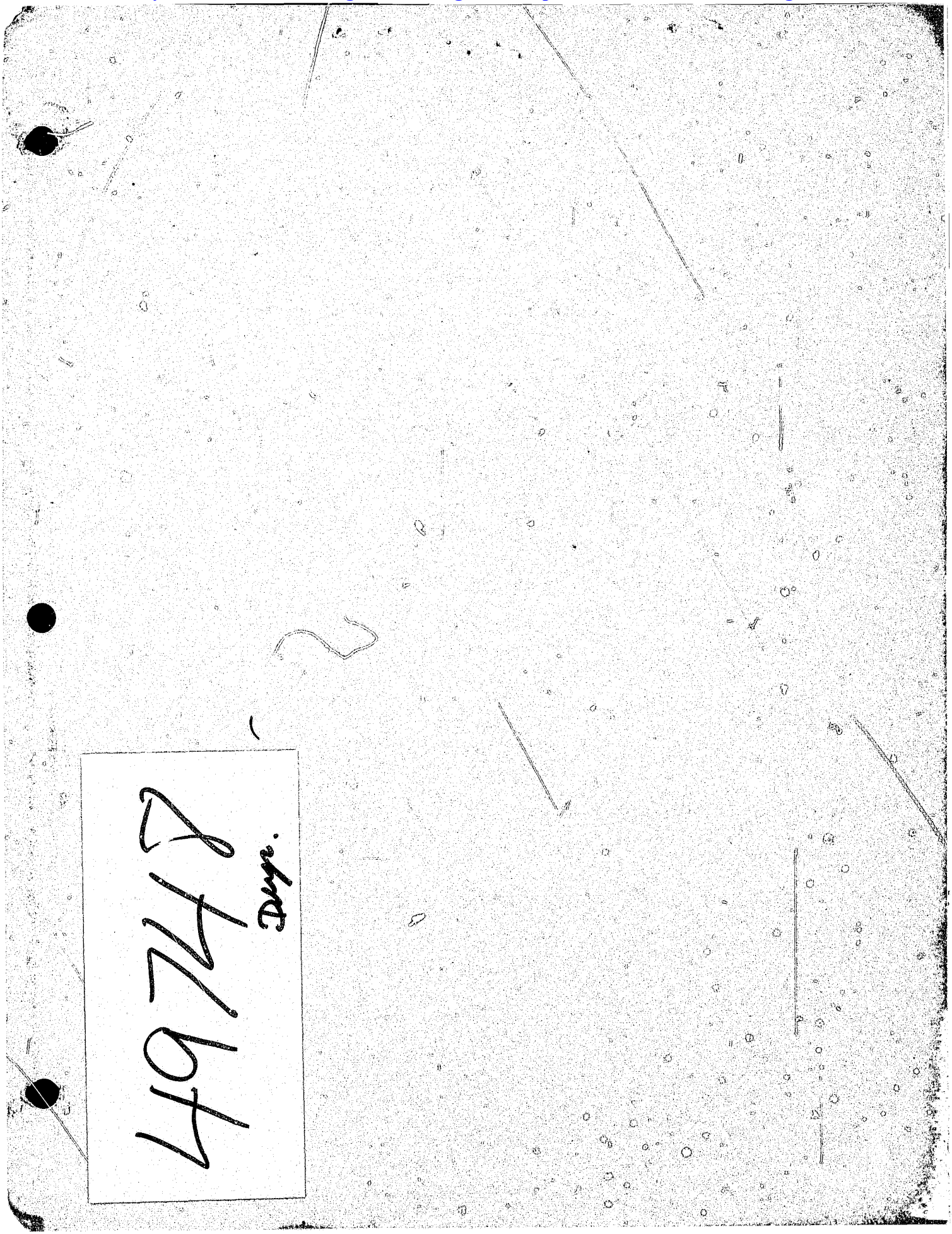

THE INTERFACE OF THE MENTAL HEALTH AND CRIMINAL JUSTICE SYSTEMS: AN EXAMINATION OF PENNSYLVANIA'S MENTAL HEALTH PROCEDURES ACT OF 1976

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CHAPTER 1. INTRODUCTION

1. The New Mental Health Legislation

On September 7, 1976, a controversial piece of legislation went into effect in Pennsylvania: the Mental Health Procedures Act, No. 143 of 1976.[1] The reason for the controversy surrounding the act was the dramatic change it brought to the existing system of involuntary commitment of the mentally ill. The elements comprising this change were the incorporation of civil and due process rights for the mentally ill and the introduction of stringent new criteria for involuntary commitment, designed to reduce substantially the numbers of people entering mental hospitals on an involuntary long-term basis.

The Supreme Court had introduced these changes into judicial law during the previous decade[2] so that, in a sense, the new legislation did no more than to formalize existing judicial law. However, judicial law is declaratory rather than imperative and is not easily enforced, especially in the area of mental health.[3] Therefore, on a more practical level, the legislative grant of civil rights to the mentally ill involved vast changes in the existing system of civil involuntary commitment. These changes are reviewed in detail in Chapter 2. For the moment, it is sufficient to mention two changes around which controversy raged. One was the increase in the power of the judiciary to decide who would be involuntarily committed, and the consequent reduction of the power of the medical profession to make these decisions. The other related change was the introduction

of stringent legal criteria of dangerousness to self or others for involuntary commitment, in accordance with the judicial fiat of Lessard v. Schmidt.[4]

Prior to the new legislation, under the Pennsylvania Mental Health Act of 1966, a wide range of behavior could have led to involuntary, indeterminate hospitalization.[5] Act 143 severely restricts in two ways the numbers of people who may be involuntarily committed. Substantively, the definition of "mentally disabled" was narrowed. A person may be committed against his will only if

> as a result of mental illness, his capacity to exercise self-control, judgment and discretion in the conduct of his affairs and social relations or to take care of his own personal needs is so lessened that he poses a clear and present danger to himself or others. (S.301)

Further, such danger must be proven by evidence of acts committed within 30 days prior to the commitment hearing. Threatened acts are not sufficient evidence (S.301). Persons with a primary diagnosis of senility, mental retardation, alcoholism or drug addiction may not be involuntarily committed (S.102). Procedurally, the act introduces strict standards of proof of the alleged condition. Decisions are made by Mental Health Review Officers who are members of the Pennsylvania bar and who are appointed by the Court of Common Pleas. Patients have the rights to counsel, to confrontation, to call expert witnesses in rebuttal, and to silence. Any procedural imperfection in the process will result in dismissal, even if the substantive requirements have been met.

2. The Consequences of Freedom for the Mentally Ill

The controversy and opposition to the new legislation derives largely from the new freedom granted to the mentally ill. This freedom can be traced to the judicial decisions which were strongly influenced by the ideology of individual freedom which typified the decade of the seventies. During this time an increased emphasis was placed on civil rights for minorities--juveniles, blacks, women, and the mentally ill. Each of these groups has in common a lack of power and has been, or is being, controlled by an identifiable group and/or social institution. Juveniles are controlled by adults and the juvenile justice system, women by men and the political-economic system, blacks by whites and the political-economic system, and the mentally ill by the psychiatric profession and the mental health system.

The stated motivation for the control is always benign, and its justification is the helplessness of the controlled group.[6] For example, in the case of juveniles, "it is claimed that juveniles obtain benefits from the special procedures applicable to them which more than offset the disadvantages of denial of the substance of normal due process."[7] Similar arguments apply in the case of the mentally ill, concerning whom the psychiatric profession claims professional knowledge and expertise which, by definition, cannot be shared with "lay" persons. Psychiatric wisdom claims that refusal to be treated is itself a symptom of mental illness. The refusal of some of the mentally ill to submit voluntarily to treatment has led

at least one practitioner to claim that "society may have to alter some of its concepts about human rights in order for us to treat effectively."[8]

Nonetheless, the judiciary has decided that the need for equality under law as guaranteed by the Fourteenth Amendment overrides the special "needs" of juveniles,[9] blacks,[10] women,[11] and the mentally ill.[12] These judicial decisions and the legislation which derives from them are thus based on ideological rather than pragmatic considerations.[13] The underlying philosophy is aptly stated by Szasz: "The real issue is not whether this practice [involuntary commitment] is effective, but whether in a free society it is morally tolerable."[14] Others, however, do not find this abstract criterion of morality applicable. The other minority groups mentioned above differ from the mentally ill in that they are capable of demanding their rights independently, whereas the mentally ill are represented by spokespersons who are not themselves members of the minority group.[15] The second outstanding difference between the mentally ill and the other minority groups is that the mentally ill cannot, like the others, take full advantage of their freedom from oppressive laws and become self-sufficient. Only Szasz and others who believe that mental illness and its consequent handicapts do not exist,[16] or those who approach the question from an abstract ideological aspect, can afford to ignore the consequences of granting civil rights to the mentally ill.

> The mental health oligopolists did not face the critical question of what would be the social costs for the community and family when they assumed a greater responsibility for the care of the mentally ill.[17]

Many of the objections raised when Act 143 was proposed were based on the "social costs" of change in the mental health system. Community organizations protested against the increased pressure on families who could no longer commit a mentally ill member to the hospital.[18] The psychiatric profession was especially vociferous in its complaints. The protests were generally expressed in terms of the exclusive expertise of the profession and centered on the substantive consequences of applying ideologically based rules to a minority population possessing characteristics understood only by psychiatrists. According to this line of reasoning, only psychiatrists could predict the social impact of the legislation, and disappointment was expressed that they had had so little input into its planning.[19]

3. The Hypothesis of Diversion

Some of the psychiatrists' objections could be traced to the reaction against the reduction of power of the profession. There was, however, one objection which was based on logic and on the experience of other jurisdictions where similar policy had been implemented. This was the claim that one effect of the new legislation would be the diversion of many mentally ill persons into the criminal justice system, by arrest for minor offenses.

There are two bases for this claim. One is logical and can be deduced from the assumption that the mental health system has traditionally been used to control deviant behavior. According to Leifer, the social control function of the mental health system has been conveniently disguised by the terminology of the "medical model."[20] Most psychiatrists, of course, do not agree with this analysis (with the noteworthy exception of Szasz).[21] We will examine this assumption in more detail in Chapter 4. For the moment, if we take as given that the mental health system has been used, covertly, to control deviant behavior, it follows that if this means of control is removed, others will be used. The major means of social control in society is the criminal justice system. It has been stated that the criminal justice system is an alternative to the mental health system--"the penal-mental health system operates as an overlapping reciprocal system for the control of deviance."[22]

It is, therefore, logical to conclude that if the mentally ill cannot be controlled by the mental health system, they will be arrested and jailed;[23] provided of course that their behavior constitutes not only a nuisance, but also a breach of the law. Chapter 3 examines this proviso and concludes that in many cases, the behavior of the mentally ill can indeed be interpreted as a violation of one or more of the less serious sections of the penal code which deals with offenses against the public order.

