Journal of Criminal Law and Criminology

Volume 89
Issue 1 *Fall*

Article 8

Fall 1998

Book Review

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Recommended Citation
Book Review, 89 J. Crim. L. & Criminology 393 (1998-1999)

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0091-4169/98/8901-0393
THE JOURNAL OF CRIMINAL LAW & CRIMINOLOGY
Vol. 89, No. 1
Printed in U.S.A.
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BOOK REVIEW

TREATING THE MENTALLY-ILL OFFENDER: THE CHALLENGES OF CREATING AN EFFECTIVE, SAFE AND JUST SYSTEM

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TREATMENT OF OFFENDERS WITH MENTAL DISORDERS. *Robert M. Wettstein*, editor. The Guilford Press 1998. 438 pp.

This useful book provides a number of valuable perspectives on the pressing problem of how to address the treatment needs of mentally-ill offenders. The book also addresses the needs of prison, hospital, and community-based administration and staff, whose multi-faceted and sometimes contradictory responsibilities are: to protect the public, to provide humane treatment for patients aimed at the release of most from custody, and to provide a safe, supportive, and productive working environment for those who work with mentally-ill offenders. An added challenge of working with mentally-ill offenders is the reality that even with the best treatment programs, predictions of future conduct can never be certain. However, the public demands protection from offenders who are feared, sometimes with, and sometimes without justification, to be dangerous recidivists.[1] The dilemma

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[1] Metzner, Cohen, Grossman, and Wettstein note in Chapter 5 that as of June, 1994, local jails held 492,442 adults, a 119% increase over 1983. At the end of 1994,

of the therapeutic community is to respond to its duty to patients as well as to the political realities which can affect the efficacy and scope of programs designed to reintegrate mentally-ill offenders back into the community.

The problem is pressing because the number of our citizens subject to the jurisdiction of our penal systems has risen sharply in recent years. With that increase, those charged with addressing the problems of mentally-ill offenders see increasing numbers of inmates who are mentally-ill. Estimates of the percentage of the mentally-ill in prison populations vary from 5%-16% with serious mental illness, 35% with personality disorders, and 25% with substance abuse problems.[2] Adding to the gravity of the situation, 2%-10% of the prison population meet the diagnostic criteria for mental retardation, and 88% of the remaining population is mildly impaired.[3] Sexual offenders are a particularly difficult population to treat, especially those whose behavior is chronic.[4] Indeed the Supreme Court of the United States, in response to evidence that this population is difficult to treat, permitted the state of Kansas to civilly detain a prisoner who had completed his sentence on the ground that he was dangerous due to a "mental abnormality" rather than a mental illness.[5] The various approaches to treating this popula-

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the total number of prisoners under state and federal jurisdiction was 1,053,738, a 141% increase over the 1983 U.S. prison census. Black and Hispanic males are vastly disproportionately represented. Jeffrey L. Metzner et al., *Treatment in Jails and Prisons, in* TREATMENT OF OFFENDERS WITH MENTAL DISORDERS 211, 213 (Robert M. Wettstein, ed., 1998).

[2] *Id.* at 230.

[3] William I. Gardner et al., *Treatment of Offenders with Mental Retardation, in* TREATMENT OF OFFENDERS WITH MENTAL DISORDERS, *supra* note 1, at 329-30.

[4] Barbaree & Marshall observe:

> rates of reoffense among untreated offenders [are] remarkably different across different studies with rates of 10% to 29% among nonfamilial child molesters who offended against females and rates of 13% to 40% among men who molested boys . . . [r]ecidivism rates for sexual offenders varied considerably, depending on whether the patient was a first or repeat offender.

Howard E. Barbaree & William L. Marshall, *Treatment of the Sexual Offender, in* TREATMENT OF OFFENDERS WITH MENTAL DISORDERS, *supra* note 1, at 265, 269.

