal questions currently emerging regarding the definition of the management of the mentally disturbed offender. Several cases in court on which decisions will be rendered within a month or so deal in essence with the treatment for these persons.

I want to talk a bit about the question of dangerousness prediction in regard to treatment, and the ways you may wish to handle them as alternatives to the present structure in which we handle these persons.

Ohio, as well as Florida, has a sexual psychopath law (unless Florida has changed statutes and laws in the past year or so), which provides for the management of two classes of offenders. There are those who should be mandatorily examined and those with whom the courts may exercise some discretion in wanting them to be examined. The mandatory examination on statute is extremely serious. An examination by the Ohio State hospital for the criminally insane is necessary and a subsequent recommendation should be made back to the court for either commitment or non-commitment, indefinite commitment or treatment. The second category for the so-called non-mandatory offenses, which the statute says do not automatically require examination, are offenders for whom the judge may ask for an examination based upon either pre-negotiation process, observation of his behavior, or suggestion on the part of a defense or prosecuting attorney. The judge may, in fact, refer the person for any type of offense, be he adult or juvenile, to the Ohio State Hospital for examination.

The mandatory laws are almost all sexual in nature (rape, attempted rape of a female under 12, attempted rape of a female under 16, sodomy, incest, indecent liberties). With the exception of indecent liberties and attempted rape, all of them are additionally non-probational offenses, meaning that if a person is found guilty and is not to be sent to the hospital for treatment (which is in another portion of the statute) he must be incarcerated within a prison structure. There are some other options and alternatives.

The courts are not required to follow the recommendations of the psychiatric staff. They may or may not elect to follow the recommendations. Just as a point of interest, they do have some substantial agreements on the recommendations of some 84 percent of the cases being recommended for either treatment or non-treatment being accepted with accordance with other options available.

I chose Ohio State law simply because there are numerous other states

with very similar laws and it is the way in which we try to handle the question of the mentally ill offender and his interface with the criminal justice system. The court may find that "the option of continued enforcement of the applicable statutes will not afford to the public protection of possible future criminal conduct of such mentally retarded or psychopathic offenders." Mentally retarded is defined in the code as a person who "exhibits criminal tendencies and, therefore, is a menace to the public." Psychopathic offender (and here the law becomes very vague again in one of the characteristics that is supposed to be very specific) means "any offender who is adjudged to have a psychopathic personality or exhibits criminal tendencies, and who by reason thereof is a menace to the public." (Some of the dimensions of psychopathic behavior are listed).

Procedures for determining who fits the psycho category are based upon the intake process after the conviction and court sentence. The trial court "shall refer for examination all persons convicted and sentenced and all persons convicted of abusive or otherwise injury-causing action toward a child" to the Department of Mental Health and Retardation or to a State facility designated by the Department of Mental Health and Retardation, or to a psychiatric clinic approved by the Department, or to a psychiatrist. Prior to the sentence, the court may refer a non-mandatory sentence except for a murder in the first degree. In both the mandatory and discretionary cases "there shall be not more than 60 days of examination and the unit referred should make a careful examination of such a person and furnish the court with a report in writing as to the findings of the mental condition of the person." The sexual psychopath hearing is described: "The court shall hold a hearing therein not earlier than 10 days and not later than 30 days after receipt of the report (the attending psychiatrist making the report need not be present) and if this report is accepted as uncontrovertible," which raises some interesting questions about due process. If the court finds that there is mental illness, retardation, or psychopathy, there is some choice in the matter. The court may select one of several alternatives or it may impose the appropriate sentence for the offense for which the person was convicted. Simultaneously the court shall enter an order of indefinite commitment of such a person to a mental health institution "wherein the execution of the sentence shall be suspended." Guess what will happen when he gets well. Subsequent sections of this statute provide for the release procedures. Whenever the superintendent of the institution believes there has been a recovery or when maximum benefit has been received, he shall report back to the Commissioner of Prison Psychiatry, who then orders a report prepared to send back to the court for consideration. The court may call a hearing within the 10th and 30th day after the receipt of the report (everyone is very careful about the time frame, but not the content) in which the evidence is produced. The judge may suspend further execution of the sentence and place the defendent on probation if it is a non-mandatory, probational offense and a definite pattern of recovery is found and the circumstances of the case are such that he is not likely to engage again in an offensive course of conduct and the public good does not demand or require that the original sentence be carried out. If the person is disqualified for probation according to the statute and he is recovered, the prison psychiatry commissioner shall order the termination of the person's indefinite commitment for which he was sentenced and which was suspended by the court and shall forthwith go into effect and the person be transferred to the appropriate penal reformatory. The time of confinement