The second basis for the claim is empirical and is based, to a large degree, on the California experience. In 1969, California

enacted the Community Mental Health Services Act, which became known as L-P-S after its authors, Senators Frank Lanterman, Nicholas C. Petrie, and Alan Short. L-P-S brought about two main changes. One was the securing of civil and due process rights for the mentally ill and the consequent reduction of the numbers of persons who could be involuntarily committed to state hospitals. Studies on the effects of this part of the act indicate that the possibility of diversion into the criminal justice system is a real one, although no study is truly conclusive.[24] These and other studies will be reviewed in Chapter 4. They show that support for the hypothesis of diversion exists.

A second major change brought about by L-P-S was the reorganization of the delivery of health care services in the direction of county-based community mental health centers and away from state hospital care. The movement to remove the care of the mental patient away from state hospitals and into community mental health centers has been a national one which began during the Kennedy regime and which has been accelerating ever since, although not with equal speed and consistency in all states.[25] The policy of releasing patients from state hospitals into the community has given rise to protests similar to those deriving from the restricted use of involuntary commitment to dangerous individuals only. Employee organizations protest the loss of jobs, and those psychiatrists who object to such policy protest that "the state hospitals have an essential treatment contribution in the care of intermediate illness,

and especially in long-term care."[26] The issue of diversion has been raised in this context also.[27]

The development of programs to reduce the populations of mental hospitals and the enactment of legislation granting civil rights to the mentally ill are, then, concurrent phenomena. As states develop programs to move the mentally ill from state hospitals into community mental health centers, they also formalize into law the civil rights of the mentally ill. As a result, protests are directed against both phenomena, as both raise the issue of diversion of the mentally ill into the criminal justice system.

4. The Deinstitutionalization Movement and its Consequences for Diversion

The reduction of the state hospital population and the expansion of the community mental health system are matters of social policy and are generally not as visible as legislative change (with the exception of California where the systems change was legislated into existence). In fact, the reduction of the state hospital population is a gradual process which has been taking place over a number of years.[28] It is only when controversial legislation such as L-P-S or Act 143 is enacted that the issue becomes public and visible and gives rise to such statements as "precipitous and massive discharge prematurely from hospitals into communities without resources and facilities cannot be tolerated."[29] Such statements are inaccurate in that the "massive and precipitous discharge" is not the inevitable result of legislation of the type under investigation here, especially

in cases where the state hospital population has been gradually declining over the past few years.

The claim that the new legislation will result in the large-scale deinstitutionalization of patients may be due to the failure to separate the effects of policy change, which is gradual, and legislative change, which is abrupt. The degree to which the new legislation will cause deinstitutionalization of patients depends upon the degree to which existing policy has been carried out. It may simply accelerate an existing trend. If this is the case, and if deinstitutionalization has been occurring gradually, then any diversion which has been caused will have kept pace with the deinstitutionalization movement. The degree to which the new legislation will cause deinstitutionalization and the hypothesized diversion into the criminal justice system depends on the degree to which existing policy has been implemented.

Diversion could, therefore, be caused by the gradual movement of patients out of state hospitals as a result of policy change, or by the abrupt reduction of the state hospital population as a result of legislative change. The source of the diversion is important to the choice of methodology. This research is concerned with the hypothesis that legislation alone will cause the diversion and, therefore, the method is a type of "before-after" model in which two dependent variables--arrest rates and commitment rates--are expected to differ considerably following the implementation of legislative change. On the other hand, if the cause of the diversion is considered to be

the gradual influence of policy change, exacerbated only slightly by the legislation, the appropriate methodology would be a longitudinal model. Failure to support the hypothesis could thus indicate not a lack of diversion, but rather its gradual occurrence as a result of policy change. There are other reasons why diversion may not appear, and these are concerned with alternative fates of the released mentally ill. We have said above that the diversion hypothesis depends upon the assumption that the mental health and criminal justice systems are the major means of "dealing with" the mentally ill. This assumption is not, of course, proven. There are four possible alternative paths which the newly-freed mentally ill may follow.

5. Alternatives to Diversion

First, it has been shown[30] that a decrease in the state hospital population is accompanied by a rise in the population of board and care homes. Some of these homes are operated by profit-minded individuals who use restraints, both physical and chemical, on their residents. The exact proportion of mentally ill people so restrained is not known. Such restraint in a board and care home could preclude the possibility of diversion. Many such homes are located in run-down areas of the city[31] where law enforcement is not at a maximum. The low visibility of these individuals could then mean that their illegal actions may be overlooked and not officially recorded.

The second possible fate of the mentally ill is simply that they

will be left alone. We have said that most of their offenses are petty, and it is known that police prefer not to prosecute mentally ill persons.[32] Further, police cannot comply with a "full enforcement mandate"[33] and a "determination not to arrest is most common at the level of the petty offender."[34] It is possible, then, that the police will not arrest the mentally ill petty offender.

Arrest or nonarrest depends to some extent upon the existence of an insistent complainant. Community acceptance of the mentally ill in their midst is the third possible reason for the failure of diversion to occur. There is some indication that the intention of the legislature in California[35] and in Pennsylvania[36] was to create an increased community tolerance. Studies have shown, however, that the possibility of introducing social-attitudinal change through legislation is not great.[37]

Finally, the mentally ill may follow the route planned for them by the makers of the social policy--that is, to take advantage of the services offered to them by the growing community mental health system and, thereby, manage to live without coming to the attention of the criminal justice system.

6. The Social Relevance of Diversion

It is important to know whether the predicted diversion is occurring as a result of the new legislation for three main reasons. First, diversion into the criminal justice system would prove that the legislation and the judicial law on which it is based are self-

defeating in intent. The expressed intention of the courts is that "to deprive any citizen of his or her liberty upon the altruistic theory that confinement is for humane therapeutic reasons, and then fail to provide adequate treatment violates the very fundamentals of due process."[38] If substantial numbers of mentally ill persons are diverted into the criminal justice system for petty offenses, such confinement without treatment would show that the legislation has done no more than to exchange confinement in jail for confinement in a mental hospital.

Second, the question of police and court resources should be considered. If the diversion is of such an extent that it involves a substantial number of police man-hours, problems in law enforcement could result. As most of the offenses involved would be misdemeanors, a change in the ratio of the order maintenance and crime control[39] functions of the police would occur in the direction of order-maintenance. The desirability of such a fortuitous and unplanned change during a time of high crime rates and budgetary restrictions is doubtful. Again, the addition of many mentally ill misdemeanants to an overcrowded court system[40] would further complicate matters.

Third, the reduction of the state hospital population is occurring at the same time that changes are taking place within the criminal justice system nationwide. The failure of the rehabilitative ideal has been, in many ways, the moving force behind both areas of change. The mental health system has been told, in effect, to release from confinement those whom it cannot treat. The criminal justice system

is experiencing a reorganization of priorities. The current trend is to imprison "hard-core" recidivists in order to provide social protection. Rehabilitation has been relegated to a secondary role, and treatment facilities no longer occupy a place of primary importance. For example, in some jurisdictions, parole has been abolished.[41] The entry into the criminal justice system of large numbers of mentally ill people in need of treatment could create serious problems during this period of reorganization. The question of whether diversion into the criminal justice system will occur is thus also dependent upon the policy of the criminal justice system. The possibility exists that the mentally ill who reach the criminal justice system will be speedily diverted from it and will reenter the community.

It is clear, then, that the fate of the newly-freed mentally ill person in the community depends upon a number of interrelated factors and that diversion into the criminal justice system is not the inevitable result of "dehospitalization." Diversion is, however, a possibility which depends upon the factors enumerated above. Its presence or absence will, therefore, shed some light upon the total fate of the mentally ill person in the community. It is, then, a convenient starting point to answer the question, "Where have all the patients gone?"[42]

Footnotes to Chapter 1

[1]This legislation will be referred to throughout as Act 143.

[2]These cases will be referred to in the body of this and later chapters.

[3]Bruce Ennis, Prisoners of Psychiatry (New York: Harcourt, Brace, 1972).

[4]349 F. Supp. 1078 (E.D. Wisc. 1972).

[5]This act is described in detail in Chapter 2.

[6]For explications of the benign justification of the need for oppression of blacks, see Royce Singleton, Jr. and Jonathon H. Turner, "Racism: White Oppression of Blacks in America," in Don H. Zimmerman, D. Lawrence Weider, and Sui Zimmerman, eds., Understanding Social Problems (New York: Praeger, 1976), pp. 130-160. For the mentally ill see Ronald Leifer, In the Name of Mental Health: the Social Functions of Psychiatry (New York: Science House, 1969). For juveniles, see Anthony M. Platt, The Child Savers: the Invention of Delinquency (Chicago: University of Chicago Press, 1969); and for women, see Germaine Greer, The Female Eunuch (New York: McGraw-Hill, 1971).

[7]In re Gault, 387 U.S. 1 (1967), J. Fortas.

[8]Jonas Rappeport, Philadelphia Bulletin, September 26, 1976.

[9]In re Gault, op. cit.

[10]Brown v. Board of Education, 347 U.S. 483, 74 S. Ct., 686 (1954).

[11]Frontiero v. Richardson, 411 U.S. 677 (1973).

[12]Lessard v. Schmidt, 349 F. Supp. 1078 (E.D. Wisc., 1972); O'Connor v. Donaldson, 95 S. Ct. 2486 (1975).

[13]It may be argued, of course, that there are economical considerations underlying legislation which grants civil rights to the mentally ill. A particular case in point is the convenience to states of maintaining federally-funded community mental health centers as opposed to state-funded hospitals. That point is not disputed here: rather, the emphasis is placed on those sections of the law which adopt the judicial pronouncements on civil rights.

[14]Thomas Szasz, Law, Liberty and Psychiatry (New York: Macmillan, 1963).

[15]In this aspect, juveniles resemble the mentally ill more than the other minority groups, in that they are represented by spokespersons.

[16]Thomas Szasz, The Myth of Mental Illness (New York: Dell, 1961).

[17]H. Foley, Community Mental Health Legislation: the Formative Process (Lexington, Mass.: Lexington Books, 1975), p. 144.

[18]Comments made at the Third Annual Conference, Mental Health Evaluation, "The Impact of Act 143 on the Quality of Care and Patient Rights," Philadelphia, May 20, 1977.

[19]Comments made at Fall Meeting, Pennsylvania Psychiatric Society, Hershey, Pa., November 5, 1976.

[20]Leifer, op. cit.

[21]Szasz, Law, Liberty and Psychiatry, op. cit.; and The Myth of Mental Illness, op. cit.

[22]Alan Stone, Mental Health and Law: a System in Transition (Rockville, Md.: National Institute of Mental Health, 1975), p. 63.

[23]Rappeport, op. cit.

[24]See, for example, ENKI, A Study of California's New Mental Health Law, 1969-71 (Chatsworth, Calif.: ENKI Corp, 1972).

[25]H. Foley, op. cit.; Eugene Bardach, The Skill Factor in Politics: Repealing the Mental Commitment Laws in California (Berkeley: Berkeley University Press, 1971).

[26]Philadelphia Psychiatric Society, Statement of Pennsylvania's Mental Health Issues, Fall 1976 (mimeograph).

[27]H. Santiestevan, Deinstitutionalization: Out of Their Beds and into the Streets (Washington, D.C.: AFSCME, 1976).

[28]Foley, op. cit. See also National Institute of Mental Health, "Changes in the Age, Sex and Diagnostic Composition of First Admissions to State and County Mental Hospitals, United States, 1962-1972," Statistical Note no. 97, September, 1973.

