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MENTAL HEALTH PROGRAMS

FOR CRIME AND

JUVENILE DELINQUENCY PREVENTION

NCJRS

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INTRODUCTION

This is a report of the role of mental health clinics in the prevention of crime and delinquency. It includes a chapter on the history of the mental health clinics in delinquency, a classification system, an evaluation of preventive programs and recommendations. By mental health clinic we mean public outpatient facilities. Investigating the outpatient mental health clinic as a preventive institution has been a frustrating but exciting program. Frustrating because there has been no previous interest or study in this area. This is exemplified by the fact that there are no bibliographies or references concerning the topic. To our knowledge the role of the mental health clinic in criminal prevention has not been investigated. This report is probably the first such attempt. On the other hand the task has been exciting because of the discovery of some very promising activity in prevention.

We originally planned to investigate only the literature concerning mental health clinics. The absence of references, however, led us to visits and talks with the personnel of such clinics trying to gain as much mouth-to-mouth information as we could. We also incorporated literature from such related facilities such as child-guidance clinics, drug-addiction clinics alcoholic clinics and community mental health centers. The literature in this area is richer and much has been drawn from it. This report then, reflects more the interests and activities of mental health in general, rather, than interest of out-patient mental health clinics. This reports starts by orienting the reader, briefly, to the historical development of the interest the mental health clinics have had in the earea of crime prevention. A subsequent chapter gives an overview of that interest's present state of affairs.

The writer's experience has been that, a meaningful diagnostic classification system of offenders for preventive purposes, has yet to be developed. Classifying them according to offense has hardly any value concerning treatment and prevention. In chapter 2 we present a classification model which can be a value to prevention, at least, until a more sophisticated one is developed. This model indicates clearly enough the type of client most suitable for prevention within the framwork of the mental health clinic.

The main part of the report describes and analizes both, successful and unsuccessful programs of prevention by various types of mental health facilities. Few programs set up to prevent criminality have been adequately evaluated with respect to effectiveness. The evaluation of prevention programs is extremely difficult. There is no definite proof that all of the pre-delinquents were going to end-up offenders. Therefore, the follow-up studies can only tell the preventive personnel of their failure, not their success. The successful cases could have been successful even without the preventive agency's intervention.

Compounding the study of the role of the mental health clinic as a preventive agency, is the complete lack of statistics. While the Biostatistics Department of the National Institute of Mental Health publishes very comprehensive statistical reports of the nation's mental health clinics, their classification does not include or describe any segment of the clinic's clientele, as potential criminal. Their classification is confined to the one prescribed by the American Psychiatric Association. For our purposes, this system is neither adequate nor appropriate.

Every person with mental problems is a potential offender, especially, if he has a tendency of acting-out. The whole mental health

clinic population is not our focus of interest. We are interested, mainly, in those types of mental problems which seem to culminate, most frequently, in aggressive antisocial behavior. It should be noted that of the thousands of references checked, only one article (a foreign one) made an attempt to describe the mental problems most likely to result in crime.

At the end of each chapter, a list of recommendations can be found, result of the preceeding discussion of various projects and research experiences.

While the mental health clinic's role in criminal prevention has been neglected in the literature, its task and responsiblity have been more strenuous; but its future role, as seen by this writer, is more comprehensive and very promising.

RECOMMENDATIONS

1) It is suggested that a bibliography of the role of the mental health clinics in the prevention of criminality be compiled. Such a project will be highly helpful to future research in this area. The bibliography at the end of this report could be used as a starting nucleus.

2) Knowledge is needed concerning the types of mental health problems most likely to result to crime. Research in this area is highly recommended.

3) The Biostatistics Department of NIMH will enhance research in this area if in its statistical reports, besides the APA classification, some indication is included of cases which showed dangerous anti-social (criminal) behavior.

Chapter 1

MENTAL HEALTH AND CRIMINAL BEHAVIOR: A brief historical orientation.

The activity of psychiatry and psychology in the field of crime and delinquency have become more pronounced only after the II. World War. But the interest of psychiatry, (and particularly the role the child-guidance has played in the elimination of delinquency) date back to the early days of the mental health movement in the United States.

One of the first brave attempts to receive mental patients in a facility without bars, was that one of Dr. George Zeller who, as early as 1902 was operating in the Peoria State Hospital, in Illinois, a completely open-door hospital. The Boston Psychopathic Hospital, in 1912 was the first to open an out-patient clinic for children. But, as Ridenaur describes in handbook of the History of Mental Health, the most important year to the mental health of this country was 1908. (123)

The mental health movement in America commenced on May 6, 1908 when a small group of people came together, upon the invitation of the 32-year old Clifford Whittingham Beers, to organize the Connecticut Society for Mental Hygiene. It was the first State Association of its kind. The same young man nine months later (Feb. 19, 1909) brought in New York City a similar group of a dozen people. There were instrumental in giving life to the National Committee for Mental Hygiene, later known as the National Association for Mental Health.

During the same year, 1908 the new Henry Phipps Psychiatric Clinic, the first of its kind, was opening its doors under the directorship of Adolf Meyer. At the same time St. Laurence State Hospital in N.Y. State was starting a clinic

for treatment of incipient mental cases" - the first outpatient clinic in a State mental hospital. While Clark University was getting ready to receive a great visitor, Sigmund Freud, the following summer, Dr. Henry H. Goddard was starting to use a new test-scale devised by doctors Binet and Simon, two french psychologists.

While the profession of the psychiatric social worker had not yet been created, the seeds of its growth had already been planted and the first professional social work appointment in any hospital had occured three years before.

In the midst of all this feverish mental health activity, 1908 saw another vigorous and pioneering activity which established and promoted a strong tradition of the interest of psychiatry in the field of delinquency. In Chicago, Dr. William Healy was holding the first meetings to discuss the Juvenile Psychopathic Institute he was planing to start the following year. This was the first systematic effort at the pychiatric examination of juvenile offenders - actually the first child guidance clinic in America. In 1917, Dr. Healy and his associate Brouner went to Boston to head the new Judge Baker Foundation (later known as the Judge Baker Guidance Center) which became the prototype of all child guidance clinics.

The child-guidance clinic movement started with people who were concerned about juvenile delinquency. In those days, even as now, juvenile delinquency was a grave problem, and dreadful things were being done to children in the name of punitive justice. The Commonwealth Fund (established in 1918) was advised in 1920 by the national committee for mental hygiene that Dr. Healy's type of work was an area deserving support and advancement. At a conference in Lakewood, New Jersey, in 1921, the Fund decided to finance a five year program on the "prevention of juvenile delinquency" to be administerd by the National Committee. The program

would create in various cities clinics modeled after Dr. Healy in Chicago. Because of the stress on juvenile delinquency, the first clinics were thought of as adjuncts to juvenile courts and were so offered to the community. The first of the Commonwealth Fund demonstration clinic was in St. Louis, where it was connected with the juvenile court.

Out of this interest of psychiatry for delinquent youths, an activit of professionalisation spread and produced two organizations which became of utmost importance. The American Orthopsychiatric Association and the American Association of Psychiatric Clinics for Children developed directly out of the child guidance clinic movement. The first was the product of Dr. Karl Menninger efforts who, during the winter of 1923, invited psychiatrists around the nation to form a new organization of "representatives of the neuropsychiatric or medical view of crime". The second, established in 1948, became the standard-setting agency for child guidance clinics.

The passage of the social security act in 1935 stimulated the development of local public welfare programs, some of which obtain grants for work on crime and delinquency prevention. A flood of exposés in the 1940's about the dreadful conditions in mental hospitals * gave an added impetus to the interest in mental health.

In 1948, the Public Health Service Act was ammended to authorize grants to the states for extending and improving community mental health services. Another development was the device for encouraging the expansion of community facilities by offering subsidies out of state funds through Community Mental Health Service

* Popular magazines, the Reader's Digest for one, published shocking articles like " The Shame of our Mental Hospitals".

Act to improve psychiatric services in general hospitals, psychiatric clinics, psychiatric rehabiliataion, consultant and educational services to schools, courts and health and welfare agencies. New York State was the pioneer in 1954. During the same year Congress gave the Children's Bureau a supplemental appropriation to enable it to expand its services to juvenile delinquency. The Division of Juvenile Delinquency Service was established in October, 1954.

Probably, one of the most meaningful decisions for the mental health clinic and the general mental health movement, has been the Community Mental Health Centers Act of 1963. Its importance transcends the limits of this brief historical orientation and will be taken-up more extensively in Chapter 4.