or the order of indefinite commitment shall be counted as time served for good behavior on the optimum sentence. Also, where the commitment period exceeds the maximum allowable sentence by the law and the person has been deemed to be barred probation by the court, the person shall terminate indefinite commitment. The sentence shall go into effect and the person shall be sent to the appropriate penal institution, where as a matter of course, the probation board allows him to stay for a minimum period of six months prior to coming before the board for the first time and usually after observation as to how he will do on the street (it doesn't say they don't trust the people at the State Hospital for their treatment and diagnosis) and they usually let the person loose on parole regardless of the maximum sentence. Bear in mind that he also served time in the hospital. Well, what about the people for whom the maximum sentence has been exceeded and there has been a recommendation for release by the psychiatrist for the institution and the authorities in that institution? In that case, the defendant my institute proceedings on his own behalf in which he proceeds to demonstrate that there has been a recovery or sufficient improvement to warrant his release. He may continue on an annual basis to institute such proceedings. This procedure clearly puts the proof of recovery on the defendent. It is an interesting approach to the problem of mental illness. I should tell you at this time that there is a class action suit called Watkins vs Davis in a Toledo court which has been argued and some preliminary orders have been issued. There are 22 counts in this class action suit in which mentally retarded offenders and psychopathic convicted offenders are lumped together in a class action suit asking impunity damages for non-treatment, for a writ of habeas corpus instantaneous release, and they are suing the commissioner, the head of the hospital, and certain attending psychiatrists for impunity damages saying they did not receive treatment when they were incarcerated to an agency. This makes it difficult since we do not have very much in the way of conventional treatment for psychos of this type. I should also tell you that the principle of absolvent impunity was abolished in our 1974 revised code revision.

The preliminary orders are quite clear. The court has ordered that the Department of Health and Mental Retardation, in conjunction with any of the court who may enter the case, establish a definition of treatment and the necessary conditions of the treatment. At the time, the then head of the Department of Health and Mental Retardation said, "Treatment is (and he had a previous statment of what he thought treatment to be) a diagnosis of the difficulty, a statement of prognosis, a step-by-step treatment plan which is periodically reviewed, and the treatment plan changed in conjunction with changes in the behavior of the person involved." They then ordered a team of people (three to five) as long as one of them was a psyciatrist and one a member there, to review every case presently in the institution and forthrightly to recommend those cases in which there was reason to suspect that the treatment had been adequate or that maximum benefit had been achieved by treatment. This institution's population is dropping rapidly. It was an interesting case. It was the first time in which convicted offenders and mentally ill offenders were handled together in a case which asked impunity damages. The right to treatment has been fairly well suggested in courts, but has only been impacted on mental health civil commitment persons. In this case, you have mental health civil commitment persons who have been referred to the Ohio State Hospital and criminally convicted offenders in the same case.

Let's talk first about the termination of psychopathy. The substance of the medical examination at the Ohio State Hospital is a process of trying to find the coincidence between the legal and medical definition for psychopathy. The legal categorization which by its very nature must obey in all criteria with precision stands in contrast to a more imprecise medical concept. In other words, the psychiatrist and the clinical psychologist are asked to combine medical and legal criteria. This combination is achieved with tests administered to the alleged psychopath in the legal definitions furnished under the statute. The process is further complicated by the fact that the psychiatrist is required to combine two irreconciliable standards but is to determine the existence or non-existence of criminal tendencies. In fact, it is this element which identifies the psychopath as such as a dangerous person, and that commitment is necessary to protect society. Furthermore, the concept of criminal tendencies is a legal concept in its origin. Thus, a psychiatrist or a clinical psychologist is required not only to define concepts which belong to different disciplines, but in the process of this combination, make a legal evaluation. As a result, the psychiatrist makes legal determinations as a medical expert. If you want to push this contention to its extreme consequences, we can take the case of an exhibitionist who is adjudged to be a psychopath. From the adjudgment of psychopathy on this man, we are entitled to say that this man is criminally dangerous and a public menace.