[29]Philadelphia Psychiatric Society, op. cit.

[30]Eileen and Julian Wolpert, "The Relocation of Released Mental Hospital Patients into Residential Communities," 1974 (mimeograph).

[31]Uri Aviram and Steven Segal, "Exclusion of the Mentally Ill," Archives of General Psychiatry 29 (1973):126-131.

[32]Richard G. Fox and Patricia G. Erikson, "Apparently Suffering from Mental Disorder: an Examination of the Exercise of Police Power under S.10 of the Mental Health Act of Ontario," University of Toronto, Centre of Criminology, 1972 (mimeograph).

[33]Herman Goldstein, "Police Discretion: the Ideal vs. the Real," Public Administration Review 23 (September, 1963):40.

[34]Ibid.

[35]ENKI, op. cit., p. 15.

[36]Interview with Senator W. Louis Coppersmith, Principal Author, Act 143.

[37]Vilhelm Aubert, "Some Social Functions of Legislation," Michael Banton, "Law Enforcement and Social Control," and Adam Podgorecki, "Attitudes to Workers' Court," in Vilhelm Aubert, ed., Sociology of Law (Harmondsworth: Penguin, 1969).

[38]Wyatt v. Stickney, 325 F. Supp. 781 M.D. Ala. (1971).

[39]James Q. Wilson, Varieties of Police Behavior: the Management of Law and Order in Eight Communities (New York: Atheneum, 1971).

[40]President's Commission on Law Enforcement and the Administration of Justice, The Courts (Washington, D.C.: U.S. Government Printing Office, 1967).

[41]Marvin E. Wolfgang, "Changing Perceptions in Crime and Criminal Justice," Daedalus 107 (1978):143-158.

[42]California State Employees' Association, "Where Have All the Patients Gone? A CSEA Report on the Crisis on Mental Health Care in California," Sacramento, 1972.

CHAPTER 2. DEVELOPMENTS IN MENTAL HEALTH LEGISLATION, 1951 TO 1976

An historical review of developments in mental health law and commitment procedures in Pennsylvania reveals a clear trend in the direction of the reduction of the power of the medical profession and an increase in the power of the judicial profession. Concomitant with this trend is an increasing emphasis on the rights of the mentally ill.

The period to be reviewed covers three main pieces of legislation[1] which reflect increased bureaucratization of the mental health system, increased knowledge concerning mental illness, and the encroachment of the judiciary on the powers of the medical profession. It is interesting to note, at the outset, the change in nomenclature in the legislation which reflects the substantive social changes of the period; the Mental Health Act of 1951 was replaced by the Mental Health and Mental Retardation Act of 1966, which in turn was repealed and replaced by the Mental Health Procedures Act of 1976. Similarly, the place where treatment was carried out was, according to the 1951 act, a "Mental Hospital." In 1966, the term changed to "facility," a notion which apparently needed explication. It was defined as

> any mental health establishment, hospital, clinic, institution, day care center or other organizational unit, or part thereof, which is devoted primarily to the diagnosis, treatment, care, rehabilitation or detention of mentally disabled persons (S.102).

The 1976 Act drops the detention function and refers simply to facilities approved for treatment by the County Administrator (S.105). We see here the expansion of the numbers and types of treatment facilities, the centralization and bureaucratization of their administration, and a return to the emphasis on treatment, as opposed to detention.

Commitment Procedures from 1951 to 1966: The Mental Health Act of 1951

This act provided for four main types of commitment. These were voluntary, civil involuntary by physician (medical), civil involuntary by the court (judicial), and commitment of the criminally insane[2] which could be either medical or judicial. There was also a provision for a brief emergency comitment, and later amendments added the "voluntary" commitment of juveniles by their parent or guardian.

In order to commit oneself voluntarily, application was made to a mental hospital, where the director decided whether to admit the applicant. Once admitted, the applicant was free to leave at any time within ten days after he had given notice of his desire to leave (S.304[a]). The procedure for voluntary commitment has changed relatively little over the years, although the psychiatrist rather than the director has become the decision maker; and as of 1976, the voluntary patient can be held no more than three days after he gives notice that he wants to leave.

Most commitments were involuntary[3] and the criteria for commitment were, by today's standards, extremely broad. An individual could be

hospitalized against his will if he suffered an illness

> which so lessens the capacity . . . of a person to use his autonomy, self control, judgment and discretion in the conduct of his affairs and social relations as to make it necessary or advisable for him to be under care (S.311).

There standards were used in both medical and judicial commitments, the former being the predominant type.[4] The procedure for medical commitment was fairly simple. The applicant presented his sworn statement together with two physicians' certificates to the superintendent of a mental hospital who, "on receipt of an application and certificates . . . may receive and detain the person sought to be admitted as a patient" (S.311). The commitment, once made, was indeterminate, and release was obtained only at the discretion of the facility. There were extremely rare cases of release by writ of habeas corpus.

The persons who could apply for commitment were listed. They were: relative, friend, legal guardian, person having custody, or other responsible person. A 1959 addition to this list states that

> in the case of a patient having no legal guardian or available responsible friends or relatives, [application may be made by] the executive officer or authorized agent of a health and welfare organization" (Act 585 of 1959).

In the same vein, Act 316 of 1961 added a section relating to persons having no living "parent, spouse, nor issue, nor next of kin, and for whom no legal guardian has been appointed." In the case of such per-

sons, the superintendent of the hospital was permitted to "determine when elective surgery should be performed."

Judicial commitment involved a more complicated procedure. The petition was presented to the court which then appointed a commission, known as the Lunacy Commission, which consisted of two physicians and a lawyer. The Commission examined the material and then presented its recommendations to the court which, if it saw fit, ordered the individual committed. It would appear that in most cases the Commission recommended commitment and that the court followed this recommendation.[5] The period of commitment was indefinite, and release of the judicially committed patient was at the discretion of the mental hospital. The very fact that the act says nothing about release is indicative both of the informal nature of mental health procedures at the time and also of the rare use of the judicial form of commitment.[6] Both types of commitment resulted in an indeterminate detention, and it seems that there was no particular advantage in using the more complicated and lengthy judicial form.

Later amendments to the original act indicate an increase in the use of the judicial form of commitment. The original act, for example, stated that every commitment could be appealed by a writ of habeas corpus (S.351). This was amended in 1963 (by Act 429) to provide that the court receiving the petition for the writ could transfer it to the Court of Common Pleas, in the case that the court receiving the writ had originally committed the patient. This indicates the more frequent use of both the writ of habeas corpus and the judicial form of commitment.

Other amendments also indicate an increasing use of the judicial form of commitment. It was, apparently preferred in cases where the legality of the detention was questionable, as, for example, in the case of minors. The original act of 1951 made no reference to the detention of minors, and it was not until 1961 that a section was added which provided that the parents or guardian of a person under 21 could "voluntarily" commit him for a maximum period of 40 days. After this period, the minor had either to be released or to be committed by the court (Act 648 of 1961). In 1953, an amendment provided for emergency detention for 48 hours of the individual who refused to be examined. This procedure required judicial sanction as it involved an infringement on person freedom before proven mental illness could be used to justify the infringement of rights (Act 377 of 1953, S.326).

It seems, then, that judicial commitment was used in cases where the legality of the detention was questionable or, in other words, where the possibility of a civil rights conflict existed. Thus, several years later, when the legality of all involuntary commitments was called into question, the most logical move was to transfer all commitment proceedings from the doctors' offices into the courtroom. We shall see shortly that this indeed was the case. The same period reveals an expanding system of mental health services, with a concomitant formalization of procedures and centralization and bureaucratization of administration. For example, the original act permitted the court to commit the individual to "the institution named

in the petition" (S.328). In 1961, this section was amended to read that the court could commit the person to "the Department of Public Welfare for treatment in an appropriate institution" (Act 648 of 1961). In 1963, the Department of Public Welfare was given power to administer and enforce the laws relative to mental health (Act 294 of 1963). Finally, in 1965, the office of the Commissioner of Mental Health was established (Act 503 of 1965).

Among the duties of the newly created bureaucrat was the organization and training of personnel to work with the criminal population, and the establishment of psychiatric units to work with the parole board.[7] It is interesting to note that the emphasis on research made its appearance in relation to the criminally insane. Also of interest is the manifestation of more sophisticated knowledge of mental illness in sections relating to the detention of the criminally insane. For example, in 1951, the effect of commitment to a mental hospital on pending criminal proceedings was to effect a stay "until his recovery" (S.347). In 1961, this was changed to read "until his condition has improved sufficiently to enable him to participate intelligently in his own defense" (Act 429 of 1963).

This legislative recognition of the discovery that mental illness is a continuous rather than a discrete phenomenon seems to have had no impact at all on the civil sector. It would seem to follow logically that the establishment of mental illness as a "fact" is not possible, and that the most that can be hoped for is its establishment as a <u>legal</u> fact according to specific criteria. This was the case with

regard to the criminally insane in 1963, but in the civil sector it was a long and slow process to integrate this viewpoint into law. The Mental Health Act of 1966, which replaced and repealed the 1951 act, gave equal import to both medical and judicial commitment. It also repeated the teleological definition of mental illness of the 1951 act: viz., an individual is mentally ill if he is in need of care (1951, S.311; 1966, S.102). It was not until 1971 that medical certification for indefinite commitment was declared unconstitutional by the judiciary.[8] Finally, the Mental Health Procedures Act of 1976 established judicial commitment as the main procedure. Medical certification was used for three-day emergency commitments only.

Commitment Procedures from 1966 to 1976: The Mental Health and Mental Retardation Act of 1966

This Act, which replaced and repealed the 1951 act, will be described in some detail because it was during the decade 1966-76 that the judiciary made its onslaught into the field of mental health. Its effect on this piece of legislation was to render it, section by section, ineffective.

The Act provided for four main types of hospitalization: the voluntary hospitalization of adults,[9] the "voluntary" hospitalization of minors, civil involuntary commitment of adults, and commitment of the criminally insane.

Voluntary hospitalization of adults was of two types, one leading to involuntary commitment and one which could not lead to involuntary commitment. Under both sections, the individual applied to a facility,

was examined, and admitted according to the physician's decision. Section 402 allowed the individual to remain in the hospital as long as he wanted to and to leave at will. If, however, the admission was made under Section 403, the patient could remain only 30 days. If he wished to remain longer, he had to reapply. The effect of these differences on the administration of mental health facilities is not known, but in all probability it was slight.

There was another distinction between the two types of voluntary commitment and that was that that "402" patient who expressed a desire to leave had to be released immediately, whereas the "403" patient could be kept involuntarily for ten days following the expression of his desire to leave. During this ten-day period, the facility could apply for an involuntary commitment. It is therefore to be expected that the facilities preferred the "403" voluntary patient so that it could have some control over his comings and goings. There is some evidence to bear this out.