CHAPTER 2

AN OVERVIEW OF THE TOPIC

SOME DEFINITIONS

In the field of crime and delinquency, the term prevention has two main connotations. One is the "pure" term of prevention, meaning the application of some accepted principles attempting to short-circuit a process whose symptoms are known to herald future criminal implications with the law. The other connotation is interrelated with the practice of correction. In this case the dangerous process has not been prevented early enough and has culminated in some criminal , as defined by the legal systems, act. The aim of the corrective agencies is to prevent further criminality by rehabilitating the offender.

This report concentrates its interest, mainly, in programs whose goal and philosophy adhere to the first definition, the "pure" one, as we have called it. Henceforth , a referral to prevention will have the meaning of "pure" prevention. Occasionally, though, some treatment programs will be described if they contain "puristic" preventive elements. This is to be expected. Both prevention and treatment have the common goal of eliminating symptoms , which are alarming. to the pre-criminal case, and have resulted to some criminal act in the case of the offender. Therefore, the exchange of knowledge between the two fields in inevitable and since there is hardly as much activity in prevention as in treatment, what we do know about treatment should be useful to prevention. Work with repeaters is especially useful to prevention, when dealing with identifying common significant characteristics among repeaters. This might become, a major break through for preventive work reducing costs by permitting concentration on the most needy cases. (1)

SOCIOLOGICAL AND MEDICAL TERMS

Having hardly started this report, we are being aware that some old but important questions have already been raised. A brief discussion might be useful to clarify our stand.

Preventiom, rehabilitation, treatment and other medical or medically-related terms have been used freely, so far. This has been done because, we feel, that since our topic incorporates the knowledge of both, mental health and social science, an exchange and acceptance of each other's terminology is, on one hand, a familiarizing process and on the other a token of faith on both sides. The social scientist's era of insecurity when he made every effort he could to borrow the medical man's terminology and thus acquire some of the deference showed to the latter has long passed by. Also, the dawn of the social scientific emancipation, when he made stubborn attempts to avoid borrowing meaningful terms from other disciplines and labored over producing his own jargon, has been substituted by an era which emphazises sincere cooperation for meaningful social contribution. Preoccupation with building-up a professional ego is a luxury we can hardly afford when dealing with the dire problems of social welfare. Therefore, medical and sociological terms will be used in this report with comfort, where need be.

Another question which may be raised concerns the idea of prevention itself. Prevention implies diagnosis. Is prevention possible? What are the ethical implications of diagnosis? Do we possess reliable diagnostic tools?

A discussion and research findings on the diagnostic tools of criminality will be taken up in Chapter 4 , but some remarks concerning the possibility of prevention will be analyzed presently.

PREVENTION VS. TREATMENT

To begin with the existing activity in both prevention and treatment is far below the demanding need. "The effort to controll crime in the United States is a massive one. The cost is four billion dollars a year. Despite the size of the operation we do little research to obtain an understanding of the causes of crime, on preventing delinquency, or on rehabilitating the offender. Less than 1 % of the entire criminal justice budget is allocated for research and most of that is spent inefficiently. In comparison the Defense Department spends 15 % of its budget on research." (2)

But research and work in prevention suffer comparatively much more than treatment. In NIMH publication of Grants related to Crime and Delinquency 23% are related to prevention and about 77% to treatment.

Since twice as many first offenders, at least in the juvenile case, as repeaters appear in court, it would seem that concentration on preventing the first offense would be the most promising area for dealing a decisive blow to delinquency rates. Nevertheless, this is not the case.

Almost ten years ago, Mr. Stockwell reporting to the congress informed that there were, then, few programs set up to prevent delinquency which had been adequately evaluated with respect to effectiveness. He also added, that programs specifically designed for work with potential delinquents and with children who had already been delinquent were few. Most cities of 500,000 and over had one or more programs of this sort but few of those were large programs. (145)

Almost ten years later, the picture is not much brighter. While some effort exerted by individual institutions, foundations and states has provided the field with some valuable knowledge in the area of research and encouraging

results in the area of practice, on the national level, the field of prevention can be considered neglected.

The lack of interest can be attributed mainly to the shortage of funds. The present decade has been a costly one involving the nation in a war, the conquest of space and the enforcement of law against the soaring rates of crime and delinquency. Unfortunately, the social scientist's view that prevention is the most effective way of crime control, has not been accepted fully since the social scientists themselves have not quite managed to agree that prevention is at all possible, to begin with. Their ideological arguments become the second most important impediment to dynamic activity in the field. A discipline can hardly persuade the government to support it if it has not believed itself in its own existence.

Mr. Stockwell , in his report, informed the congress in 1960 that " The particular children who are going to become delinquents cannot be picked out by any means (test or other) now used. Delinquency is not predestined." (145) The definiteness of this statement is not justified. It implies not only that up to 1960 there had not been any definite predictive techniques, but also that such techniques could never be developed. In our discussion on prediction (Ch. 4) we will see that some good predictive methods have been developed recently and some old ones preceeding the congress' report's date have been proven quite reliable.

" Perhaps", Mr. Stockwell adds, " the group of children from among which a considerable proportion of delinquents will come can be identified but even this has not yet been proved. Insofar as such groups have been identified they have been found to contain a great many children who never get to court on delinquent charges. Setting children apart as likely future delinquents and so stigmatizing them - is apt to create the very problem whose solution is sought. For children, especially in adolescence, when they are seeking

an identity, are likey to develop the characteristics that are attributed to them by the adults they deem important" (145) This argument reminds one of the mother who waited and took her child to the clinic only after his first spitting of blood. When the first fevers and general weakening of his physical condition showed, she avoided a clinic lest the other patients there communicate the disease to him, in case he suffered only from a bad cold. It seems that Mr.Stockwell worries to much about terminology. A few decades ago, the word lunatic inspired fear. But mental health and mental knowledge have taken away from the public the fear of the word. The word lunatic evolved into a "mental patient" and today to a person who simply has problems or "goes through a life crisis". Today few discriminate against a person who visits a psychiatrist or a mental health clinic. The same applies to the terminology in corrections. The young criminal of yesterday has become the delinquent of today. This does not mean that we have to stop there. There should be effort to evolve the word into "exceptional children", possibly,if this is going to eliminate the stigma and promote a willingness to join therapeutic preventive groups and clinics. If under the title of "exceptional children" we were to classify the very intelligent and the very unintelligent, those whose family has behavior or economic problems and those who show alarming delinquent signs, by being called an "exceptional child", or whatever we decide to call them, we eliminate the social stigma and, possibly make the problem-youths themselves, feel important by having them discussed and associate with the professional personnel of the preventive facilities. No one has to attribute to them any negative characteristics. They will be addressed and treated like individuals who have unique views and attitudes and are visiting a clinic to gain

insight into their uniqueness. Young people, especially in adolescence when they are seeking an identity, they complain that no one understands them. The local mental health clinic could become the place where this type of complain is accepted, even invited, and where one can find people willing to try and understand the "ununderstood" youths.

We admit , that it can make a world of difference being called a "delinquent" or a "unique" child. But, we also believe, that the negative connotations and our unfortunate terminology should not discourage us from our most important task of prevention. It is an evolution in our vocabulary that is needed rather than a halt of our creative efforts. Much of the elimination of the stigma associated with the word lunatic has been due to the fact that such a reputable science as medicine has made insanity and mental problems areas of interest in serious study. It has come to the point that seeing a psychiatrist today is quite respectable and fashionable. It is being called " getting insight into one's character". Having our delinquents visit a mental health clinic and attend therapy with other "exeptional children", under the supervision of a psychiatrist or social worker, may very well eliminate the stigma associated with having contact with the police, the courts or the local jails.

Most pre-delinquents come from the poor and deprived socioeconomic classes and city neighborhoods. Even for those children, whose alarming delinquent signs may never result into actual criminal acts, the mental health clinic has the potential to add something to them in terms of insight and self-knowledge, they may never had the chance to acquire otherwise. It is the contact with the professional personnel and the therapeutic enviroment which is more important than the chance to get together with other fellows

and exchange information of how to break into the local vending machine more effectively.

Another of the impediments to the progress of prevention is the type of argument presented by Mr. Stockwell to congress as follows: " If in spite of this danger, it were thought worthwhile to make the attempt to involve all the identified children and their parents in social psychological treatment, the attempt would probably fail because: a) The numbers to be treated would be too large, b) Treatment must deal with current problems not future contingencies. Many of these children and their parents would have no sense of problem in this area, present or future since much of the behavior considered indicative of future delinquency (fighting, swearing, truancy, smoking at early ages, associating with delinquents) is regarded as normal in the segment of society in which they live" (145)

To counteract his last argument first, research has shown (see our discussion on "Work with Families"), at least in the last decade, that work with families of potential delinquents has been very succesful. As a matter of fact, the many projects indicating success has persuaded us to make such practice one of our most important recommendations for present and future programs.