There is yet another problem in this area of medical examination. The examiners in principle should not be influenced by the question of guilt or innocence in the case brought to them for determination of psychopathy. Yet, if you ask a psychiatrist if he can make a diagnosis in the absence of knowing what the person was convicted for, he will tell you "no." As a practical matter, it is often difficult for the psychiatrist not to consider the guilt or innocence.

The commitment of the psychopath may terminate when the court, upon certification of recovery by the superintendent, adjudges him cured and no longer a menace to society. If these conditions are not met, the alleged psychopath must return to the state facility for further treatment. The consequences of commitment on further criminal proceedings causes no fundamental problems.

When a defendent comes before the court for the first time and, therefore, is declared guilty, say for a sex crime, he is a criminal and sent to the hospital for evaluation. If he receives treatment and the hospital superintendent certifies the fact that he is recovered and then, therefore, the patient goes before the court again and becomes a criminal, thereupon he is ordered to the institution for the implementation of the sentence. The reason for this unique procedure is that the psychopath laws are an addition to and not substitution for criminal proceedings, and I think that is the point at which the courts are going to strike down.

I should like to move now to my final point. The basis for commitment under psychopath laws is to provide us an increased protection from a menace to society from people who are dangerous, although in statute and principle the opposite of that is declared a statement for treatment.

There may well be a denial of due process if the accused is put in

double jeopardy and forced to testify against himself in the process of working with the psychiatrist. The Ohio law guarantees certain rights. Still, the consequences of testifying and working and cooperating with the psychiatrist may be, in fact, that you receive a double penalty: one for being a psychopath and another for being a criminal. This is a problem for which we must find ways of protecting ourselves from further depredations from these persons, and at the same time, staying within the confines of constitutional rights.

On the matter of handling the psychopathic offender in prison, the Ohio statutes allow the director of the Department of Rehabilitation and Corrections to make a transfer, a paper transfer of authority, transmitting the psychopath, the mentally ill person, or whatever, to the Division of Forensic Psychiatry. The parole board will not hear the case while it is under the control of the Division of Forensic Psychiatry. People who are sent to a mental hospital for psychopathic treatment and who are declared to be recovered or are no longer a menace can be transferred back to the prison structure. These people face a double problem. One learns to adjust inside a hospital and adjustments in the hospital are predicated on overt cooperation which is something which is not necessarily useful in getting before the parole board and making a successful exit. I have some real misgivings about that particular statute. It is a very large problem and it is an interface we will be looking at in greater detail.

Discussion from Panelists.

Dr. Mitchell Silverman.

I think the issues just raised are critical problems for all of us. Laws like Dr. Allen described become footballs which we are all confronted within the system. Who has jurisdictional rights, who is responsible for the individual who has been institutionalized? In many cases, as Dr. Allen pointed out, the individual has no rights, unfortunately.

I think a classic example of a case of this type came up when I was serving my clinical internship. I had a 33-year old retarded fellow with the mentality of a 6 to 9 year-old (I am using that range because at that age it is very difficult to measure the mentality) who was playing in the field where one of the staff member's little girl was playing. They had been playmates for a number of years because the man had been assigned to the house, and he had done a lot of work there. He picked up the girl out of affection and kissed her and set her down again and walked away. Well, one of the other workers saw this and ran home to mama and said, "Your daughter is being raped." Now, on the staff of this hospital, the immediate thing that happened was to see the medical officer who said, "mental psychopath." This meant an immediate transfer back to the ward of the hospital. Fortunately, we had a superintendent at this hospital that used his head. He came to me and said, "Mitch, what's going on here. This pediatrician who is working as a psychiatrist has labeled the man as a sexual psychopath which has all kind of legal interpretations which our facilities are not allowed to handle by law." I began digging into the situation to find out actually what had happened. I interviewed the individuals about the little girl. I interviewed the parents of the little girl, who were not at all upset when the facts came out, and I interviewed the retarded fellow. Now, the same medical fellow who had labeled the man a psychopath had also, in the medical record, noted that this fellow was

sexually impotent. Very interesting. He never put the two together. He never realized that he was working with an adult body and a child's mind and that this fellow was affectionately kissing the little girl goodbye as if she was his little sister. If we hadn't caught it or, if we hadn't had a superintendent who was on his toes and realized something was out of line, this fellow may have rotted the rest of his life in some back ward. Because, with his mentality, he would not have been able to make any waves. I just wanted to use this case to illustrate how ludicrous this concept can become when it gets out of line or is misinterpreted.