The staff manual of a large state hospital is significant in its instructions regarding the acceptance of voluntary patients because it emphasizes the 403 type. "A patient in an emergency situation, if willing to do so, can sign a 403 and be an appropriate after-hours admission."[10] It is thus easy for the admitting doctor to offer a 403 voluntary admission. However, the procedure for the 402 commitment is more complicated. The same manual goes on to say that

> many cooperative patients may be admitted under [S.402] <u>if approved</u> by the appropriate emergency service. The Administrator must then initial the form to indicate his own evaluation and approval [emphasis in original].[11]

The admitting doctor is himself not encouraged to offer the patient a 402 which involved so much more administrative work.

The OMH court records make note of voluntary commitments made at court hearings. Often the patient is offered a voluntary commitment as an alternative to involuntary commitment, and often he accepts it. In 1973, there were 1,396 hearings. Of these, 151, or 10.82 per cent resulted in the pre-patient signing a voluntary commitment. In 1974, 185 of 1,449 pre-patients signed voluntary commitments (12.77 per cent). In 1975, 12.77 per cent of pre-patients signed voluntary commitments; and in 1976 (January through August), 17.18 per cent signed voluntary commitments. The problem with these data is that the records do not always mention what type of commitment was signed. When the type was noted, it was usually a "403." Voluntary commitment of adults is represented in Figure 2-1.

Voluntary commitment of children. The same sections provide for the admission of a minor as a voluntary patient by parent, guardian, or person standing in loco parentis. The commitment is in fact not voluntary because "only the applicant or his successor shall be free to withdraw the admitted person so long as the admitted person remains 18 years of age or younger" (Section 402 [2][c]).[12]

The voluntary commitment process of children is represented in Figure 2-2. It will be seen that in the case of a child, both Sections 402 and 403 can result in involuntary commitment. This arrangement permits the indeterminate involuntary detention of a minor without any contact with the juvenile justice system. The advantage to the child of such an arrangement is debatable.

Figure 2-1

Voluntary Commitment of Adults under 1966 Act

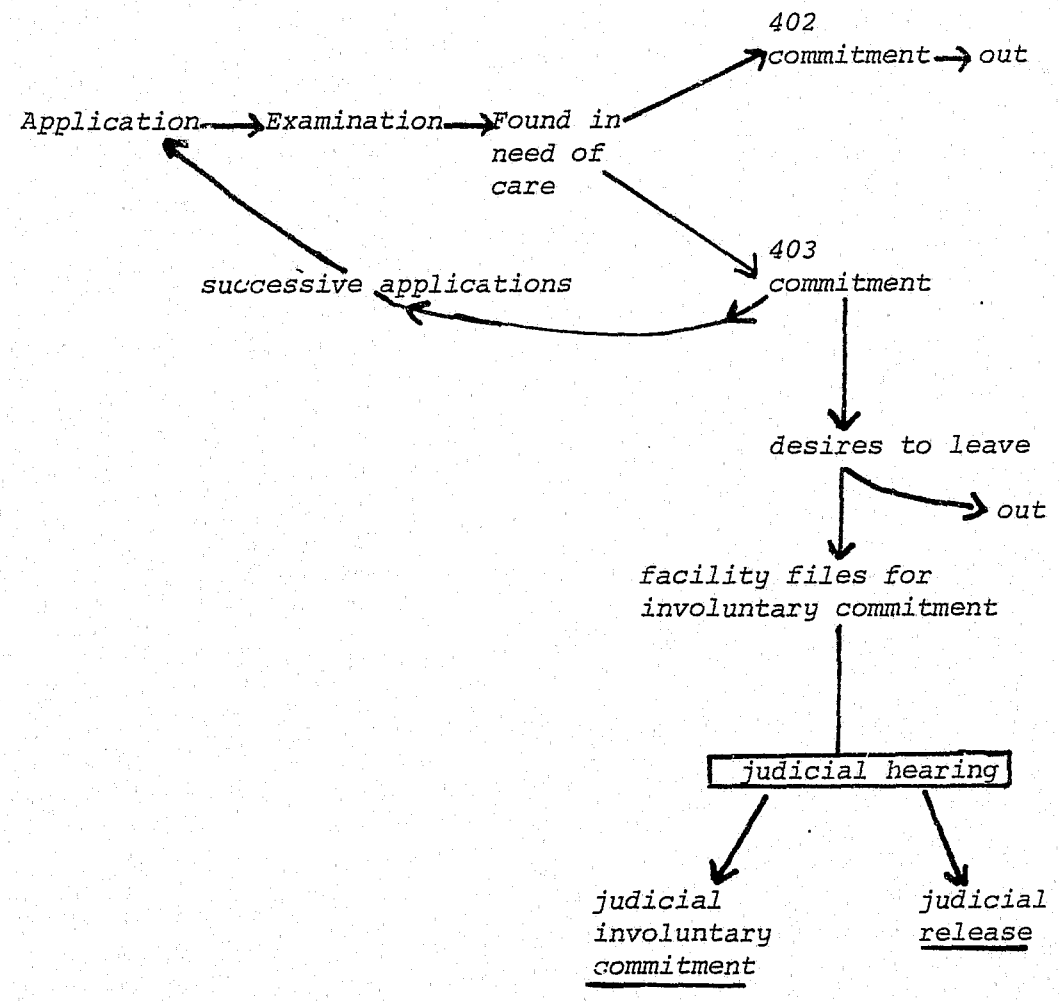
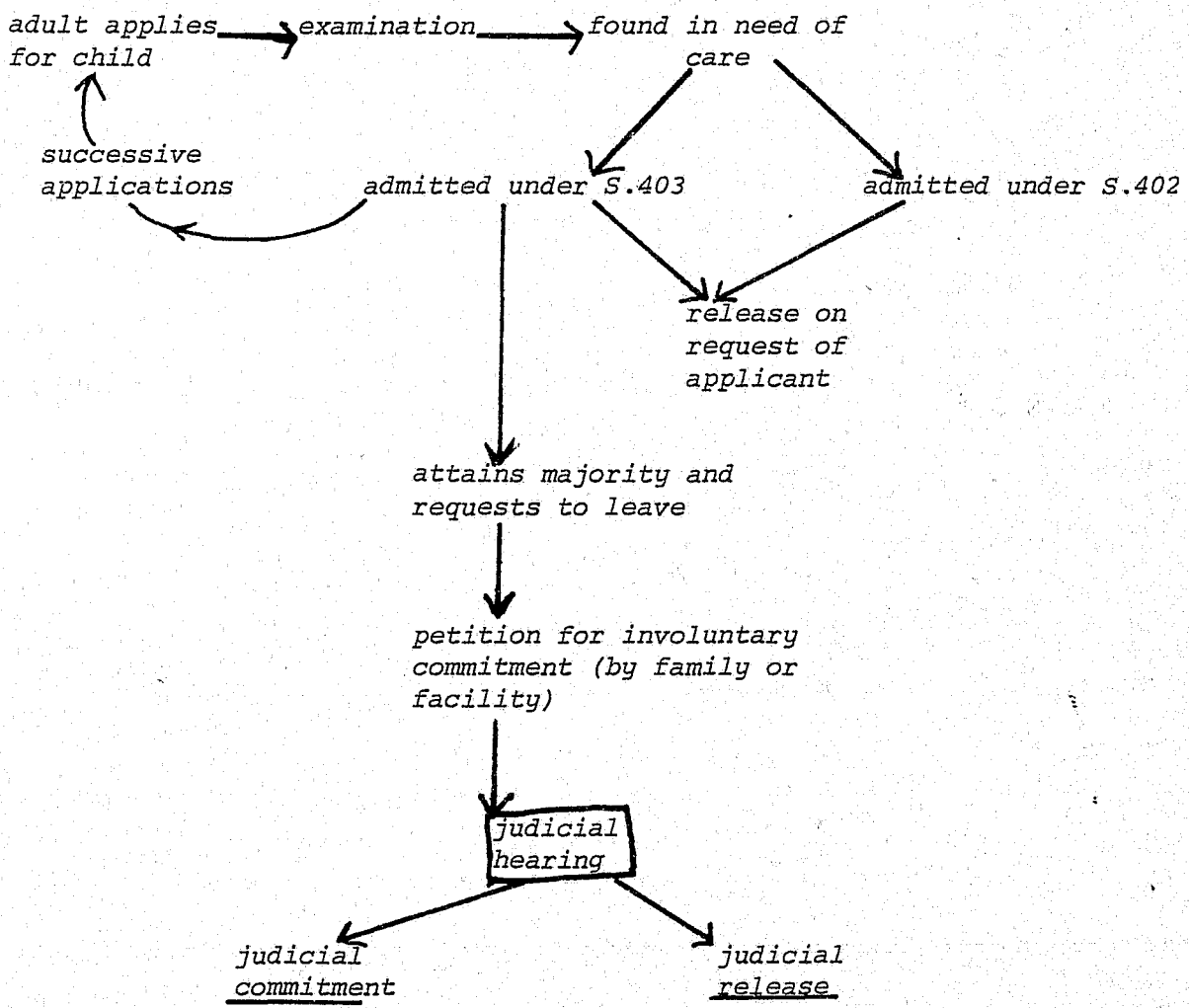


Figure 2-2

Voluntary Commitment of Minors under 1966 Act



Civil involuntary commitment of adults was of three main types. There was a ten-day emergency commitment which was medical, a medical indeterminate commitment, and a judicial indeterminate commitment.

The ten-day emergency commitment began with an application by any interested person to the County Office of Mental Health for permission to take into custody an individual who appeared "by reason of his acts or threatened acts, to be so mentally disabled as to be dangerous to himself or others and in need of immediate care" (S.405[a]). Once in custody, the individual was examined by a physician who could then certify that the individual should be committed for up to ten days. The requirement of dangerousness was interpreted widely and vaguely.[13] The emergency commitment section (Section 405) has not been challenged in the courts, despite the dictum in Lessard v. Schmidt[14] that the period of emergency detention should not exceed two days (we shall see shortly that the 1976 act reduced the period from ten to three days).

If, during the ten-day detention, the facility or the applicant felt that a longer stay was in order and the individual was not willing to commit himself voluntarily, the facility could

> notify the applicant (other than a police officer) or the administrator of the county of the person's residence, to make application for such person's commitment under other provisions of this Act" (S.405[f]).[15]

The "other provisions" referred to in S.405 were Sections 404 and 406, under which an individual could be committed for an indeterminate period of time. Section 404 was a medical commitment. The petitioner

obtained the certificates of two physicians stating that the individual was mentally ill and in need of care, and the individual was admitted by the facility on the strength of these certificates. The length of the detention was indeterminate, and the decision to release the patient was a medical one. This section was declared unconstitutional in 1971 on the grounds that it violated the individual's right to a full hearing in a situation where his liberty was at stake.[16]

Section 406 involved judicial involuntary commitment. It provided for commitment by the court of common pleas for the individual who was either

> already hospitalized under the 405 ten-day emergency provision
>
> voluntarily hospitalized under S.403 and had given notice of his desire to leave, against medical advice
>
> at large in the community.

The first step in the process was the filing of a petition in the court of common pleas by any concerned person. The petition included either the results of a physician's examination or, failing this, indication of "efforts made to secure examination of the person by a physician" (S.406 [a][2]). The court then issued a warrant for the person to appear, fixed a date for the hearing, and notified all interested parties. The act made no provision for counsel for the allegedly mentally ill person. However, since the early 1970s, the court's warrant to the person included the notice of his right to retain counsel and gave him the name of the public defender assigned to him

in case he did not wish to retain private counsel. This innovation was brought about following a judicial fiat concerning counsel.[17] In most cases, the court was the "Master's Court" whose personnel is fixed, so that the same public defender acted for all clients.

