THE CRIMINALLY INSANE: A COMMUNITY FOLLOW-UP OF MENTALLY ILL OFFENDERS. By Terence P. Thornberry and Joseph E. Jacoby. University of Chicago Press, Chicago. Pp. 292. 1979. $19.00.

In a landmark study, *Careers of the Criminally Insane,* Steadman and Cocozza investigated the behavior of patients who were released from institutions for the criminally insane in the State of New York. Protesting the court decision *(Baxstrom v. Herold)* mandating a transfer to civil hospitals for evaluation and possible release, state corrections officers claimed their patients were "too dangerous" for that degree of freedom. In the tradition of the *Baxstrom* study, Thornberry and Jacoby's research makes a solid contribution to understanding the institutional decision-making process by which mentally ill criminal offenders — the "mad and bad" — are confined over long periods of time.

Like Steadman and Cocozza's study, the current research takes advantage of a natural experiment resulting from a court decision. In 1969 a Pennsylvania court ruled that because of an absence of due process in the commitment of patients to Farview Hospital (a maximum security mental institution), the continued incarceration of Donald Dixon and others whose sentence for criminal conviction had expired was unconstitutional. Again paralleling *Baxstrom's* outcome, the *Dixon* court required that sentence-expired mentally ill offenders be transferred to civil mental hospitals where, after re-evaluation, decisions about their release to the community would be made. The transfer was resisted by the staff at Farview who claimed their patients were "too dangerous" for even civil hospitalization.

Accuracy of Predictions

The project first investigates the accuracy of predictions that the patient will behave "dangerously." Thornberry and Jacoby suggest that assessments of patient dangerousness are actually "political predictions" based not on the characteristics of an individual, but on the assumed characteristics of a group to which the individuals belong. Because the group is thought to have a high probability of producing violent or assaultive behavior, each individual member is assumed to be "dangerous." Further, the political context of decision-making allegedly encourages clinicians to "over-predict" dangerousness to avoid public criticism and sanctions resulting from the release of someone who turns out to be harmful to others. Consistent with their observations are prior studies finding assessments of patient dangerousness resulting in very high rates of false positives, *i.e.,* those predicted to be dangerous who are not actually assaultive. While the authors describe two components of "political prediction" — evaluator's perception and situational pressures — they are unable to address the relative contribution of each to the outcome because neither one is carefully measured. The influence of situational pressures (resulting in decisions to continue confinement) is simply assumed to exist. The attributional process (by which group

characteristics are transferred to individuals) is inferred from some comments made by Farview staff and administrators. Whatever the specific cause, the authors focus on outcomes of a system which results in most inmates being found dangerous and in need of extremely long periods of confinement.

The accuracy of Farview staff assumptions about patient dangerousness was examined through studies of actual patient behavior. Unlike previous research which examines patient behavior following long-term confinement (and a high probability of being "burned out" and incapable of aggressive actions), Thornberry and Jacoby also document patient behavior during confinement in both the maximum security and less "contained" civil hospital to which they were transferred. Using incident reports and ward notes, they find very low rates of violent behavior in the maximum security hospital. Even in the absence of much assaultive activity, Farview staff presumed the group and each of its members to be violent. After transfer to the less restrictive civil hospital, the patients continued to display very low rates of violent or assaultive behavior. As in previous research, low rates of violent activity are reported in police and hospital records for those released to the community. Approximately one quarter of the patients leaving a confinement averaging 14 years were arrested for a crime and only one-fourth of those were associated with violence. The recidivism rate of *Dixon* patients approximated that of normal parolees.

Additional information about patient adjustment was gathered through follow-up interviews. The authors report adjustment scale scores which were quite similar to released civil mental patients and not greatly different from "normal" populations. Further, three-quarters of the interviewed *Dixon* patients indicated they had relatives with whom they could live and more than half actually went to live with a relative upon release. Residential patterns of released patients were also found to be remarkably stable.

While Thornberry and Jacoby recognize the limitations of relying on state police and hospital records as measures of post-hospital behavior (*i.e.,* problems of under-reporting), they assume serious assaultive acts with harmful consequences would be detected. But the under-reporting of assault may be even greater than the authors suspect, given extremely high levels of domestic violence found in studies of "normal" families by Gelles, Steinmetz and others. Additional problems of interpreting findings about post-hospital stability and adjustment result from following only 52% of all living patients and 38% of those released. While the investigators must be admired for successfully contacting so many former inmates as long as four years after release, the inability to locate more than a minority of those in the community make the findings of high residential stability and adjustment somewhat suspect. Nevertheless, the results certainly support the hypothesis that a system of "political prediction" results in excessively long periods of

confinement for large numbers who are not actually "dangerous."