Dr. Herbert Quay.

As depressed as I was after hearing Dr. Vetter yesterday, I am even more depressed after hearing Dr. Allen. I suppose all these laws were enacted in good faith, but with incredible naivete as to what mental health professionals can and cannot do within their own framework and within the legal framework. After these two days, I have almost decided that there is not way mental health and the criminal justice system can do very much for each other and, in fact, many concepts may be injurious to what I consider to be a rational correctional process. That is, a process in which everyone is dealt with on the basis of behavior and educational and vocational needs, without the imposition and overlay of a lot of concepts which are not necessarily useful in this process. Frankly, I think if one could take the correctional system and make provisions for the small number of people who are blatantly psychotic or retarded that the system could function within a rehabilitation context in quite an active fashion without a lot of consideration of concepts taken over from the medical model of the mentally ill problem.

Dr. Hilary Harper.

I think this is the sort of subject dear to the heart of Dr. Vetter. I will ask him to respond both to your commentary and to Dr. Allen's and then I'll ask you, George, for your comments.

Dr. Harold Vetter.

I am glad someone else is saying the same things I have been saying. I was beginning to feel like a one-man minority group.

A year or so ago I was approached by a group who called themselves Insight Incorporated. Having tapped into some funds somewhere, they were going to put together some kind of program for people who were being released from a prison in Louisiana. I attended a meeting. After some of the bookkeeping problems, etc. had been dealt with, they started to put together what they thought was an appropriate staff. "Let's see, we'll need a psychiatric social worker and a consulting psychiatrist, and we'll get some group therapy groups going." I sat there with my two favorite ex-convicts, who were on parole for armed robbery, and when it came my turn to talk I said that a psychiatrist would be the last person I wanted to have added to the staff. What these people don't need is to have their heads candled or to be psychiatrically profiled. What they do need is some human contact. They need someone to say that they give a damn. They need

someone to approach them as fellow human beings who had been through experiences which had not left them branded with AR for armed robbery, that required them to wear a red patch on their shoulder, etc., but that it was now time to get on with "making it." The basic task is to get these individuals who have been on a furlough from the human race back into the human race, and do it in such a way that they are not forever stigmatized as ex-convicts. In this process on asks, "What has the mental health specialist to contribute to the task of criminal justice professionals?" If the picture painted here in the last two days is grim, it is grim only because it's grim to change some basic stereotypes and assumptions that we have cherished and worked with for a long time. One of these is that the psychiatrist is a god-like figure (along with Marcus Welby) who is privy to some kind of insights and special skills for the management and alteration of deviant behavior. Once we have divested ourselves of some of these stereotypes, maybe we can get back to looking at what the task is. The task is not a medical problem unless the individual who is irrational in his behavior also happens to be organically deranged, but is a problem of "making it." We have people in prisons, lock-ups, jails, penitentiaries who never learned any ways of making it, who never learned the ways of effectively coping with the increasing complexities of the kind of environment we live in, with the paradoxes that confront people on every hand, with the multiplicity of mounting demands, with sheer difficulty from going from day to day, making a living, raising a family, saving some money, having a good time, etc. and doing this in such a way that they are not treading on someone else's rights. After twenty years in the mental health field, I come back to what I said yesterday: that I was forced to re-evaluate everything I had learned and had been exposed to and throw out most of it as irrelevant. I started with the premise that what the mental health specialist has to contribute to the problems of the criminal justice professional is, first of all, a movement to scuttle or seriously abrogate the whole concept of "mental illness" or call some sort of moratorium on the continued use of this kind of conceptualization as a waste basket category into which we dump everybody in our society organically deranged or doesn't know how to "make it." Sometimes the ways he can't make it include not making it in terms of an abrasive contact with institutional norms that are expressed in our criminal laws. That to me is the basic consideration in wherever we go henceforth in the interaction between the mental health specialist and the criminal justice professional.

Mr. George Shepard.