[5] The Supreme Court upheld Kansas' legislative judgment that "sexually violent predators generally have anti-social personality features which are unamenable to ex-

tion need further evaluation, the evidence tending to support the development of "comprehensive" treatment programs.[6] The provision of mental health services for delinquents is also a key issue for the therapeutic community. Unfortunately, the provision of services to children in trouble with the law is governed more by what services are "available" than by informed choices based upon knowledge of appropriate treatment choices.[7]

The legal rules governing the rights of offenders who are mentally-ill are evolving in response to the realities of prison and community based correctional systems. In an informative chapter on the development of the law governing the administration of treatment programs for mentally-ill offenders, (including those in prisons, mental hospitals, and out-patient treatment settings), Thomas Hafemeister documents the tension between the needs of administrators for flexibility in running their programs and the treatment needs of mentally-ill prisoners, noting that

> [a]lthough only a limited right to treatment for nonsentenced offenders with mental disorders has been recognized, ironically, pressure for an enhanced right to treatment may come from a setting where traditionally few individual rights were recognized, namely prisons. . . . Judges presiding over prison cases have shown a tendency to discuss whether the

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isting mental illness treatment modalities and those features render them likely to engage in sexually violent behavior." Kansas v. Hendricks, 521 U.S. 346, 351 (1997).

[6] "Sexual crimes derive from a complex interaction of cognitive, physiological, and situational variables. Accordingly, a comprehensive treatment program that targets deficits and excesses important to the commission of sexual crimes is our best hope to prevent reoffending." Barbaree & Marshall, *supra* note 4, at 317.

[7] Gordon and his colleagues argue that delinquents often receive treatment which is dependent upon where the delinquents reside rather than what the children need:

> In spite of differences among some of the subgroups of delinquents, the majority of delinquents are offered treatment that varies less with their behavioral and psychological characteristics and more with what is locally available. Herein lies a major reason why more serious delinquency is not treated effectively. Institutionalized delinquents are given group milieu therapy and delinquents on probation in the community sometimes receive individual psychotherapy (and occasionally family therapy).

Donald F. Gordon et al., *Treatment of the Juvenile Offender*, *in* TREATMENT OF OFFENDERS WITH MENTAL DISORDERS, *supra* note 1, at 365, 365-66.

> treatment provided represents a substantial departure from the professional judgment expected in this setting.[8]

Hafemeister's chapter also discusses such important issues as the right to refuse treatment, the law governing treatment techniques such as aversive therapies and experimental drug programs, and informed consent for experimental programs. This comprehensive chapter also includes discussion of the law governing disclosure of information gained in the course of treatment, transfers from one institution to another, the conflict between the need for community placements and community concerns about safety, and the power of legislatures to maintain control over "dangerous," but not "mentally-ill" offenders.[9]

The chapters which address the legal aspects of treatment, and the various approaches to the treatment of different populations in different settings are preceded by an informative chapter which addresses the nuts and bolts of the administration of treatment programs for mentally-ill offenders.[10] This chapter looks at the problem of how to provide for this difficult-to-serve population from the standpoint of those who are actually responsible for the day-to-day administration of such programs. It provides a useful overview of tension between treatment and community safety that these administrators face:

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[8] Thomas L. Hafemeister, *Legal Aspects of Treatment of Offenders with Mental Disorders, in* TREATMENT OF OFFENDERS WITH MENTAL DISORDERS, *supra* note 1, at 44, 57 (footnote omitted).

[9] *See* Hafemeister's discussion of *Kansas v. Hendricks*:

> The Court, as it had in the past in the context of other commitments for treatment, found that commitment here did require a finding of dangerousness either to one's self or to others and that this finding required proof of more than a mere predisposition to violence. However, the Court did not require proof of present dangerousness, which might be difficult to establish when the individual has been confined and closely monitored in a prison environment. Instead, a finding of dangerousness could be based on previous instances of violent behavior, which, in turn, could be used as indicators of future violent tendencies.

Id. at 103.

[10] Joel A. Dvoskin & Raymond F. Patterson, *Administration of Treatment Programs for Offenders with Mental Disorders, in* TREATMENT OF OFFENDERS WITH MENTAL DISORDERS, *supra* note 1, at 1, 1-43.

> The dilemma facing every forensic administrator is the difficult dual mandate society imposes with regard to the treatment and custody of offenders with mental illness. On one hand, politicians, courts, and the press have made clear their desire to have these "criminally insane" individuals removed from the community and thus incapacitated from harming presumably innocent citizens in the community. On the other hand, the courts have made it clear that long-term restrictions on a person's liberty place several heavy burdens on the state, not the least of which is the provision of adequate psychiatric treatment.[11]

This chapter goes on to describe the tensions between providing for effective treatment and public safety, underscoring the need to create and to preserve credibility among the public by making careful release decisions according to a protocol which always involves more than one professional.[12] The chapter then describes the role of mental health advocates in developing effective programs with particular emphasis on the need to educate the public about the merits of treatment-oriented as opposed to punitive programs.[13] Dvoskin and Patterson argue that mental health administrators must win the confidence of the public and the staffs of treatment providers by effectively managing programs, by seeking accreditation, and by providing

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[11] *Id.* at 2 (footnotes omitted).