Also, to say that a comprehensive preventive program would be too big to handle is a defeatist attitude. The nation which enabled men to tread the "Sea of Tranquillity" should be able to provide the money and the personnel to create tranquillity on the streets of its cities. At least, this is the attitude the correctional men should have, if progress is to be made. The argument, that we do not know enough or we do not have enough money to

prevent crime, is a poor excuse for ignoring those who are killing and maiming each other three blocks away from the U.S. Senate Building. The question is not how much we know or how much we can spend but whether we have the courage to use what we do know and putting ideological issues aside, persuade this nation to provide us with what we do need.

JUVENILE DELINQUENCY VS. ADULT CRIMINALITY

While this study has aimed to embrace both juvenile delinquency and adult criminality with an equal degree of interest, a look at our reference list or a count of the programs discussed will reveal quite an imbalance in favor of juvenile delinquency. This is a true reflection of the state of affairs in prevention research. In NIMH publication of Grants related to Crime and Delinquency 83% of the projects deal with juvenile delinquency; 17% deal with adult problems. By juvenile or youth projects we mean those dealing with youth below the age of 18 - 19. If we were to exclude presentation of a number of juvenile or youth program with the purpose of avoiding imbalance of interest, then this report would be a very short one. The uneveness in interest is reflected not only by the mere numbers but also by the great variety of juvenile programs overwhelming the limited adult ones concentrating mainly in alcoholic and drug-addict projects. This emphasis on the prevention of youth criminality has, besides its historical origin, * some more profound theoretical and practical justifications.

* Dr. Healey, in 1908, was one of the pioneers in prevention through psychological treatment of youthful offenders. (see discussion in Chapter 2)

First of all, the interest in juvenile prevention is a result of the alarming and increasing rates of youthful offenses. During the preceeding decade 1950 - 1960 , in this country, while the population of 10 - 17 year olds increased 50 %, the rate of reported Juvenile Delinquency doubled, that is, showed an increase of 100 %. Careful analysis of the available data suggests that the increases are not anticrafts of better reporting or more efficient law enforcement but are real. (3) Since the majority of offenses are committed by the 17 - 26 year old male population, inherent in the interest in youth is the hope that if we can prevent those who are about to become delinquent just before they become part of this highly criminalistic age span, we can eliminate a lot of crime.

The activity in favor of juvenile prevention reflects the philosophy of both, the correctional and mental health experts. It is believed by both, that the most effective time for prevention for emotional or behavior disorders is during childhood. (4) Not to be ignored, of course, is an inevitable emotional - humanisitc atttitude toward the young offender, blended by elements of compassion for the waste of his youth, the belief in the immaturity of his judgment and the convinction that he is much more of a society's victim than the adult, presumably, "sophisticated" criminal. Thus, a stronger emphasis on juvenile research and action programs.

FEMALE CRIMINALITY

It will be noticed, that our report describes few female programs as compared to the ones designed for the male criminal population. This again reflects the lack of interest and activity in the field of female prevention.

Preventive social defense is most active when dealing with the possibility of a violent attack. This is one of the major reasons female prevention is poorely

attended to. The majority of female violators do not commit violent or physically dangerous crimes. Drunkness, prostitution and a variety of sexual offenses in the adult, and incorigibility in the young woman are the most frequent offenses with which they disrupt the social order. These are not offenses which threaten directly the general public. These are aberrant acts which while they raise the moral indignation of the public, they are considered most harmful to the individual offender herself. Prostitution and other sexual offenses have come to be looked upon with tolerant contempt.

Also, since the criminal motives and psycho-make-ups of female offenders seem very perplex and very little work or knowledge exists in the field, researchers are reluctant to attack an area about which hardly anything substantial is known.

RECOMMENDATIONS

1) Prevention can learn a lot from treatment. Work with recidivists may lead to identifying common significant characteristics among repeaters. This will be of great help in classification which in turn will reduce prevention costs by concentrating on the most needy cases.

2) The concentration of many coordinated forces is the best way to deal with prevention. Psychiatry, psychology, sociology, social work and other helping professions have significant contributions to make, either in the area of research or in the practice of prevention. The multidisciplinary approach to prevention is highly advocated.

3) Ideological and other arguments should be kept private within the house of prevention. A unified front should be presented to the public and every effort made to persuade it that prevention is the best and least expensive way of combating crime.

CHAPTER 3

A CLASSIFICATION MODEL

What type of pre-delinquent or pro-criminal should a mental health clinic accept as client? Theoretical guidelines do not exist. The only indication of the types of clients accepted is provided by the clinics' practice of accepting and rejecting this practice is far from uniform and quite inconsistent. This does not reflect a flexibility but rather a lack of clearly understood valid admissions criteria.

Does the woman who feel a very strong obsession to shoplift belong to a mental health clinic clientele? Most probably, yes. But this is an easy case to define. How about the psychopathic personality or the low class youth who has just joined a violent gang? Is it the clinic's duty to treat the well behaved church-going, straight -A 6th grader, who is the pride of his Kentucky-placed community, and two hours every day, after school help his father like an obedient son, make moonshine? How about the citizen who feels confused and ready for anything in the midst of a culture which has failed to provide him with any proper guidelines of behavior?

All the above and many other cases constitute potential criminal or delinquent individuals. Is the clinic to accept all these cases? Or just some of them, and if so, which ones? As we have indicated the answer to this has been vague so far and this has been an impediment to treatment and a confusing element in admission policies. Forthis reason, we are proposing, here, a system of classification of potential offenders which, we hope can help improve admissions policies and enable specific cases to be fitted to programs designed specifically for their needs. We believe that, during a group therapy, for example, the exploration of the gang leaders motivation for violence is not

going to be relevant to the Kentucky moon-shiner, and vice versa. Individualized treatment is advocated here, and such a goal requires the particular guidelines of a classification system transcending the limits of the established psychiatric terminology.

We can classify pre-criminals and criminals themselves into three broad categories based on criminogenesis. *

Environmental Criminality: This is the first dimension of our model, and includes all those whose delinquent or pre-delinquent behavior, is the result of environmental approval and encouragment. Here we include, all those individuals whose delinquency is cultural; all those whose antisocial behavior is a result of a learning process which is considered "normal" in the environment they were brought up. Here we classify persons whose **emotional life and every day activity is in accord with their cultural** cultural environment to which they are well-adjusted. They do not feel any particular psychological tensions or conflicts. Their criminality is not the result of any psychological maladjustements but one of the ways of becoming an intergral part of their immediately surrounding culture. It is not they, who are at odds with their culture, but it is rather their culture which is a odds with the norms of the society at large.

* The author is grateful to Dr. P. Legins, Professor of Sociology and Director of the criminology program at the University of Maryland, for exposing him to the model and clarifying its details in various seminars and private discussions.

Here belong cases of cultural isolation, like the moonshiners' culture of the Kentucky hills, already discussed, and cases of city-located subcultures, like the subculture of the juvenile gang and the racial or slum ghettos.

To attempt psychoanalytically oriented therapy, in such cases, constitutes a misdirected and useless approach. Most of those types of offenders are well adjusted psychologically with themselves and their immediate environment.

The best approach toward prevention is based on re-education. Pre-criminals must be treated (re-educated) individually and in groups, and in the case of pre-delinquents, their parents (carriers of the deviant culture) have to be included in treatment. In addition, the main effort of the preventive agencies must be to change those aspects of the environment of children that are conducive to crime. As a last resort, the pre-delinquents' transfer out of the criminalistic subculture must be considered and attempted.

The preventive elements in such cases are mostly educational and therefore, schools and other socio-educational services would seem to be more suitable for the task. The mental health clinic can contribute to this task with group therapy, sessions, educationally rather than psychoanalytically oriented. Guttmacher finds group therapy of such cas very effective. He approximates that 75 to 80 % of all criminals fall in thi group. (69)

Psychological Criminality: Here are included all anti-social persons whose deviency is a result of a psychological maladjustment or organic defect. Here we consider neurotic, psychotic and psychopathic personalities coming from all socio-economic strata.

Their aggressive acting-out is the result of emotional disturbance. Their particular environment does not, necessarily, have to be anti-social. Here there is no break between the delinquent's social environment and the society at large, but rather between the delinquent and his immediate environment or the extended society.

In the case of the anti-social personality living within the boundaries of a criminal subculture, his delinquency is in accord with the behavior of his immediate culture. His criminiogenesis, though, is psychological in nature.

Psychotherapy is the best treatment here for preventive purposes.

There is evidence that programs dealing with neurotic individuals or with children caught in transient family or parent-child crisis are quite successful. These cases can be handled easily by the mental health clinic.

The behavior of the psychotic is quite unpredictable. His ego is overwhelmed by primitive aggressive drives.