This issue intrigues me, too, and I agonize over it a great deal. For two days now I have been here as a mouthpiece for law enforcement talking to the mental health specialists for this assistance. I have also been in all my career an exponent of the diversion from the juvenile justice system. But, I know that every single day in every single community in this big country of ours whenever a sex crime is committed, the first task law enforcement has is to investigate the known criminal files and then begin an investigation of those unfortunate dregs of society who have been through the whole criminal justice system and the mental health process and are now back, ostensibly, in the society. There are prime suspects, but I will admit that the department would be remiss if they did not explore that avenue of investigation. Yet, I have to sit here and admit that the situation is very agonizing to

to somebody like me who tries to keep a foot in each world. I know that in the process of investigation of sex cases a lot of innocent people will be stepped on and when innocent people who are victimized or are victims of an unjust system, who didn't treat them, you are really not making yourself very well liked in the community because every time this happens (we had 2 or 3 cases just recently in Washington) there will be a vociferous meticulous group of people who will scream aloud, and I understand it, about the practice of law enforcement in dealing with unfortunates and branding and labeling people simply because they were sick at one time and are not back and trying to "make it." I haven't any answer and I don't know, my friends, if you have either, but I suspect that it is something that is a very evasive issue, but something that binds us very strongly to the whole problem.

THE MENTALLY ILL: A PROBLEM FOR THE CRIMINAL JUSTICE PROFESSIONAL

Presentation Made at Session V, Friday Afternoon

Dr. Mitchell Silverman, Chairman
Criminal Justice Department

SUMMARY

In behalf of the Criminal Justice Department, I wish to thank Dr. Quay, Mr. Shepard, and Dr. Allen for agreeing to come down and share their views with us. Among this group, and the one I have saved for last, is a member of our faculty with whom I am involved on a daily basis, Dr. Hal Vetter, who I want to thank for agreeing to be a participant on the panel.

I was asked by Dean Northcutt to give his regards and say he was sorry he could not be here continuously.

To those of you who attended this conference, I extend my thanks. In some ways, we were sorry not to have the place filled with 400 people sent to Tampa from other places in the State, but, in some ways, the people who did come are here because they really give a damn, and maybe that is even more important. You are really concerned. It is a lot easier to go on a trip or attend a meeting when someone else is picking up the tab. It is more difficult when you have to take the initiative. So, I want to thank you very, very much on behalf of myself and the panelists for coming and really actively participating in the questions and dialogues and in the coffee breaks after the sessions. I think some of your views are going to be taken very, very seriously in terms of programming in this facility and as Dr. Quay brought forth, he has some serious reservations about some of the ideas he walked in here with. He is responsible for teaching professionals in the criminal justice system, so you do have an impact.

Where do we go from here? I think there are several important dimensions we must look at. First, we must forget about talking about "mental illness" even though we did use that as the title of this conference. Mental illness immediately implies pathology and pathology stems from a medical model. Dr. Vetter is the one who killed the golden egg to some extent. I think some of you knowing Dr. Vetter very personally and as a colleague and fellow professor, know that he is not as pessimistic as he sounded up here. I think what he was trying to do was over-emphasize that we have been locked into a system of futility in terms of our thinking, our theory, and our practices. Future workshops will have in the title, instead of mentall illness, perhaps something like "emotional factors" that must be considered by the criminal justice professionals in their daily work. If we broaden the concept so that we can include theories, facts, experimental data (some of which have been discussed), legal data, etc., without being locked into one position, and if we broaden our prospective and increase our frames of reference, then, maybe, we will be ahead of the game.

Another issue that has come up again and again is where do people in

the mental health professions cross over in terms of being able to help criminal justice professionals? Unfortunately, we are using the term "mental health professionals" where, in reality, we are talking about a series of individuals who are trained in different disciplines. Social work, sociology, economics, psychology, political science, and even medical practitioners all have something to offer. I think we have to look at this in terms that there are many different disciplines that can make contributions that are useful within this field.

I am not as pessimistic as some in the audience perhaps relative to what will come out of this conference. I think there are a number of directions that this conference spells out for us to go. One is to bring professionals from parole and probation, law enforcement, the judiciary, and corrections together with professionals in the behavioral and social sciences so we can sit down and look at the problems from all the perspectives. We may, in fact, find out that we can help each other in many, many ways.

There are new techniques on the horizon. Some substantiated in the experimental data which can be used. We are in very primitive stages of their use, but we also have to continue to try. We have to turn around a system based on paperwork, labeling, and body processing into a system which takes into account the unique individual differences of the people who are our consumers. Unfortunately, our consumers carry a stigmatism. We use all kinds of labels. We call them sexual psychopaths, we can call them anything else we wish, however, when we get right down to it, they are people with problems - problems that are socially, educationally, and experientially based.