Coping in the Community

A second aspect of the study sheds light on the consequences of a policy that has shifted care from residential hospitals to outpatient facilities in the community. The "Decarceration Movement" has come under increasing attack from professionals such as Andrew Scull (*Decarceration*) and the media (*e.g., New York Times; Philadelphia Inquirer*) as a politically-inspired "dumping" of back-ward patients into low income areas where they receive little support and are preyed upon by residents and landlords.

Thornberry and Jacoby report that resources are indeed lacking for released patients in their study, although the gaps are not as great as those suggested in recent exposes. Over a quarter of those released and interviewed claimed that no post-hospital treatment was provided (which is troubling if such treatment could be assumed to have been efficacious for this group). The authors imply that the quality of treatment was less than desirable because it was received more from public than from private sources and more from social workers than from psychiatrists. But given the accumulated social and economic disadvantages of *Dixon* patients, it seems appropriate that public social work contact predominated. However, it is striking that despite considerable contact with social workers (and others), over three-quarters received no help with major problems of employment. Thus, both the quantity and quality of care could be improved. It is interesting to speculate whether assistance had any impact on recidivism or rehospitalization, but unfortunately the authors overlook this question.

It must be noted that despite deficits in outpatient professional support, only 2.8% of those interviewed in the community preferred living at Farview and 7.7% preferred a civil hospital to the community. It appears that legislation mandating "least restrictive alternatives" would be supported by those most directly affected by it.

Characteristics of "Dangerous" and Released Patients

Finally, the study attempts to differentiate between characteristics of patients who actually behave "dangerously" and those who do not, and between patients selected by the civil hospital for release and those retained as inpatients. Not surprisingly, released patients who commit criminal acts of violence were younger, spent less time in the maximum security hospital and had a history of more serious criminal activity. However, the authors are quick to note that using even a combination of these variables would not enable the clinician to predict assaultiveness for individual patients with any degree of accuracy. If the environmental context of release (*e.g.,* situational stress, presence of social support, etc.) had been considered in addition to patient characteristics, prediction of patient assaultiveness might be improved.

Interestingly, those selected for release by the civil hospital are also younger, with less time spent at Farview, and a more serious criminal

background. The authors describe a process in which the civil hospital, being more oriented toward therapy and adjustment, released those with less "institutionalized" personalities (younger, hospitalized for fewer years) because they were evaluated to be more capable of coping with the external environment. Prior to *Dixon,* a "Catch 22" was said to exist because by the time patients were old enough to appear harmless and released by the security-conscious Farview, they had deteriorated to a state in which the civil hospital — where they might eventually be transferred — would judge them incapable of coping with release to the community. The observation is sobering, although the authors make it without presenting any data on the association of age and release from Farview.

Thornberry and Jacoby conclude that resolutions of issues associated with the involuntary confinement of mental patients do not follow from the findings. Nevertheless, some suggestions for reform are offered. One is to remove the authority for releasing patients from the hands of those who are responsible for treatment. Many jurisdictions already provide that separation. Clinicians need only present assessments to the court which technically has the responsibilty to decide about confinement. Of course, the court often defers to the expertise of clinicians for a decision. Perhaps the need is for role clarification rather than new law. Still, it is not likely that the removal of political pressure, in itself, will reduce overprediction. Others have pointed out that clinicians often presume the presence of illness, overestimate their ability to help, and are statistically bound to overpredict events with a low frequency of occurrence. Further, legal scholar Alexander Brooks has argued that psychiatrists will often claim their patient is "dangerous" if that is the jargon required to obtain a desired confinement. Thus, simple reduction of the situational pressures contributing to a "political prediction" may not yield the desired result.

The reader is left with additional unresolved issues. Will society be comfortable with a recidivism rate comparable to normal parolees of "only" 25%? And should family suffering and preferences be considered? the work of Pasamanick, *et al., (Schizophrenics in the Community),* cited by the authors as evidence that schizophrenics do well in community care, also reveals much suffering in a majority of the families living with former patients. Nevertheless, Thornberry and Jacoby conducted an important piece of research which will contribute to a more infomed debate on public policy associated with confinement of the mentally ill. While some unavoidable methodological problems keep the results from being less than definitive, it is among the best studies available to date on confinement and release of the "dangerous" patient.

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