The role of the clinic in preventing psychotics from committing offenses consists of making sure that those clients are committed to mental hospitals, where proper treatment and restrain can be exercised. Psychotics do not constitute a big problem in criminality. Guttmacher calculates that only, about 1.5 - 2 % of all criminals are psychotics. (69)

The organically or constitutionally pre-disposed (retarded, epileptics etc.) constitute a very small portion of the criminal population and the clinic can prevent the potential criminality by identifying the organic defect and referring them to farm-type colonies which are the most effective in these cases. (69)

The psychopathic personality is the least understood and most difficult to revert from criminal behavior since its main symptoms are anti-social acts accompanied by very little or nor remorse or guilt feelings. Guttmacher estimates that 10 - 15 % of all criminals are psychopathic.

The psychopath like the psychotic can hardly be considered for out-patient care or treatment and, therefore, should be referred to mental hospitals or to institutions specifically designed for their treatment.

The role of the mental health clinic in this case can be extended to involve the after-release care of such cases.

Anomic Criminality: The third dimension of our criminogenic classification model includes the alienated individuals of a society which has failed to provide its members with clear, uniformly accepted standards of behavior and values.

In the case of alienated personality, there is not only a break between the individual and his immediate socializing agencies, not even between these agencies and the society at large. This is a case of a break in communications, among the individual, his immediate environment, and the society at large, due to lack of uniform standards and behavior.

Man feels confused, discontent, desperate, and, at times, his

desperation culminates in acts like suicide, withdrawal, drug addiction or criminal behavior. Alienation is characteristic of modern industrial nations. The implications for such an industrial giant, like the United States, can only be speculated, since actual research has yet to indicate the portion of criminals whose anti-social behavior is the result of an anomic alienated pattern of life.

RECOMMENDATIONS

1) A conceptual frame work, treating alienation as a psychosocial phenomenon, and its implications for treatment are offered for psychopathology in Israel Zwerling's book on, Alienation and the Mental Health Professions. Relevant treatment techniques include the therapeutic community, the day hospital, family therapy, and social network therapy. (169)

2) A classification model for pre-delinquents and pre-criminals is needed urgently to facilitate specialized treatment suited individually for each case. Until such is developed the system described above is proposed. The mental health clinic is fit to deal best with the psychological criminality. Its future duties must include the rehabilitation and re-socialization of the cultural criminality cases. Its function in combating alienation and anomy is limited to helping the local community become a safer and a more sane place to life, through improving mental health and aleviating its disintigration.

3) The greater percentage of delinquents and criminals fall in the environmental criminality class. This type of offender should become the major focus for development prevention programs.

CHAPTER 4

PREVENTION PROGRAMS

In the following sections the presentation of various prevention programs will take place. Instead of presenting the elements of similar projects briefly, we have analyzed, relatively in depth, programs which are representatives of the findings of many others.

The suggestions derived from the cases presented are those which would have been derived if various similar projects had been presented. Those programs not presented are, nevertheless, included in the bibliography for purposes of further reference.

Some of the major findings are : the importance of working with the families of pre-criminal individuals; the emphasis on the "reaching-out" and "intervention"; more dependable diagnostic tools; chemicobiological advancements for the detection of disturbed men and women; new and figorous drug- addiction and alcoholic programs; the emergence of the mental health clinic as an all-encompassing agency providing therapy, education and training of professionals and non professionals, research and consultation; the utilization of non-professionals and volunteers as crime preventive personnel in the mental health clinic; and the promising aspects of short-term and group psychotherapy.

DIAGNOSIS

Successful prevention implies reliable diagnostic tools. But possession of these tools is not enough to clear the way for a wide application of preventive principles. Among other ideological and theoretical objections to diagnosis, its legal implications are of such importance that, at least, a brief presentation of them

will be taken up along with various diagnostic techniques.

The legal arguments against diagnosis are summarized by Fornataro in the Canadian Journal of Corrections. He insists that "delinquency" like "crime" is a legal concept and not a clinical syndrom, meaning that some dispostion or judgment has been made after some law violation has been ascertained by judicial process. But pre-delinquency is a condition whose symtoms are known to herald delinquency. Thus certain symptomatic forms of behavior, which are not unlawful in themselves, may be confused with judicially determined violations of law. The bad arrangements developed to accomodate pre-delinquency are due to its defective conception. Legally no-one is a pre-delinquent. Still, in certain states, legislation has been enacted which "blankets in " their version of what constitutes a pre-delinquent with the legally defined delinquent. Under such an arrangement, "truant","incorrigible", "unmanagable", "beyond the control of their guardians" and "in need of protection" children will receive the same treatment with delinquents "In effect" Fornataro adds "the so-called pre-delinquent who may have violated no law whatsoever is treated in the same way as though he had broken the law." (55)

Such an argument implies a lack of understanding of the philosophy backing the treatment of delinquents. The point is that the state actually "protects" the delinquent, assuming the place of a guardian. The philosophy is not punitive but protective. Forantaro implies that terrible and destructive things are being done to the delinquent which the pre-delinquent does not deserve to share. In jurisdictions where the treatment of young offenders is neglected such arguments have merit, of course. But where the care of delinquents is careful and constructive the legal argument has no realistic basis.

"Thoughtful reflection" adds Fornataro" and an abundance of tragic experiences should leave no doubt about the futility of attempting to 'prevent'

delinquency by the pre-judging of individual troubled children whose behavior not legally delinquent - is a symptomatic call for help" (55)
But since the first symptoms of delinquency frequently appear, in early childhood, varying in onset between two and ten there is hope for development of techniques for early identification and reversal of the aberrant processes. (154)
A number of such techniques is presented in the following sections.

HAND-TEST: A very recent development in the psychological effort to identify violent offenders is the "Hand-Test" having a biological Darwinian basis. Its theory is that, within limits, all organisms adapt their bodies to exploit their special environment. It is conceivable that certain body characteristi facilitate the use of violence by those possessing those characteristics more than those who do not possess them. The hand-test involves the drawing and the evaluation of drawings and pictures by the subjects. Results showed that the test could pick-up 73 % of the assaultive offenders. (166)

BRISTOL SOCIAL ADJUSTMENTS GUIDES: D.H. Stott of the University of Glasgow found that the Bristol Guides are highly predictive of adult criminality in boys and girls tested in youth. (134)

THE GLUECK SOCIAL PREDICTION TABLE: This is one of the most controversia predictive instruments. Charles Prigmore and Michael Hakeem found that the scale lacks rater reliability, that is the rater's characteristics affect the scale.

They, also found that the inferential Glueck factors, **particularly those con-**cerned with affection, lack reliability.

Still, the scale has been validated by the New York City Youth Board which found a good deal of reliability among raters.

The foreign literature examined is quite favorable toward the scale.

MEDICOBIOLOGICAL TECHNIQUES: About 3 % of the population of **this country can be considered retarded. Retardation is not a serious causitive factor in criminality. The retarded child though, may drift into delinquent** behavior as a result of his association with delinquents who may use him in purpose, since hardly anyone would suspect him. He may also commit an offense due to his inability of absorbing societal values and distinguishing right from wrong. Another way the retarded can cause crime is by becoming the easy victim of criminals.

The percentage of offenders found retarded is small. Gutmacher gives us a rate of 0,6 %. (69)

But even this number can be eliminated by arresting retardation itself. Some very significant advancements in this area have taken place recently.

One by-product of a series of investigations on the metabolic factors associated with mental retardation, was the development of a simple and inexpensive means of testing for metabolic disorders in a large number of newborn infants or older children. (162)

In other research, a test has been developed which detects the presence of phenylketonuria, a cause of mental retardation, as early as the second day of life (163)

A study showed that 53 % of distrubed children had abnormal EEG patterns; of the psychiatrically normal children, none. (162)

DIAGNOSIS THROUGH FAMILIY EXAMINATION : The importance of examining and working with the families of distrubed, acting-out individuals is supported by many studies.

An NIMH supported project has indicated that the nature of partholo-gical interactions within the family can be used, not only to detect the presence of schizophrenic and neurotic disorders but, also, to identify the forms they take. Some of the pathological interactions can, possibly, take the form of violence and antisocial behavior. Data about patients and families have been used to determine successfully which patient was brought up in which family, although the therapist had no such knowledge originally. (149)

Researchers are working on a means of making family diagnoses and quick classification according to a family's style of interaction and method. of decision making. (149) These diagnoses are made at the very start of treatment instead of much later, as in the case of most research in the area to-date. Such diagnoses might eventually make possible a carefully structured short-term family group therapy - a group therapy by prescription. (149) Short-term family therapy, as will be seen later has been very successful and promising.