I do not think I would be too far out of line in saying that possibly this is the point that Dr. Vetter was trying to make the most explicit: that there is nothing magical about what we have to do, we have to look at an individual as a product of his life's experiences and in terms of those experiences try to figure out why he is coping with his environment in his unique way, even though it might be inappropriate. We must teach him, through a learning or relearning process, how to cope better with his environment in more socially acceptable manners.

There are a number of techniques which can be used to achieve these ends. One of the methods available is behavior modification which is now persona non grata in LEAA to the point where a policy statement came out stating that they would not longer support behavior modification research. Unfortunately, this term has come to mean many things to many people. To a psychiatrist, behavior modification may be electro shock. If you put enough volts into a person's head, you are bound to change his behavior. Wardens on death row have know this for a long time. The mental institutions, especially the old ones, are loaded with people now in their 50's who are walking around like zombies because people have attached electrodes and pumped juice into them.

We are now into a new area called chemotherapy. Chemotherapy is just another way to modify behavior. If you inject a foreign substance into the human body, in many cases, you can modify behavior in a number of different

and diffuse ways. One of the popular uses in institutions is to make the patients sleep so they don't give you any problems. Therefore, they are better adjusted. Unfortunately, sometimes the patients start tearing up the place indicating that they are not well adjusted and it is time to change drugs. In each case, the behavior is modified.

Yet the term, behavior modification, really stemmed from a different point of view. I am not afraid of the method because, in context, it originally developed from a learning theory approach to changing behavior, and many of the advocates of the theory believed that punishment was not necessary to change behavior.

We went over a number of issues which many of you are going to face. Many of you may be involved in lawsuits as representatives of your different governmental entities some day, because right now we are going through a series of redefinitions of civil and constitutional rights related to all types of individuals. On the one hand, we have a number of cases before the court with respect to the right to treatment, while on the other hand, we have a series of cases that contend that you may be violating rules by treating an individual. You may be violating his personal freedoms. Right now, we are in a mess as to what to do.

The easy way is to "cop out" and say "the hell with it." We have been doing that for years. We can accept this position using a number of arguments. One of which I think is beautiful and which Abraham Kaplan summarizes in his book CONDUCT OF INQUIRY. He talks about social scientists refusing to make their knowledge known because they just never have enough data to prove anything. You and I can't afford that luxury. When we have to make a decision, it's right now and without the benefit of running 52 studies.

Let's lay it out where it is. Sure, we are naive, we are primitive, we don't know very much. We can also use this as an excuse not to do anything. We can be lily white. It I were in a parole and probation office, I could use all kinds of excuses to "cop out." I'd have enough paperwork so that I could lose myself in it and never see anyone for months. Don't tell me some of you don't do this. I have seen the blue forms people send in once a month that are counted in case loads where the parole or probation officer never sees the individual as long as the paper keeps flowing. Now anybody knows that a guy with an I.Q. of 90 and above can still write his name on the paper and say, "Yes, I have been a good boy for thirty days." That lets us off the hook.

As a professor (and I am not going to let us off the hook, either) I can say, "I don't have enough data so I will just sit around and intellectualize about all these things and I'm not going to do research in your area because I don't have the methods which meet some idea in some particular discipline about what an experimental design should look like in terms of precision, because I can't control all the variables." So, I will just hide out in my ivory tower and run rats with dope because rats don't have as many constitutional rights, they do have some, but not as many as human subjects and anyway rats can't talk. I make it sound like a contribution because I've been injecting them with morphine and morphine affects their behavior. I can run very clean experimental designs and I can get significant changes. I can

"cop out" just as fast as you can.

The policeman can "cop out" very easily. Just ignore the fact that there is such a thing as emotional factors related to crime or criminal behavior. Say they don't exist. Then we can put everybody in the slammer and forget about them.

It is easier to "cop out" and not do anything. The important thing that I think we stressed today is that if you do something, use your head before you do it, and try to think it through. Try to marshall as much information as you can before you act even though sometimes it might be in a crisis. Go to those types of individuals who might offer you help rather than the self-exposed authorities that are always put before us by society's traditions.

END