[12] A "cautious" release policy may ultimately benefit the public and the patient:

> Forensic administrators have found a willingness, albeit a grudging one, among the public to accept the fact that some risk is unavoidable, but lack of caution is not; nor is premature release in the interest of the patient. Premature release, or failure to attend the obvious risk factors, is likely to cause the releasee to lose a great deal more freedom (in the event of another violent act) than is a more cautious release process.

Id. at 5.

[13] Education of the public regarding the long-term benefits of treatment is necessary to counter a natural tendency to reply on incapacitation as the key to crime prevention:

> The public pressure mounted in the media by public safety advocates, victims, and their families, and politicians advocating for public safety can sometimes result in increased funding for programs solely on the basis of their contribution to public safety. Unfortunately, this type of pressure alone tends to respond exclusively to the retributive instincts of the public and can increase punitive programs at the expense of treatment and rehabilitation.

Id. at 7 (footnote omitted).

support for staff designed to attract and retain highly qualified professionals and mental health workers. The practical considerations involved in the planning and management of mental health delivery systems discussed in this chapter are informative and enlightening.[14]

This book should be read by all treatment personnel, administrators, lawyers, and judges who attempt to address the problems of mentally-ill offenders because it provides each professional group with the perspectives of the other professional groups who work within the mental health, correctional, and justice systems. Without such cross-disciplinary perspectives, approaches to the treatment of mentally-ill offenders are likely to continue to be fragmented, ineffective, and inhumane.

Unfortunately, unlike the interdisciplinary example provided by this book, it is rare that the kind of integration of professional perspectives illustrated by the contents of *Treatment of Offenders With Mental Disorders* takes place in real life settings. Our prisons and jails often operate independently of mental health systems. Sometimes hostile relationships develop between correctional and mental health agencies over which "offenders" belong in the mental health system and which belong in the correctional system. Lawyers who represent offenders who are mentally-ill are often woefully uneducated about what kinds of treatment programs and facilities are most appropriate for their clients and therefore fail to advocate in comprehensive ways for the best interests of their clients by leaving "treatment" decisions to the unfettered discretion of correctional or mental health administrators who may not have the resources to provide effective programming for individual offenders. This is not to say that lawyers are always qualified to make treatment deci-

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[14] For example, Dvoskin and Patterson advise:

> Before building a new facility or renovating an old one, the following steps are essential: 1) Talk to staff who are currently working with the patients who will live there. Find out what *they* want in the new building. Generally, weight should be given to opinions in inverse proportion to salary, as the generally lower paid treatment assistants, nurses, and perimeter security staff are the personnel who are on site 24 hours a day and who have hands-on familiarity with the patients and equipment.

Id. at 21.

sions, only that well-informed lawyers would serve their mentally-ill clients better by being able to intelligently *question* treatment decisions made by mental health professionals. Often, this process of intelligent questioning leads to alliances between the legal and mental health communities which stimulate the creation of new programs and the creation of programs to fill existing voids.[15]

Likewise, mental health administrators and professional mental health service providers are unclear about and suspicious of the legal mandates that sometimes govern which services are provided, how they are provided, and when they must be or may not be provided. Changing rules and regulations, evolving case law, and uncertainty of the meaning of case law makes the mental health professional's guidance from the legal system and from individual lawyers and judges a frustrating process. This tension will never be eliminated given differences in legislative approaches and evolving case law. However, clear explanations of the status of the law, such as that contained in this book, as well as continuing efforts of the bench and bar to understand the nature of the problems faced by mental health services providers (such as those described in Chapter 1 of the book), should go a long way towards fostering more collaborative relationships between the mental health and legal systems. One cannot help but think that a book like this, if distributed to mental health services administrators, would contribute much to a common understanding of baselines regarding the expectations of the justice system for administration of programs that treat offenders who are mentally-ill.