ART: A new method for identifying disturbed families rearing potential offenders and neurotic individuals is studied by Lynan Wynne who examined family interactions through art therapy . Art media are used to facilitate

expression and communication in families seen together by the art therapist and a psychiatrist or social worker. (149)

A research experience in which interaction and involvement with not only the family but the total social milieu of a pre-delinquent has been quite gratifying. The interesting point here is that the diagnosis was made by teachers having no formal training in detecting potential delinquents.

The purpose of this project, involving a series of studies using the Atlantik Street Center Recording System, was to evaluate the impact of community treatment on the acting-out behavior of an experimental group of 54 seventh grade boys from the "high risk" population in central Seattle as compared to 54 plus boys assigned to control groups. Comparison of the experimental group to the control group offered the pre-service and two year service period of the test phase has indicated that there is essentially no difference in the frequency of school disciplinary contacts, that there is a trend favoring a reduction in the severity of the type of school disciplinary contacts for the experimentals, and that by the end of the project there was a significant difference in the average severity of disciplinary contacts for the experimental group as a whole in the school environment. A short questionnaire given to teachers in the two schools indicated lack of awareness of those boys who had been selected and participated in the experimental program. Therefore this difference in the average severity of disciplinary contacts cannot be credited to favorable labeling on the part of teachers. Supported by the investigation was the hypothesis that the treatment did significantly reduce the acting-out behavior of those experimental boys who were predicted to be high in acting-out behavior by the sixth-grade teachers, in comparison to their control counterparts. The differential impact of treatment on those manifesting anti-social behavior is suggested [illegible]

worker was assigned two groups to employ group work, casework, and community organization methodologies in the attempt to intervene aggressively in a "client system", i.e., in his social functioning as he interacts within the social structure, plus tutorial services, house repairs, medical and dental services, employment, food, clothing and budgeting services. (77)

OTHER DIAGNOSTIC EFFORTS: The Johns Hopkins Psychiatric Clinic for Children has been looking for more objective diagnostic means. Among the numerous measures being studied are the answers to a symptom questionnaire filled out by the parents of 400 disturbed children treated by the clinic. The questionnaire lists 70 symptoms, or types of behavior, and the parents indicates to what extent each of those applies to his child. The analysis showed that certain clusters of those symptoms are more characteristic of one type of disturbed child than of the other. Neurotic children register high on the clusters, of factors, labeled inhibited, shy, and psychosomatic. Hyperkinetics (frequently associated with delinquent behavior) register higher on the factors labeled hyperactive, tantrum behavior, aggressive acting out, and sibling rivarly. (172)

PERSONNEL

Together with the shortage of funds,the lack of trained personnel constitute the two greater handicaps to prevention and treatment.
In the following sections programs will be described which provide solutions to the problem of personnel, mainly through the use of non-professionals and volunteers.

Inmates: Studies have repeatedly shown that volunteers and non-professional personnel can be trained to become very effective elements in prevention and treatment.
This includes inmates of correctional institutions and rehabilitated offenders who, because of their background and experience, managed to have a closer rapport with the inmate and the would-be offender.
June Morrison found that inmates of correctional institutions who volunteered to help in the rehabilitation of other offenders, identified with a non-criminal reference group and are more successful after release than non-volunteers. (106)

In the School Setting: A function which the mental health clinic, at times, assumes is the work with school volunteers.
Frustrating and unsuccessful school experiences are found frequently as causes of gang membership.

Researchers have done work at detecting and remedying ineffective functioning in the primary school child. They use volunteer teacher-aides and mature housewives to give personal attention to individuals or small groups in need of emotional or academic support. The program, also, includes the use of mental health texts by a teacher trained in mental health principles and practices, and after school schedules include assistance programs, that is, visits

at home by mature college volunteers or teacher-aides in emergency situations. (162

Non Professional Mental Health Volunteers in the Community: A program was set up by the Albert Einstein College of Medizine at Lincoln Hospital in the South Bronx which tried to integrate the community mental health and social action approaches. In using the small group approach the program sought to gain access to information pertaining to the community at large through the individuals treated. This process often involved consultation with the patients, family and the close cooperation of formal and informal organizations in the community. To this end Neighborhood Service Centers were set up within the community. Staffed by non-professionals, they were designed to bridge the gap between the hospital and the community. In 1966, three of these centers were in operation, each staffed with 5 - 8 non-professional mental health workers headed by one professional. The mental health workers were often indigenous personnel, much more able to communicate with the individuals in the community than were professional workers from outside the area.

The Neighborhood Service Center is a place where a resident may turn for guidance and help with whatever problems are of concern to him and his family. (115)

Such programs are in operation in other cities as well. The District of Columbia has one with nine centers supported by the U.P.O.

The centers to which the mental health clinic can serve as consultant, and source of training of personnel, is conceived as a decisive weapon against the alienation and helplessness hovering above the people of the cities' slums.

Trained Local Youth as Mental Health Aides: A very successful innovative volunteer program is the so-called Baker's Dozen, in Washington D.C. Its most important asset is that it is designed to be of as much help to the helped as to the helper himself.

The hypothesis of the project is that trained youth who come from backgrounds of poverty and deprivation and who are employed as mental health aides under close supervision, can provide a significant effect on the mode of problem solving and life styles of youth living in a neighborhood with high rates of juvenile delinquency and social deprivation. This influence is in term of the aquisitions of better coping skills and overall adjustement on the part of the youth who are treated and serves a more effective, preventive and therapeutic function than more traditional forms of treatment for both the youth served and those trained and employed.

The aim of the project was to test a new approach to the prevention and treatment of mental health problems of youth from disadvantaged backgrounds through utilization of trained indigenous youth from similar backgrounds.

Baker's Dozen is a youth center, a new type of child guidance clinic.

8 young men and women, all of whom have grown up in this area (Cardozo, Washington D.C.) and whose families still live there, have been working for 2 1/2 years in a vigorous training program. They each have one or more groups of about eight to ten disturbed, needy adolescents with whom they work. The area has an acute lack of clinical facilities for children and adolescents. This program provides help at less cost and more effectively than it could be given by a program limited to traditional use of professionals.

The program is open almost 24 hours a day and on the weekends.

Aides, the term used for the young indigenious workers, are recruited and selected through a process of "screening in" rather than "screening out". Radio and TV announcements were made. Applicants were considered with characteris that ordinarily bar them from employment. Only a fifth grade education was required. No previous work experience was necessary. Clean police record was not a must, but it was required that no court action be pending which would interrupt the training. As to personal characteristics, the only requirements were that applicants be free of serious physical or mental problems and communicable diseases. Psychological testing was used to identify gaps and problems.

The eight trainees were subdivided into high - low risk groups, four in each. High risk youth were described a deprived youths who had had a series of police and criminal involvements, some emotional or delinquent problems, and those who may have spent time in an institution for an offense. They read at a minimal fifth grade level, dropped out of school early, worked only at odd jobs, and never worked longer than three months at any given job.

Recruits were numerous. The aides were given a stipend of $ 20.00 a week during the training period; this jumped to $ 75.00 at the end of that time. Provisions have been made to give them a GS-2 level ($4,108) and later GS 3 and GS 4. The staff reports that major changes seen in the aides can be accounted for by having steady, meaningful employment which has enabled them to support himselves and to stabilized their lives.

Major personality changes have not occured, but social adjustement has improved markedly. Both the high-and low risk groups performed well and, with the exception of one boy who dropped out early owing to trouble with the police, there were no essential differences.

The staff found that the aides could cope with many difficult situations and that, with the supervision provided them, they could perform many functions. (173)

This program has been more extensively described because, we feel it can serve as a model for other locations around the country.

Training Personnel: It would seem that the limited number of psychiatrists, especially those devoted to public mental health, would hinder programs like the above described, due to the lack of training personnel. But today the mental health knowledge has been successfully distributed and psychiatrists are not the only ones who can train mental health workers. Most any other member of the helping professions can assume the role of the trainer. Social workers have been used successfully in the Yale-New Haven Hospital Psychiatric Clinic to teach principles of public mental health not only to non-professionals but, also, medical residents. (128)

Retired Non-Professionals: The need for confident and caring mental health clinic personnel can be fulfilled by a large and available portion of the community population - the retired citizens.

Cowen and others found that retired people can indeed be effectively utilized as mental health aides. The experience is both enjoyable and meaningful to them. They are prepared to work diligently and are able to do do. The investigators point to the desirability of exploring other mental health relevant roles and settings in which retired people may be able to render useful service. This group of citizens has a lot of males which are badly needed in

work with children. Disturbed children exposed to this program have profited from their experience. This view is shared by teachers and aides. (38)

Preventing Alienation

to combat alienation and anomie, entire social systems have to be changed and reorganized. The role of the mental health clinic can, naturally, be a minor one in this respect and has to be limited to preventing and combating alienation in the local level.