The act allowed three possible dispositions for the 406 hearing. If the individual had not been examined by a doctor, it could order an immediate examination by two court-appointed physicians, or else it could order detention for no more than ten days for the purpose of examination and evaluation. (In practice, the tendency was to order detention for "e and e" for up to three weeks.) If the person had been examined, and the examining physician testified that the individual was mentally ill and in need of care, the court could commit him forthwith to a mental health facility. There was no statutory restriction on the length of the commitment.

In most cases, the court stated a specific period of incarceration which varied from several weeks to several months, rather than commit for an indefinite period (see Chapter 5). The court also had two further dispositions. These were involuntary outpatient commitment and partial hospitalization (viz., day attendance). These options were problematic in that there existed no way to enforce them.

Section 406 came under judicial attack in 1971 when the court, in Dixon v. Attorney-General, held that 406 hearings must provide rights of due process. Using Gault's case[18] as a precedent, the court held that the following rights must be provided:

the right to counsel

the right to an independent expert examination

the right to a full hearing and cross-examination

the right to a clear standard of dangerousness for commitment and a clear understanding that the burden of proof falls on the prosecution (i.e., the petitioner)

the right to a specific maximum period of detention which must not exceed six months

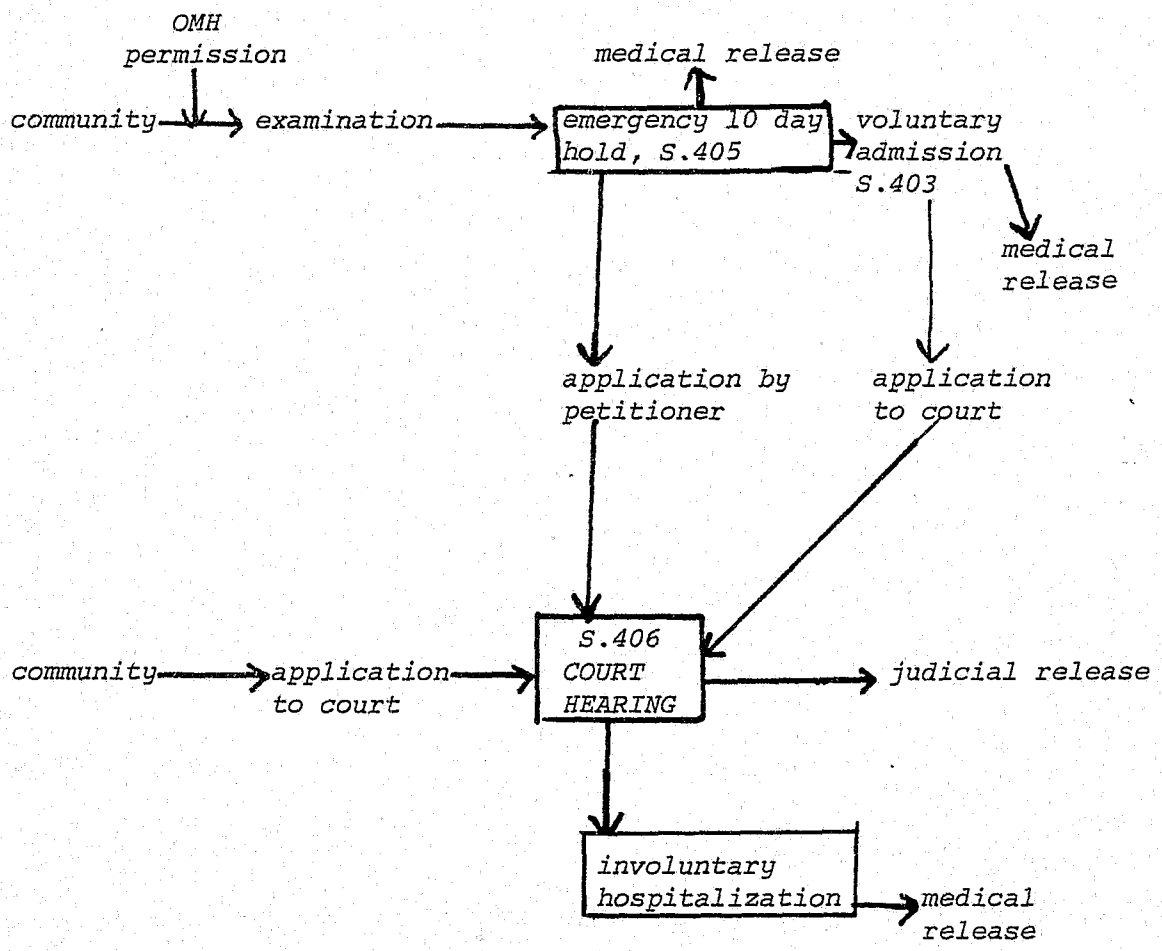
the right to a transcript of the proceedings and the right to appellate review.

As mentioned earlier, the court did provide counsel, but it ignored the other rights specified in Dixon's case, thus leaving Section 406 and its application open to further judicial attach which came in the case of Goldy v. Beal,[19] to be discussed shortly.

The procedures by which an individual could be civilly involuntarily committed under the 1966 act are presented in Figure 2-3. The medical commitment (S.404) has been omitted. It is apparent from this figure that despite the central part played by the court in involuntary admission to a mental health facility, the medical profession retained the balance of power over the release of patients. Section 418 dealt with the duration of the commitment and stated that where the court did not specify the length of the commitment, it should be "until care or treatment is no longer necessary": which is to say, by medical decree. In fact, even when the court did specify the time period, the decision to release was still that of the medical profession, as it had the option of reapplying for commitment. It was not obliged to inform the patient that his commitment had

Figure 2-3

Involuntary Commitment under the 1966 Act



expired. In 1972, the Pennsylvania Supreme Court held that medical release was obligatory when care was no longer necessary, and that the court could be permitted to interfere with the release of persons by the facility.[20]

The criminally insane were divided by the act into five categories. First were persons charged with a crime and released on bail. Section 407(a) provided that such individuals who become mentally ill should be treated as if they had not been charged: that is to say, Section 406 should be used to commit them. The difference between a bailee and a person not so encumbered is that the person holding surety could petition the court for relief of his obligation. If the court granted the relief, it could either enter new bail conditions (S.407[d][1]) or else order the director of the facility to "maintain custody and control of the committed person for the duration of his commitment" (S.407[d][2]). The court could also "enter such other orders as may be necessary to protect the rights of the committed person and the interests of the Commonwealth" (S.407[d][3]). Despite the vagueness of the last two subsections, Section 407 survived the judicial onslaught of the sixties and seventies. Most of the cases during this period dealt with criminally insane persons who had been imprisoned or who were incompetent to stand trial.[21] The relevant sections of the act dealing with these categories did not fare as well as Section 407.

The second category of the criminally insane comprised individuals charged with a crime who became mentally ill while detained--

in other words, the incompetent defendant. Sections 408 and 409 of the act dealt with this type of person. They could be committed by the court of common pleas on the petition of any of the following persons: an officer of the detaining institution, a relative, the person's counsel, or the district attorney. There was no time limit on the commitment provided that

> If such person shows a sufficient improvement of condition so that his continued commitment is no longer necessary, he shall be returned to the court having jurisdiction of him for trial . . . . (S.409[b]).

and that

> The Attorney for the Commonwealth may also at any time during the period of commitment, petition the court for a rule upon the director of the facility where such person is committed to show cause why the commitment should not be revoked and the person so committed brought to trial if the interest of justice require prosecution of such person (S.409[c]).

Upon his release, the person returned to court to face the charges which had been stayed during his hospitalization. The problem with this procedure was that it allowed indefinite commitment of the detainee, notwithstanding the above sections which are discretionary in nature. In 1975, the Supreme Court of Pennsylvania held that an individual detained under Section 408 as incompetent to stand trial could not be held indefinitely, but only for a reasonable period of time during which the probabilty of his regaining competence could be established. Following this period, he had to return to court, if he was competent, or else he had to be civilly committed, using Section

406.[22] This case was not a class action, nor did it state that Section 408 was unconstitutional, but in all probability the doctrine of Jackson v. Indiana applies. This case states that sections similar to Section 408 are constitutionally invalid in that they violate the equal protection clause of the Fourteenth Amendment.[23]

The third category of the criminally insane was the person committed in lieu of sentence: that is to say, he was competent to stand trial, but was "so mentally disabled that it is advisable for his welfare or the protection of the community that he be committed to a facility" (S.410). This commitment could not be longer than the maximum sentence for the crime committed (S.410[c]). If the maximum sentence expired while the individual was still mentally ill, he had to be committed under the civil section, which is to say, Section 406.

The fourth category of the criminally insane is the mentally ill prisoner. Section 411 provided for the commitment of such individuals on the petition of the warden, but was struck down as unconstitutional in 1976 because it provided no notice to the prisoner.[24] Since this time, the commitment of such persons had to use Section 406. Section 412 had provided for the transfer of a mentally ill prisoner to a mental health facility with no hearing at all. It was struck down as unconstitutional in 1970.[25] Section 406 had to be used to cover such cases.

The fifth and final category of the criminally insane was the person found not guilty by reason of insanity. Section 413 stated that the district attorney could initiate civil proceedings in such

cases (i.e., Section 406 was used). Section 413 has not been challenged because it complies with the decisions of the courts that such individuals are entitled to full hearings before detention in mental health facilities.[26]