From a lawyer's perspective, the book is also useful in the way that it describes the research that has been and is being done by mental health professionals to evaluate the efficacy of various programmatic and treatment approaches. The descriptions of the research are accessible to the non-scientist and provide impressive support for the proposition that the medical/treatment community is far more active and empirical than the legal profession in evaluating its approaches to the

[15] BARRY NURCOMBE & DAVID PARTLETT, *Child Mental Health and the Law, in* THE MENTAL HEALTH PROFESSIONS AND THE LAW 1, 1-11 (1994).

problems it is dedicated to solving. The effort of mental health professionals to understand "what works and what doesn't work and why" is underscored by the book's description of evaluations of programs to treat prisoners, sexual offenders, and juveniles. The chapters devoted to these subjects demonstrate that treatment professionals are constantly refining their approaches in response to research. Moreover, the research described in the book should help treatment professionals, lawyers, judges, and policy makers to make intelligent decisions about the nature and scope of programs designed to treat mentally-ill offenders.

A few, constructively critical comments are in order. Despite an excellent index, bibliography, and introduction and conclusion to each chapter, there is no comprehensive introduction to the book. This makes it somewhat difficult for the reader get a sense of the book's mission and the rationale for its organization. Those who struggle with the practicalities of administration and delivery of mental health services might benefit from an introductory "opening statement" which identifies the themes the editors had in mind as well as how the various chapters in the book contribute to those themes. In addition, those of us who have a less than complete understanding of the complex issues of research methodology and the implications of the research performed would benefit from an introduction that places the research in context. Finally, a conclusion which attempts to integrate the fine work of the contributors would support a better understanding of the book's mission and might prompt policy makers to be responsive to the many sensible suggestions about resources and programming made by the authors that might be otherwise lost.

The chapter "Treatment of the Sexual Offender" is complex. Barbaree and Marshall do a fine job of reviewing treatment programs for sexual offenders, attempting to differentiate between types of sexual offenders on the basis of their crimes, their ages, severity of offense, those who offend against children, as well as the influence of comorbid substance abuse and acute intoxication during the time of the crime. Further description of paraphiliac behaviors versus non-paraphiliac behav-

iors are included in this summary as well as different types and stages of treatment. Although this is a well written chapter describing current techniques in treatment as well as a review of prior research, there are several important questions not addressed in this chapter. Debate continues over the question of whether sexual offending is evidence of mental illness.[16]

The chapter "Treatment of Juvenile Offenders" does not contain legal and clinical definitions, theoretical frameworks for delinquency, phenomenology of delinquency, or techniques for interviewing children. It also does not contain information about more recent treatment approaches. There was also little discussion of how the initial treatment interview should be conducted or how good clinical reporting, including psychiatric evaluations, should be conducted. While this chapter does acknowledge a clear difference between adults in the criminal justice system and adolescents in the juvenile justice system, it should also be noted that the adolescent patient is far more complex than the adult patient.[17] Treatment approaches, developmental issues, and health issues applicable to juveniles are different than those applicable to adults.[18] The chapter also minimizes psychopharmacological interventions. It is important to note, however, that the primary focus of this book is on the treatment of mentally-ill adult offenders. A separate book is needed to elaborate on the evaluation and treatment issues relevant to juvenile offenders.

Wettstein and his colleagues have done a great service for those of us who work with mentally-ill populations by bringing together diverse perspectives regarding the treatment of mentally-ill offenders. One cannot help but be impressed by the sense of energy and commitment conveyed by this book among those who labor in this area. Until now, much of this energy

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[16] *See* Brief for the American Psychiatric Association as *Amicus Curiae* in Support of Leroy Hendricks, Kansas v. Hendricks, 521 U.S. 346 (1997) (Nos. 95-1649, 95-9075)

[17] W. Meyers, et al., *Psychopathology, Biopsychological Factors, Crime Characteristics and Classification of 25 Homicidal Youths*, 34 J. AM. ACAD. CHILD & ADOLESCENT PSYCHIATRY, 1483, 1483-1503 (1995).

[18] Michael G. Kalogerakis, *Juvenile Delinquency, in* CLINICAL HANDBOOK OF CHILD PSYCHIATRY AND THE LAW 191, 191-215 (Diane H. Schetkey & Elissa P. Benedak eds., 1992).

and commitment has been fragmented. *Treatment of Offenders with Mental Disorders* models in a very effective way the need for interdisciplinary work to be made available to all who undertake this very important work.