Zwerling believes that three of the elements of community mental health programs can be effective for the treatment or prevention of alienation. These are, partial hospitalization, family therapy, and the therapeutic community.

Day hospitals and clinics permit patients to retain their identity as members of their communities, block regression, and diminish the stigma of deviance. Familiy therapy opposes the alienating extrusive pressure on a member identified as "the patient" by labeling the family unit as the target of treatment, and implicitly maintains the identity of the social unit in its focus of the equilibria in the family system.

Milieu therapy and particularly the therapeutic community, substitutes the fullest recognition of the voice of the patient in decisions concerning his own behavior and the destiny of the ward group from the dehumanizing stripping of patients of their identity and responsibility characteristics of programs of custodial care.

An emergency modality - the Neighborhood Service Center of the Lincoln Hospital Mental Health Services in a number of ways promotes the involvement of the residents of a ghetto area in group social action designed to alter their way of life and thos opposes powerlessness; it opens rational and effective behavior channels for the expression of anger, and thus opposes

normelessness. It, also, provides, through the indigenious mental health workers who man the centers, a comprehensive chain of human links to the far reaches of the bureaucratic complecities of urban life, and thus opposes meaninglessness and self-estrangement.

The centers offer the widest range of services to residents of the area;- problems of housing, welfare, unemployment, schooling and legal matters have been most prominent. The three centers (each is assigned a 559 block area in South Bronx encompassing about 50,000 people) serve 10,000 persons each, annually, with a kind of psychsocial "first aid". (169)

YOUTH PROJECTS

A recent development in work with delinquents or pre-delinquents is the therory of intervention. The aim is to reach out, seek, find and involve in a therapeutic situation the total enviroment of the problem child. Of course, the first socializing agency which has to be dealt with is the child's family.

Work with families: Researchers worked with conflicts and miscommunications observed in families of disturbed youths. Their experience was that hospitalization of patients was reduced and both children and families showed considerable improvement. (13)

Another promising project is concerned with multiple family group therapy.

Each group consists of three adolescents and their parents. The boys have done poorly at school but possess the potential to do better. They have been truant, destructive, and have been stealing.

This approach combines tradtional family group therapy (which aims to use the power family members can exercise on one another) and traditional group therapy through which members of the group can challenge, support, desentitize and educate other members. (83)

Short-term therapy had been found effective not only with individuals but, also, with families.

In the Medical School of the University of Texas Multiple Impact Therapy was tested, consisting of brief intensive outpatient treatment for families in crisis because of a disturbed adolescent.

At treatment tream and a social scientist held group and individual sessions with the family six to seven hours daily for two to three days. The main idea here is

that the use of a team of treatment - members who often disagreed openly, demonstrated mature handling of conflict and encouraged families to make their own individual judgments. Since some families can be reached best at the peak of their motivation, which in this case was imminent institutionalisation of the adolescent, the refinement, understanding and teaching of this multiple impact therapy could help expand the reach of available personnel and provide a technique that will reach many families in distress who are not amenable to traditional approaches. (65)

For years the delinquents and criminals have been considered "persona non grata" by the mental health clinic. This was partly due to the claim that delinquents resist treatment and that hard-core families do not show enough interest in their children's therapy. Experience and research have changed this view.

In a therapy program for families of delinquent boys, it was found that contrary to expectations "hard core" families were intensely interested in the treatment offered. All but one of the experimental families completed the 30 session treatment, and there were very few broken appointments. (105)

Day-Hospital Service in a Child Guidance Clinic : This is a program which provides the pleasures of school within the therapeutic setting of a mental health hospital.

Daycare service is provided to children of preschool through adolescence.

The service combines the pleasures of learning and of mastering skills which contribute to psychological growth. Care is taken to protect them from social and psychological dangers. Small group educational programs take place based on

the needs of each child, as well as, recreation and individual psychotherapy. A nurse-housemother (psychiatric nurse) acts as a mother. Treatment of the paren is also included.

This program has been found particularly beneficial to children whose disorders or family circumstances are such that school, court and other community programs could not maintain them in the community. (45)

Cambridge-Somerville Youth Study: This was a very comprehensive project which gave an average of five years assistance to each boy. Although it is not a mental health clinic program its findings can be of great value to preventive work in the clinics.

Three forms of analysis were used to check the efficacy of the project in preventing crime. In the first form, 253 boys were compared, who had received treatment with 253 carefully matched in personality and background, who had received no special treatment. In this comparison it was found that the general program- consisting in guidance for the family, medical and academic assistance for the boys, coordination of community agencies, and supplementary entertainment of the boys - had been more effective in crime prevention that other community services.

Then attension was focused upon variations within the treatment group. Negatively it was found that neither the change in counselor nor the length of treatment - which, for many boys, was shorter than had been planned - could be held responsibl for the failure.

There was evidence that the program might have been more succesful had a greater number of boys been seen at least once a week by their counselors and had treatmen

been started during the first decade of the boys' lives.

Male counselors (furnishing a masculine model for the boys) were apparently as affected as female.

Female counselors (satisfying the rejected child's desire for maternal care) were more successful with very young boys (five to ten) although they were less effective with adolescents.

The main conclusion of the project was that, intimate, long-term, "supportive" counseling may prevent crime. (95)

DRUG ADDICTION PROGRAMS

The drug addict besides violation the law by the mere possession of drugs, he grequently commits criminal acts to support his expensive "habit". Especially when he comes from poor social envrionments, he has to steal, burglarize or rob, or become a peddler of narcotics himselve in order to buy the quantity he requires daily. A $ 200.00 or $ 300.00 a day habit cannot be supported by the rewards of legitiment employment. Studies have shown that drug addicts are generally convicted of larcency, (shoplifting) burglary and a few, in more violent crimes, to obtain funds to support their habits. A survey of cases, with addition histories, indicated that only sixty percent were sentenced for violation of the narcotic statutes. The other forty percent were for other criminal violations.(60

The rehabilitation of drug addicts is notoriously difficult and the results of many programs extremely discouraging. This can only mean one thing; that we know very little concerning the psychopathology of addicted persons and much less concerning their treatment.

During the present decade, voluntary agencies supported by large public grants, are the major force in developing new techniques for rehabilitating narcotic addicts. Their aims are to attack the underlying cause of addiction, help addicts in their disintegrated neighborhood and fight addiction with methadone and other supportive aides (37). **The mental health clinic is seen as the agency appropriate for the administration of these services.**

The California Experience: Here are the experiences of two Narcotic Treatment Control Units, one in the California Institution for Men at

Chino and one at San Quentin.

The program assigned parolees with a history of narcotic use to 30 men caseloads supervised by specially trained officers. It, also, included weekly narcotic detention testing of the parolees and mandatory short term reconfinement and treatment for those detected reverting to narcotics use. Administration of nalline testing was accompanied by a significant decrease in those using narcotics and in jail and prison returns. The treatment period is 90 days. One third of the parolees were married with a medium age of 30 and an IQ somewhat lower than the general population. They first use marijuana at age 17 and heroin at 20. 50 % were committed to prison for non-narcotic offenses, mostly crimes against property. Sex offenses, assault and homocide constituted less than one percent of all offenses.

It was found that those who adjusted well after release had the following characteristics: over 35, married, caucasian, with average or better intelligence and a 6th or higher grade education. Their first use of narcotics took place after they were 18 years old.

Length spent in prison had no significant relationship to parole outcome and neither did the number of prior prison commitments. The comparison of this group of parolees with another to which no nalline testing was administered is as follows:

	Experimental	Control (No Nelline)
	6 months after release	
No detention or offense	52 %	64 %
Short-term reconfinement	31 %	6 %
More than three day-jail sentence or prison term	17 %	30 %
	12 months after release	
	30 %	37 %
	31	9
	39	54 %
	18 months after release	
	13 %	26 %
	34	5
	53	69

For women, at the end of one year, 53% of the experimental and 67% of the control group had received jail or prison sentences. (24)

Mobilization for Youth, Young Drug Addict Program: Mobilization for Youth has had some very disappointing experiences with the treatment of young addicsts which are very instructive for other would-be addiction programs. This project illustrates the complete failure of a theoretically very sound approach which did not come through due to poor planning.

Since group norms have tremendous influence on teenage behavior, the plan depended upon group agreement that rehabilitation was the primary goal. The boys would stay together through most phases of a fully rounded rehabilitative program - entry as a group into a hospital for detoxification; a period of time out in a country camp where work would be very important part of the program; a half way house for a period of about a year. The period of residence in the half way house would include remedial education both in an academic and vocational program. Group members would be full time workers or students. Narcotics were completely prohibited.