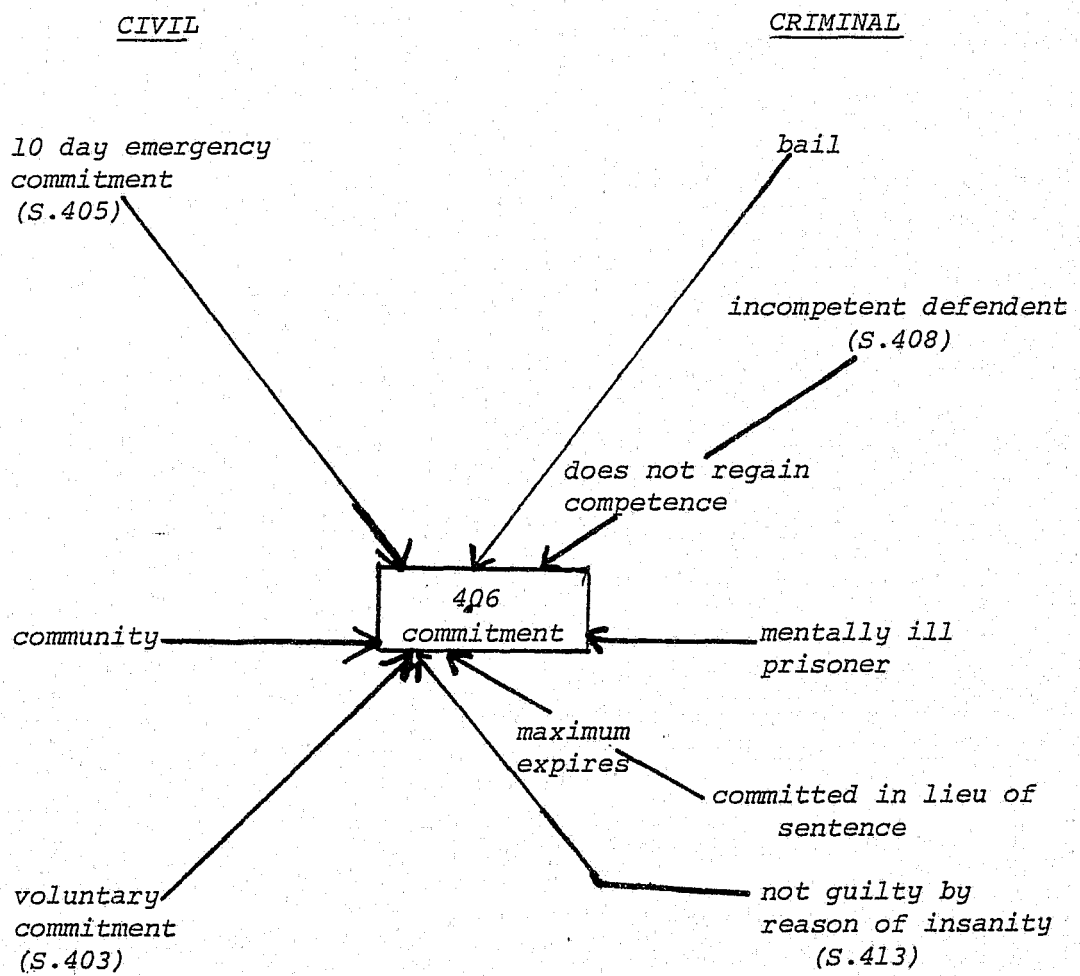
We have seen that the commitment of all five categories of criminally insane had to use Section 406. We have also seen that Section 406 was the focal point of the civil commitment process. Following the striking down of the medical commitment, Section 404, it was the only section under which a person could be civilly involuntarily committed. It provided the link between short-term emergency commitment and long-term detention. The centrality of Section 406 is represented in Figure 2-4.

However, as already stated, the Dixon case laid down stringent conditions for the procedures by which a 406 hearing should be conducted. We also mentioned that the master's court complied with only one requirement--that of counsel--so that Section 406 was left vulnerable to further judicial attack, which came on July 8, 1976, in the case of Goldy v. Beal.[27] This case declared the whole section unconstitutional. There remained almost no way at all to involuntarily commit individuals in Pennsylvania as of that date, except for the ten-day emergency hold (S.405).

The new Mental Health Procedures Act of 1976 was passed into law on July 9, 1976, but was not due to come into effect until September 7, 1976. The court entered a stay order "in order to avoid the development of any crisis or emergency,"[28] which permitted the continuation

Figure 2-4

The Central Position of Section 406 in the Commitment Process



of commitment proceedings under Section 406, provided that the standards for "severe mental disability" of the new act were used.

Procedures under Act 143 of 1976, the Mental Health Procedures Act

This act attempts to embody all of the judicial law which had accumulated during the last 10-15 years. (Our present purpose is limited to describing the involuntary commitment procedures under the act. It should, however, be noted that these proceedings are carried out in accordance with the following rights: the right to treatment,[29] the right to confinement in the least restrictive environment,[30] the right to dignity, privacy, and humane care,[31] and the right to due process.[32] The standard for involuntary commitment is that of dangerousness[33] and the burden of proof is on the state.[34] The act also provides that these rights will be available to the criminally insane.[35]) The act created the position of the Mental Health Review Officer whose position is to preside over the commitment hearings. The MHRO is to be a member of the bar of the Supreme Court of Pennsylvania, familiar with the field of mental health, and authorized by the court of common pleas to conduct hearings. In this way, the act formalized and legitimized the bureaucratically created Master's court. The act was, generally speaking, greeted with pleasure by the legal profession and with horror by the psychiatric profession.[36]

The act provides for the voluntary commitment of adults and juveniles, civil involuntary commitment of adults, and commitment of the criminally insane.

Voluntary Commitment

The act distinguishes the voluntary commitment of adults and juveniles. An adult is defined as a person over 14 years of age, and any adult may apply for voluntary hospitalization if he "believes that he is in need of treatment and substantially understands the nature of voluntary commitment" (S.201). Before the individual is accepted for treatment, the planned treatment must be explained to him, and his written consent must be obtained. There is no limit on the duration of a voluntary commitment, but it must be reviewed every 30 days by the facility. If the voluntary patient is between the ages of 14 and 18, his parents must be notified of his admission, and they may file an objection to it. In this case, there must be a court hearing within 72 hours of the filing of the objection to "determine whether or not the voluntary treatment is in the best interest of the minor" (S.204).

The act provides for only one type of voluntary hospitalization. The voluntary patient is requested (but not required) to agree to the stipulation that he will remain in the hospital three days after giving notice that he wants to leave. If the facility or another persons then feels that involuntary hospitalization is needed, there is a three-day period during which steps may be taken to obtain the involuntary commitment. As the patient is not required by the act to agree to this three-day period, the possibility exists that there can be voluntary commitments which, in no circumstances whatsoever, could lead to involuntary commitment. It is unlikely, however, that the

facilities will agree to admit an individual on a voluntary basis on these grounds, because they do not want to have patients coming and going at will.[37] The problem is more salient in the case of the involuntary patient who wishes to change his status to voluntary. Despite the act's stated intention that voluntary hospitalization is preferred (S.102), the staff of mental health facilities are wary of the system-wise patient who converts to voluntary status in order to leave. It is unlikely in any event that the facilities will encourage the use of the option to sign in voluntarily on condition of immediate release. It should be noted that the facilities retain control over admission policies for voluntary patients. This reduces much of the legislation concerning the voluntary patient to declaratory status only.

Voluntary commitment of juveniles. A juveniles is defined as a person under 14 years of age. Despite the age change, the overall situation with regard to juveniles has not changed. A parent has the right to hospitalize his child against his will, using the formal status of voluntary patient, as was the case under the acts of 1951 and 1966. Section 201 permits a parent, guardian, or person standing in loco parentis to the child to "subject such child to examination and treatment under this act and in doing so shall be deemed to be acting for the child." A form of judicial release has been added. Section 206(b) permits "any responsible party" to petition the court for the release of the juvenile committed. It is difficult to argue that this safeguard would make the section comply with the doctrine of Bartley v.

Kremens[38] unless "any responsible person" is interpreted to include the juvenile himself. The reduction of the age of majority from 18 to 14 probably has no effect on the compatibility of the section with Bartley, as this case was brought on behalf of all persons under 19. In any case, the section has very little effect, because the administration of the involuntary commitment of juveniles, under any section whatsoever, is made under the auspices of the juvenile court. This court defines its clientele as all persons of 18 and under[39] and continues to do so, notwithstanding the new mental health act. It seems that the rights of juveniles in the mental health system is an issue separate from that of the rights of adults, and that this issue has not been made as focal as that of the rights of adults. It is likely that the case of Bartley v. Kremens will spawn more judicial decisions, and eventually legislation on the rights of juveniles in the mental health system. For the moment, however, juveniles remain a relatively unseen minority.

Civil Involuntary Commitment

The procedure for involuntary commitment is designed as a series of interconnecting steps. The patient enters the system from the community via the three-day emergency examination and evaluation (S. 302). This is followed, if necessary, by a further 20-day hold and then, if necessary, by a further period of 90-days detention. If continued treatment is desired, it must be increments of 90 days, each period to be preceded by a judicial hearing (Sections 304 and 305).[40]

The criteria for involuntary commitment are stringent and revolve around the concept of dangerousness. In order to enter the system via the three-day emergency hold a person must be "severely mentally disabled and in need of treatment" (S.301[a]). A person is severely mentally disabled when, as a result of mental illness, "his capacity to exercise self-control, judgment and discretion in the conduct of his affairs and social relationships, or to care for his own personal needs is so lessened that he poses a clear and present danger of harm to others or to himself" (S.301[a]) (emphasis added). The conditions under which clear and present danger to self or others can be determined are set out in Section 301(b). It must be shown that within the past 30 days there had been an overt act--not a threat--inflicting or attempting to inflict serious bodily harm on another. It must also be shown that there is a "reasonable probability that such conduct will be repeated." (In the case of the criminally insane, this 30-day clause does not apply.) In order to show danger to self, it must be shown that within the past 30 days:

> (i) the person has acted in such manner as to evidence that he would be unable, without care, supervision and the continued assistance of others, to satisfy his need for nourishment, personal or medical care, shelter, or self-protection and safety, and that there is a reasonable probability that death, serious bodily injury or serious physical debilitation would ensue within 30 days unless adequate protection were afforded under this act; or
>
> (ii) the person has attempted suicide and that there is the reasonable probability of suicide unless adequate treatment were afforded under this act; or

> (iii) the person has severely mutilated himself or attempted to mutilate himself severely and there is the reasonable probability of mutilation unless adequate protection is afforded under this act. (S.301[2]).

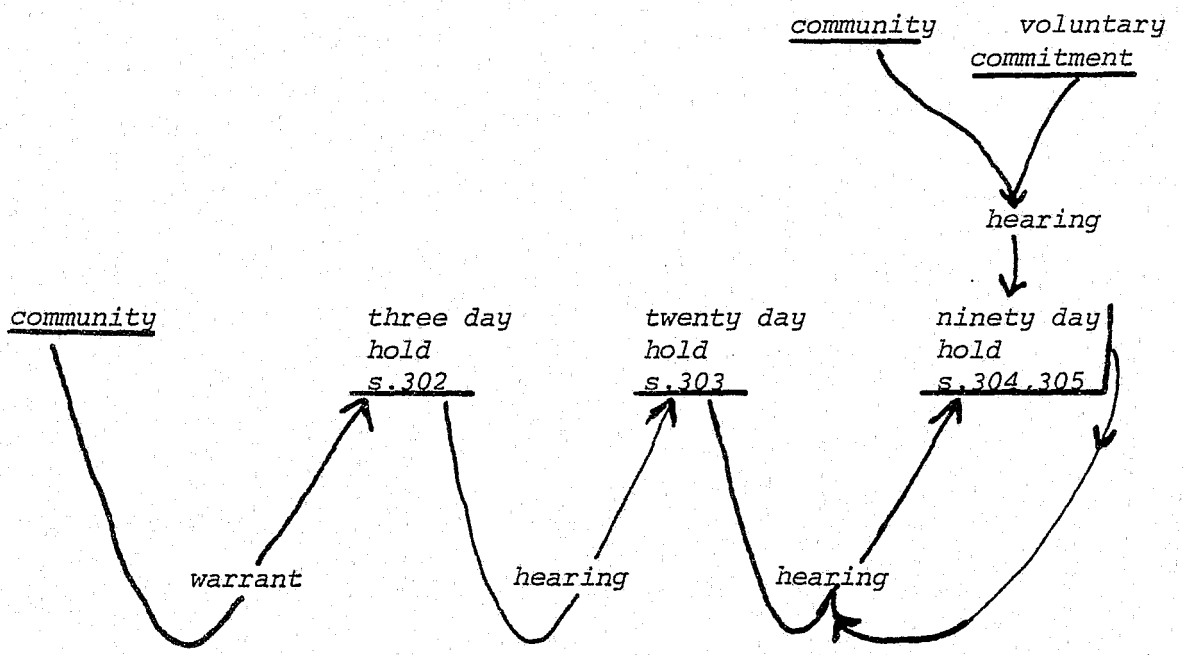
Persons who are addicts, alcoholics or mentally retarded may not be committed under this section unless they are also severely mentally disabled within the meaning of the act (S.102). The criteria of Section 301 are much more stringent than those of its predecessor, Section 405 of the 1966 act which also required dangerous behavior on the part of the patient, but which stated simply that the person could be committed whenever he appeared to be, by reason of his acts or threatened acts, "dangerous to himself or others and in need of immediate care" (S.405).