The researchers knowing that addiction among teenagers is to a large extent a peer-group phenomon, asked themselves the following question: Could the dynamics of this situation be inverted so that group pressures and sanctions which accompanied the entry into addiction would now function in reverse?

The hospital phase went very well, and most adult addicts in the hospital respected and helped the youngsters' effort for rehabilitation.

The camp phase, also,was very successful. The children learned to work hard enjoy themselves and stay away from drugs.

The return to the city was disastreous. Jobs were not obtained immediately. A half way house outside the slum could not be obtained so they had to stay within the slum. Later they managed to get one outside of the disintegrated area but by then most children had renewed their old habits and had relapsed back to drug usage (89).

Below will be presented an innovative program representing a new approach to the treatment of addicted offenders which emerged in the 1960's. Similar programs had been developed in California, New York and Pennsylvania.

The Baltimore Out-Patient Narcotic Clinic: This project was an attempt to change the frustrating experiences of trying to rehabilitate court referred and voluntary admissions in a state psychiatric hospital; excepting detoxification nothing more was accomplished under that setting. The use of "spot tests" of the urine by the hospital in order to determine the abstinence of narcotic abusers, although limited by their lack of sensitivity and reliability did emphasize potential usefullness of testing.

Subsequently, the introduction of a much more sensitive and reliable method of detecting opiates employing thin-layer chromatography suggested a plan for treating the narcotic abuser in an out-patient setting over whom mandatory supervision could be maintained. Hopefully, this approach would bypass the relatively unrewarding results of prolonged hospitalization and at the same tim provide an effective method of clinical control with a high degree of liability in indicating early deviation from abstinence.

With this objective in mind, an arrangement was made with the Maryland Department of Parole and Probation whereby known narcotic addicts from the male correctional institutions of the State would be paroled to the research out-patient narcotic clinic. In this setting they would be required to report nightly to provide a specimen of their urine obtained under direct observations as well as to participate in weekly group psychotherapy. In conjunction with these activities the parolee would be required to maintain a job and a wholesom leaving arrangement, and comply with all the usual conditions of the parole agreement.

The experiences of this program extend over a four year period beginning with the establishment of the clinic on June 1, 1964 to May 31, 1968. The study of the fifth year material is presently carried on.

Over the four years, 327 parolees with a history of narcotic usage were admitted in the program for six months or longer, twenty (about 20 %) were able to remain completely abstinent. The age range of these 20 was from 20 to 44 years, with 14 being 25 years old or older. This confirms the impression that the older narcotic abuser tends to respond better to treatment.

The combination of compulsory supervision and clinical control obtained through the application of thin leyer chomatographic analysis of urines for opiates provided a high degree of reliability in detecting early deviation from abstinence in parolees attending an out-patient clinic. In addition this approach allowed for a much more effective employment of the parole agents assigned to the program. They could intervene much more promptly if a parolee was slipping back into increasing drug usage and prevent the subject from becoming involved in new delinquencies. Furthermore, there was no patient who became readdicted to drugs while on the program (85).

Another similar project in Philadelphia was more successful and provided a wealth of findings, especially concerning the type of addict most suitable to treatment.

The Narcotic Unit of the Probation and Parole Office of Pennsylvania.

The Narcotic Unit of the Philadelphia Office of the Pennsylvania Board of Parole was established in 1960 by the Board of Parole.

Dr. Kurt O. Konietzko, a psychologist, set up and directed a permanent program using an experimental, flexible design to determine recidivism rates for addicts and to develop effective community controls and therapy methods that would reduce these rates.

Five trained parole officers with small case loads (maximum -25), gave the addicts close supervision on parole which included the frequent but irregular taking of urine samples.

As the project continued, a treatment maze method attempts to teach structured the parole environment into a learning situation with a series of choice points and subsequent punishments and rewards depending on the choice the addict makes. The learning maze method attempts to teach the addict that his behavior and choice of action controls the Parole Board's responses. With this method, the addict becomes aware that he is responsible for the consequences of his actions.

Mandatory Group Therapy was the general method of treatment conducted by a psychologist with a trained field investigator.

The treatment approach is eclectic and is based on learning theory and group dynamic principles, verbal and non-verbal desensitization techniques and the basic theory and techniques of Rational Emotive Psychotherapy (Ellis) The essential aim of therapy is to teach the addicts to break their self-defeating patterns of behavior, to learn new coping behaviors, and to develop a new philosophy of life.

It is believed that Mandatory Group Therapy has a socializing affect on criminal personalities by reducing the number of crimes they commit, by inhibiting a return to drugs for a longer period of time, and by changing the assaultive type of crime committed to crimes against property. Since the criminal and inadequate personalities pose unusual and difficult problems to correct, it is believed that more specialized treatment methods must be

utilized before long lasting of permanent changes can be made.

Some of the findings were:

Inadequate and Criminal Personalities make a poor adjustment on parole; where as, the Cyclical, Situational and Depressive addicts make a favorable adjustment.

However, even the Inadequate Personality with more than 120 hours of institutional therapy (twice as much needed by other personalities) tends to make an acceptable adjustment on parole.

The Criminal Personality who is traditionally anti-treatment apparently is successful in avoiding therapy in an institutional setting.

The more institutional therapy the better the adjustment on parole. No personality with less than 60 hours of institutional therapy received a good rating by his parole officer.

There appears to be a direct correlation between the number of hours of therapy and positive adjustment on parole.

By October 1963, Dr. Kurt O. Konietzko had decided to initiate an institutional group therapy program to provide ongoing treatment for recidivists and for inmates who eventually would come into the narcotic unit. The institutional move toward treatment provided the Philadelphia Narcotic Unit with a complete treatment cycle not found with any other treatment program in the United States.

In general, addicts exposed to institutional therapy respond much better to parole supervision than inmates not exposed to treatment. It is estimated that it takes approximately one year to break through the passive agressive defenses of addicts not initially exposed to institutional treatment. Institutional treatment from this standpoint alone is valuable. The parole

agents report parolees who have had institutional therapy are more flexible, cooperative and by and large rapidly establish more appropriate rapport with parole programs. With parolees who have had no institutional therapy, treatment in the community setting must be toned down considerably, and anxiety producing situations must be minimized because they may not show their anger to the therapy situation, but they may act it out against the community.

The results for the first eight month with these 33 cases appears phenomenally high and successful - 87.9 % success. The failure rate picks up after this period and results tend to stablilize again about the 50 % figure after another 6 months. The failure rate for drug use however, continues to remain low, but the crime rate picks up. In other words, addicts exposed to institutional therapy tend to stay away from drugs, but continue to commit criminal acts. Criminal activity appears to be of a minor nature (usually against property) in the form of larcenies.

There appears to be little if anything negative concerning the institutional therapy program conducted by the Pennsylvania Board of Probation and Parole, and those involved in it are convinced it has added an essential dimension to the eventual readjustment of the addict to fruitful community functioning. (60)

PSYCHOTHERAPY

A recent and pleasant finding is that lenghty individual psychotherapy, wh ich both expensive and time consuming, is not necessarily more effective than short individual or group therapy.

John Ryan found that delinquents, especially from minority groups and the lower socio-economic classes are highly resistant to individual psychotherapy (170).

The solution of the resistance to individual psychotherapy of antisocial adolescents was attempted very successfully in an experiment described by Stranaham and Swhartzman.

Experience has shown that young delinquents lack the insight of the adults, have a flexibility more sharply fluctuating, and goals for their own changes and growth that shift all too easily and suddenly.

The prupose of the experiment was to develop techniques of group therapy which could be used with adolescents who were unsuitable for individual treatment and for whom there were no appropriate community resources. When the time came and the therapy groups were disolved the youths were ready for individual therapy. The individual care is still needed since they return to their unhealthy, unaltere milieu with increasing demands of maturity.

After three years only about 5 % had become known to correctional institutions. 3/4 had reported back to the program about having jobs and they were surprisingly satisfied and dependable in their attitudes about work. 1/4 of the treated groups finished high school and a few went to College. Theseresults are extraordinarily good especially since those children had received a very poor prognosis. They represented the most likely court, correctional, mental hospital and public

relief cases of the future. Some who left school returned to the program for help in going to night school to continue their education. (135)

Group psychotherapy becomes very successful when combined with vocaiona treatment. A follow-up study, two and three years after treatment was terminated of boys participating in a special comprehensive vocationally oriented psychotherapeutic program, revealed that major improvements in ego functioning continue in all areas, academic learning, personality attitude and overt behavior. However, the rate of improvement seemed to decrease after formal psychotherapy had stopped. In the untreated group. the passing of adelescence tended to reduce some of the intensity of the antisocial behavior, so that a small minority of the boys began to show some improvement in ego functioning. The great majority of the untreated boys, however, showed marked and continued deterioeation over a long period of time; some served prison sentences as adult criminals. It is clear that the innovative psychotherapeutic approach based on recent theoretical developments in the treatment of chronic delinquents of adolescent age, especially those in lower socioeconomic groups, not only brought about basic personality changes during the treatment period, but also initiated a process whereby the individual on his own could continue to grow and improve in his adaptation to the world. (171)

Dr. Eisenberg, at the Children's Psychiatric Clinic at Johns Hopkins Hospital, compared the results of no-treatment and brief psychotherapy groups. The control group was a consultation-only group. After the intake process, three sessions of history taking and psychological testing, the parents were told that the child should do well without reatment if certain recoomendations were followed. The recommendations were tailored to the case. A mother who was exceptionally harsh or punitive might be advised to show more firmness. Parents

might be given suggestions for improving relations with each other. The point is that the consultation was limited to one 30-minute period, at the end of which the parents were assured that the child's condition would be checked again after two months.

In contrast, the experimental group was given brief psychotherapy, defined as five additional interviews lasting from 45 minutes to an hour. During those periods the child was seen by psychiatrist, and one or both parents by a social worker.

On measures of friendliness and aggressiveness, derived from the mothers' description of the children on a rating instrument known as the Clyde Mood Scale, the children in the psychotherapy groups showed a greater change for the better than the others.

The results of this investigation strengthened Dr. Eisenberg's conviction that psychiatric clinics should place considerably more emphasis, in treating disturbed children of the neurotic type, on brief psychotherapy. For one thing, it works. For another, a given clinic can reach more people with it. The investigator indicates that, "brief psychotherapy makes much more sense to the parents, who in general are grateful for the statement that you will see their child so and so many times instead of the vague, 'well, it may take a long time.' With brief psychotherapy there are few drop-outs."

PSYCHOTHERAPY AND MEDICATION : Frequently, mentally suffering cases are too disturbed to benefit from individual or group therapy. Drugs have been found useful in treating or bringing these cases to a condition where they can benefit from psychotherapy.

In a recent pilot study, most of the more severly disturbed children improved on chloropromazine, a widely used tranquilizer; about half improved on another drug; none improved on placebo treatment.

Among the other children - mainly neurotic and sociopathic - the affectiveness of chloropromazine, in terms of the percentage of children who improved, differe little from that of a placebo.

Improvement in the first case seems to depend primarily on the effectiveness on the drug being studied; in the second, upon such factors as hospitalization, psychotherapy, and special education.

60 % of severely disturbed children can be moderately improved by presently available drugs. Among children in an outpatient population who were too disturbe to benefit from psychotherapy, drugs enabled 1/4 of them to go to regular schools and another half to participate in group activities and special classes. (162)

The Johns Hopkins Childrens Psychiatric Clinic has successfully treated with drugs neurotic and hyperkinetic children.

The hyperkinetic child's behavior possesses many of the alarming signs of future criminality. He is distractible and forever on the go. In school he pays attention to every disturbance rather than to the main activities of the class He does not follow directions. He is often accused of being aggressive because he does not keep his hands to himself. His parents complain that they can not manage him and are afraid he is going to get into serious trouble.

In the drug study, 40 of the hyperkinetic children were given either dextroamphetamine or methylphenidate, commonly used with adult patients as stimulants and the rest were given a placebo. At the end of the eight weeks study period, those who have been receiving a drug were rated both by clinic personnel and by teachers as significantly more improved than the others. As

viewed by the mothers, they still scored high in aggressiveness but less than before.

An impulsiveness test given to the children revealed, eight weeks after treatment, that, the placebo group showed no improvement, but the scores of the drug treated group shot up about 15 points.

Children with the lowest IQ's - all of which were within the normal range - showed the greatest improvement.

Dr.Eisenberg believes that the child who is functioning well is not going to be driven by the drug to levels of superfunction. But children with relatively low IQ's may have a better potential than the IQ scores indicates. These are the children who may be helped the most. (172)

The same group of investigators has studied the effect on drugs on delinquents. Twice within recent years the group has gone into a training school and tested the effect of psychactive drugs on delinquent boys ranging in age from 11 to 17. The first time the team used perphenazine, a tranquilizer. Some of the boys in the study were given the tranquilizer, others a placebo, and the rest nothing.

Those who got medizine, whether it was the active drug or the placedo responded with a substantial improvement in behavior.

Though the improvement lasted no longer than the treatment, the Johns Hopkins groups holds that, further research with delinquents along the line it has pioneered is a compelling social necessity.

Dr. Eisenberg does not think that delinquent symptoms can be eliminated by medication. But if youngster's anger, hostility and aggressiveness can be diminished so that instead of fighting everything he may be willing to listen to what is

said to him, then the ordinary treatment procedures might be more effective.

PROGRAM FOR ALCOHOLICS

The reason alcoholic programs are included in this report is because alcohol is much more linked with criminal behavior than it is generally thought.

Of a nationwide total of 4,955,047 arrests listed for 1965 by the Federal Bureau of Investigation, 2,225,578, or about 45 percent, were for offenses of drunkenness -- public intoxication, disorderly conduct and vagrancy. (144). The cost of America's taxpayers for the arrest, trial and maintenance in jails of these excessive drinkers has been estimated to be many millions of dollars a year.

Additional investigation is needed to clarify the significance of alcohol in more serious crimes. Police records indicate that alcohol is often involved in homicide, assault, offenses against children, and theft, but to what extent has not been established. A recent California study of more than 2,000 felons concluded that "problem drinkers were more likely to get in trouble with the law because they needed to continue drinking" (25).

Individual vs. Group Therapy: Some experienced therapists claim that individual treatment on a one-to-one basis is the most successful. Others prefer group therapy, especially when a group of patients is treated simultaneously by a team of therapists.

An outstanding example of the latter approach is the State of Georgia's Georgian Clinic in Atlanta.

With a staff of specially trained internists, psychiatrists, nurses, social workers, psychologists, vocational rehabilitation counselors, occupational therapists and clergymen of many faiths, the clinic opened in 1953. It now treats voluntary patients from all over the State, either as inpatients, outpatients, day hospital patients, night hospital patients, or some combination of these. If possible, each patient begins therapy by living in the center from seven to ten

days while undergoing an intensive diagnostic an treatment design process. The program is as follows: After physical evaluation, the patient undergoes psychiatric social and vocational screening in an attempt to determine his recovery potential. Medical management and treatment prescription is begun immediately and continued throu out the contact. A series of orientation procedures follows: The patient sees appropriate films, attends personal interviews and counseling sessions, and participates in group meetings. Each week, there are 69 group meetings, together with 16 staff group meetings. A network of occupational, recreational and vocational activities designed to aid self-expression is woven into the program. The patients themselves form a therapeutic community, earlier members sponsoring the newer and more frightened. This "acceptance attitude therapy" is an important factor in orienting and strengthening the new patient. After leaving the clinic, all patients are urged to attend group meetings regularly for at least two years in the outpatient clinic, or at a lical chapter of Alcoholics Anonymous or a community-based clinic, and to continue indefinitely if possible.

In 1964, the Atlanta clinic was capable of treating 237 inpatients a year, at an average cost of about $14.53 a day, each. Together with a smaller clinic at Savannah, it could provide day hospital or outpatient care of about 1,500 patients a year.

Chances of Recovery: In evaluating the future outlook of alcoholics, many therapists divide patients into three broad groups.

1. The psychotic alcoholics. These are patients usually in State mental hospitals, with a severe chronic psychosis. They may account for five to ten percent of all alcoholics.

2. The skid Raw alcoholics. These are the impoverished "homeless men" who usually no longer have--or never did have-- family ties, jobs, or an accepted place in the community. They may account for three to eight percent.

3. The "average" alcoholics. These are men and women who are usually still

and still are accepted and reasonably respected members of their community. They account for more than 70 percent of the alcoholics.

From the scanty information available, it would appear that the prognosis for chronic psychotic and Skid Row alcoholics is poor, and that less than 10 to 12 percent can obtain substantial aid from ordinary therapy. For most therapists, the goal of treatment is complete abstinence from alcohol, in any form and under any condition, for the rest of the patient's life. According to available information, only a small percentage--perhaps less than 20 percent of all treated patients have been able to maintian absolute abstinence for more than three to five years. In certain highly selective industrial and business groups, the rate of abstinence may be as high as 50 percent. (153).

There is no evidence that any particular type of therapist--physician, clergyman, AAworker, psychologist or social worker--will achieve better results than another. The chances for a successful outcome apparently depend more on the motivation of the patient and the competence of the therapist than on the type of psychotherapy employed The earlier that treatment is begun, the better are the prospects for success, although some patients have been treated successfully after many years of excessive drinking.

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