In order for the patient to stay in the system beyond three days and up to 23 days, the above criteria must be proven at a court hearing. Once the individual has been in the system for 23 days, and it is desired that he remain for further period(s) of 90 days, it is sufficient to prove that "the conduct required by Section 301 in fact occurred, and that his condition continues to evidence a clear and present danger to himself or others. In such event, it shall not be necessary to show the reoccurence of dangerous conduct, either harmful or debilitating within the past 30 days" (Section 304[b][2]).

It is possible for a person to enter the system at the point of the 90-day hold. In this event, the criteria are the same as for the emergency three-day hold (S.304[c]). The system is represented in Figure 2-5. The steps involved are described in more detail below.

Figure 2-5

Civil Involuntary Commitment



All admissions are judicial, except for the emergency three-day hold. The three-day hold may be described as a medical-administrative commitment and can be initiated by any concerned person. The first step is to request a warrant from the OMH. If the warrant is granted, the police can pick up the person for examination[41] which must be held within two hours of his arrival at the facility. Its purpose is to determine whether he meets the criteria of Section 301 for "severely mentally disabled." If so, he may be detained for 72 hours. If a policeman or physician witnesses the behavior upon which the commitment is to be based, a warrant is not needed, but the OMH must be notified. In this case, the physician who witnesses the behavior must not conduct the examination. The patient must be notified of his rights as soon as he arrives at the facility. During the three-day detention, the patient may be discharged by the facility, sign a voluntary admission, or a petition for a 20-day hold may be filed.

In the latter case, a hearing known as the "303 hearing" is conducted by the MHRO. Although the patient is represented by counsel, the hearing is informal and should, if practicable, be held at the facility (S.303[b]). If the court is convinced that the criteria for severe mental disability as set out in Section 301 have been met, it can order a commitment for up to 20 days. It can also order that the patient attend outpatient or partial care, even though there is no way to enforce these orders. If the hearing was conducted by a MHRO rather than a judge of the court of common pleas,

the patient has the right to request a review by the court of common pleas. At the time of this writing, one year after the act went into effect, there had been only two such requests. In both cases, the judge reversed the finding of the MHRO.

During the 20-day period of detention, the person may sign a voluntary commitment, receive a medical discharge by the facility, or be the subject of a petition to the court for a further period of detention for 90 days under Section 304. This petition is followed by a hearing at which the petitioner must show that the behavior which led to the original emergency detention did, in fact, occur, and that the underlying condition which caused it continues.

At this point, that is, at the 304 or 90-day hearing, an individual may be admitted into the system from the community. The petition may be filed by any person, and the court must be convinced that the criteria of Section 301 are met. The court may also order an examination on an outpatient basis before the hearing. In addition to the rights to counsel and to cross-examination and to confrontation of witnesses which the patient has at the three-day hearing, the patient is given additional rights. They include the right to employ a mental health expert to testify on his behalf, at the expense of the local mental health program. During the first year after the act had gone into effect, this right had been used only a handful of times. In one case, the public defender demanded an independent expert, with the result that the patient was kept in detention for some weeks beyond the period of legal commitment while awaiting the independent examination.

If the court is satisifed that the criteria for involuntary commitment have been met, it may order a period of detention of up to 90 days. It also has the option to order outpatient treatment or partial hospitalization.

If, during the 90-day detention, the patient has not received a medical discharge by the facility or signed a voluntary admission, the director of the facility or the county administrator may petition the court for a further 90-day period of detention (S.305).[42] The criteria for this second 90-day period of detention are the same as for the first as well as "the further finding of a need for continuing involuntary treatment as shown by conduct during the person's most recent period of court-ordered treatment" (S.303). The law states that in the case where the initial emergency commitment had been on the grounds that the patient was dangerous to himself (and not to others) the patient "shall be subject to an additional period of involuntary full-time inpatient treatment only if he has first been released to a less restrictive alternative (S.305) (emphasis added). The court need not comply with this requirement, however, if the facility director or county administrator states that it would not be in the person's best interest, and the MHRO agrees. The court can continue to order periods of detention under Section 305 if necessary.

It thus appears that Section 304 occupies a central part in the system. It is the point at which long-term detention begins, and is the point at which an individual who is free in the community can be

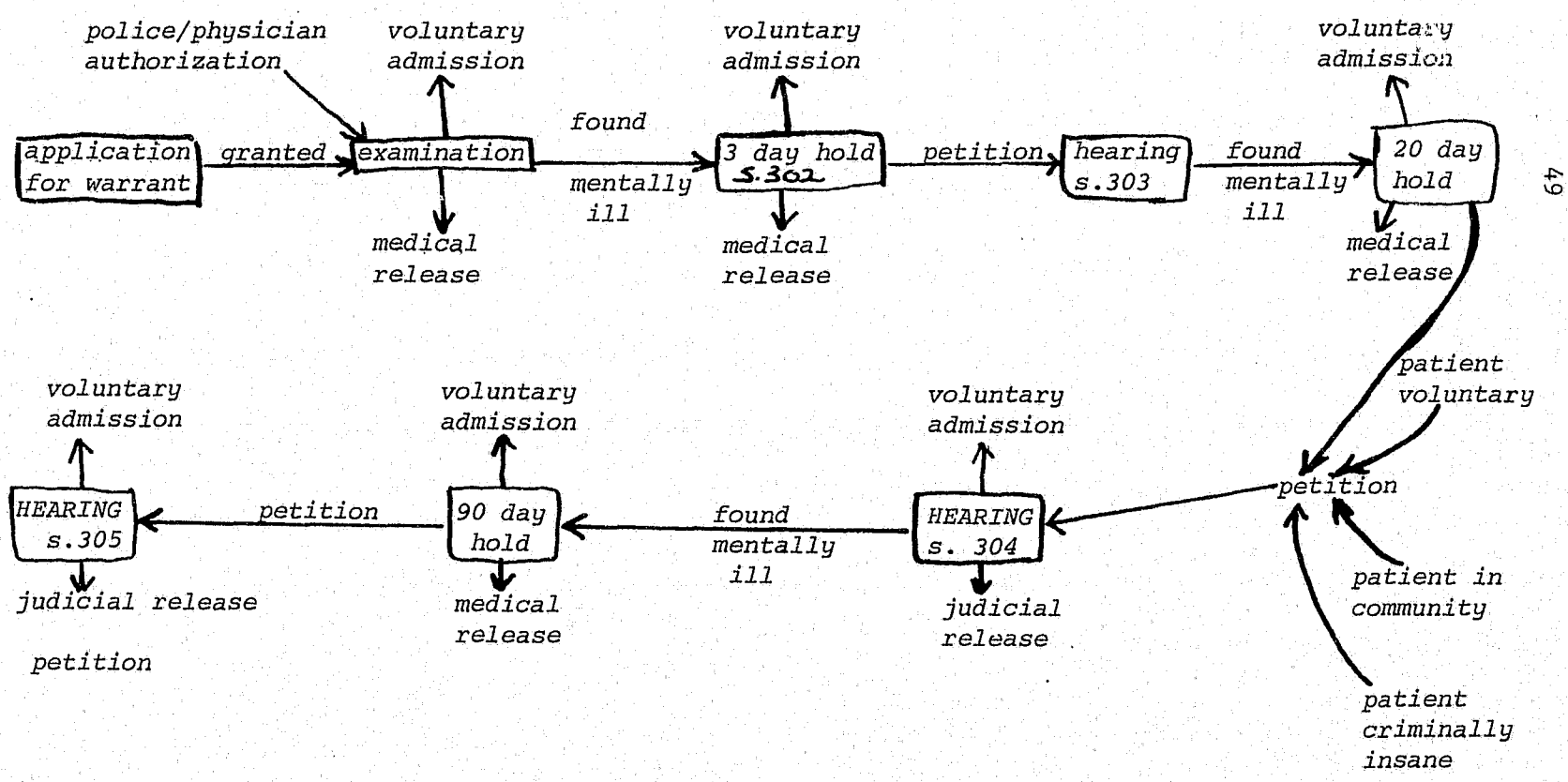
forced to enter the system for long-term treatment. It is the point at which the voluntary patient becomes involuntary,[43] and, as will be seen shortly, the point at which the criminally insane enter the mental health system. The system is outlined in Figure 2-6.

If we compare Figures 2-6 and 2-3 it will be seen that the power of the judiciary over admission and release policies has increased considerably. All admissions (except the three-day emergency) are judicial, and the number of points at which a judicial release may be obtained has increased considerably since 1966. In fact, however, the medical profession retains power over admissions by agreeing or refusing to petition the court for further periods of detention.

It remains to consider the case of the criminally insane, of which there are four categories: the incompetent defendant, the person acquitted by reason of insanity, the person charged with a crime or serving a sentence, and the person committed in lieu of sentence. All four categories enter the mental health system in the same way as the civilly committed, that is, via Section 304. By removing the separate and different procedures for the criminal insane, the legislature has abided by the decisions in the major cases concerning the criminally insane.[44] The only difference between the criminally insane and those committed in the civil sector is that persons who have been found incompetent to stand trial or who have been acquitted by reason of insanity and whose severe mental disability is based on acts giving rise to murder, voluntary manslaughter, aggravated assault, kidnapping, rape or involuntary deviate sexual

Figure 2-6

System for Involuntary Commitment under Act 143 of 1976



intercourse, can be committed for up to one year rather than for up to 90 days (Section 304[g]).

An exception to the general rule exists in the case of the person who is found incompetent to stand trial but who is not severely mentally disabled within the meaning of the act. In this case, he may be confined for up to 30 days in order for him to regain competence (S.403). If he does not regain competence within 30 days he may be committed, if he fits the criteria of the act, under Section 304, like all other incompetent defendants. The procedure is outlined in Figure 2-7.

The second category comprises the person found not guilty by reason of insanity. A person so acquitted may be committed under Section 304 if a petition is filed by the district attorney or other interested party.

The third category is the person charged with a crime or serving sentence who becomes mentally ill. In such a case, proceedings are to be instituted under the act "in the same manner as if he were not so charged or sentenced" (S.401). If he is found severely mentally disabled and is admitted into the mental health system, the time spent there is credited as time served in prison. If he is discharged before his sentence has expired or while charges are still pending, he returns to serve the remainder of his sentence or to stand trial. The process is outlined in Figure 2-8.

The intention of the act appears to be that the same strict standards of dangerousness should apply to both the criminally insane

Figure 2-7

Detention of the Incompetent Defendant

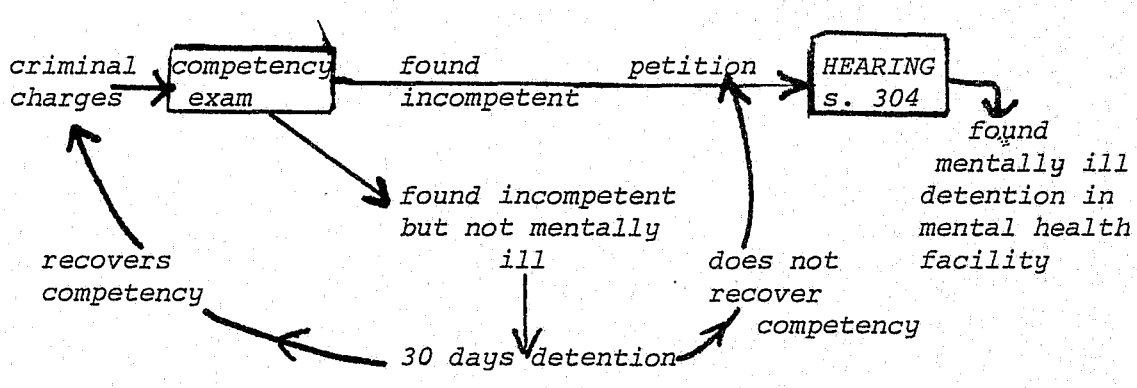
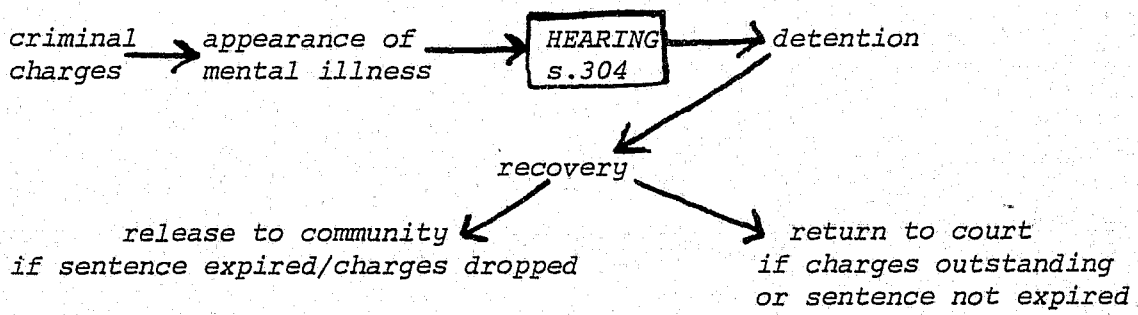


Figure 2-8

Commitment of Person Charged with Crime or Serving Sentence



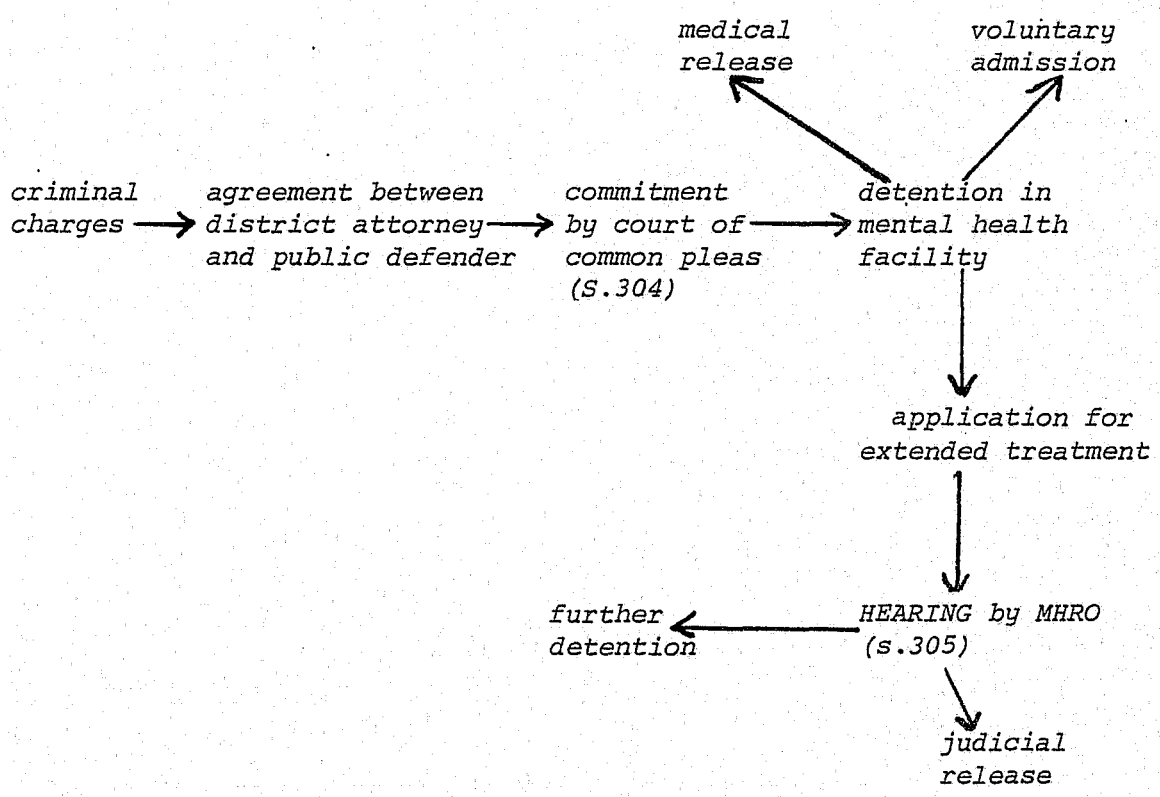
and to those committed in the civil sector. However, in Philadelphia, an informal agreement exists between the assistant district attorney in charge of mental health and the public defender. If both agree that the defendant appears to them to be mentally ill, and if the defendant agrees, the public defender waives the protections of the act, the district attorney enters a plea of nolle prosse and they request that the judge commit the individual under Section 304. The judge generally agrees with their recommendations. After the initial period of detention (of up to 90 days) the case is heard again by the MHRO, as set out in Figure 2-9.

The public defender and the district attorney feel similarly about the question of what constitutes mental illness. Their interpretation is much broader than the definition required by the act, with the result that many of the individuals detained in this way are released by the facility before the first period of detention is up, or else they are released by the MHRO as not mentally ill at the 305 hearing. Chapter 5 will review these cases further.

Finally, we have the category of the individual who is subjected to a psychiatric examination as an aid to sentencing (Section 405). The 1966 act permitted the court hearing the criminal charges to commit to a mental hospital in lieu of sentence. The new act does not permit this. It states that following the phsyciatric examination, the individual <u>may</u> be committed under Section 304 if the district attorney or any interested party files a petition. The act does not say how the criminal justice system retains jurisdiction and control over an individual who enters the mental health system in this way.

Figure 2-9

Informal Agreement to Commit a Mentally Ill Defendant



In the case of the incompetent defendant, the determination of incompetency effects a stay of prosecution for as long as the incapacity persists. In no case, however, shall the proceedings be stayed longer than five years or beyond the maximum sentence which could have been given, whichever is less.

The individual acquitted by reason of insanity cannot be controlled by the criminal justice system once he has been acquitted. Prior to the enactment of the current legislation, such persons were often committed under the civil provisions and detained indefinitely in a state hospital for the criminally insane. This type of indeterminate detention in a high security facility no longer occurs.

Finally, in the case of the person charged with a crime or serving a sentence, the criminal justice system retains jurisdiction while the individual is detained in the mental health facility until the period of imprisonment expires or until charges are dropped (S.401[b]). It is likely that similar considerations apply in the case of the person committed as an aid to sentencing.

The control of the criminally insane by the criminal justice system is now a great deal more restricted than it was under the previous act. Concomitant with this legislative restriction, occurred the newspaper exposé and subsequent investigation by federal agencies of Farview State Hospital, the hospital for the criminally insane which was under the joint administration of the prisons department and the department of health. The result of this publicity and the finding by the federal government that Farview did not begin to reach approved levels of care[45]

was less utilization of this facility. Since the enactment of the new mental health act, most of the criminally insane are detained in the Philadelphia State Hospital (the only state hospital in the county) or in the low-security community mental health care centers.

This delegation of control of the criminally insane to the civil sector was made public shortly after the enactment of the 1976 act, when the Philadelphia State Hospital released a woman, who had been acquitted of homicide by reason of insanity, as no longer mentally ill, one year after her initial confinement. The woman had committed a particularly grisly crime. She had killed a pregnant neighbor by removing her baby from her womb. She was due to return to live in the neighborhood where she had committed the act and where the relatives of the dead woman still lived (with the child, who had survived). The family and the neighbors protested volubly, and their protests helped publicize the new legislation and led to more generalized complaints concerning the lack of control of the criminal justice system over the criminally insane.[46] The complaints are similar to those made concerning the limitation of the power of the mental health system over the civilly committed individual (or, more correctly, the newly noncommitable individual): that is to say, many dangerous and disturbing people will be free to roam around free in the community. The next chapter will investigate the basis of these complaints and will try to decide whether the behavior of a substantial proportion of mentally ill people is dangerous and/or disturbing.

Footnotes to Chapter 2

[1]The Mental Health Act of 1951, P.L. 533; the Mental Health and Mental Retardation Act of 1966, P.L. 6; and the Mental Health Procedures Act of 1976, P.L. 143.

[2]Throughout this work the concept of "criminally insane" includes the incompetent defendant, the person found not guilty by reason of insanity, and the mentally ill prisoner.

[3]Ronald S. Rock, Marcus A. Jacobsen, and Richard M. Janopaul, Hospitalization and Discharge of the Mentally Ill (Chicago: University of Chicago Press, 1968), chapter 8.

[4]Ibid.

[5]Ibid.

[6]Judicial commitment was required in the case of a dangerously mentally ill person who had been detained without certification for ten days and whom the hospital wanted to retain. In all other cases, the use of the judicial form of commitment was elective, even in the case of the criminally insane.

[7]Here we see the first indication that persons other than physicians were able to work with the mentally ill, an innovation which reached its peak in the 1976 act. This act introduced the concept of a treatment team which could be headed by a clinical psychologist. This innovation was received with protest by the psychiatric profession.

[8]Dixon v. Attorney General of the Commonwealth of Pennsylvania, 325 F.Supp. 966, 974 (M.D. Pa. 1971).

[9]The 1966 act defined an adult as a person over 18 years, in contrast to its 1951 predecessor which defined an adult as a person over 21 years. The 1976 act defined an adult as a person over 14 years.

[10]Norristown State Hospital Manual, April 2, 1975, p. 71 (mimeo).

[11]Ibid., p. 75.

[12]The constitutionality of this section has been challenged. In Bartley v. Kremens, 402 F.Supp. 1039 (E.D. Pa., 1975), a class action suit, those parts of Sections 402 and 403 pertaining to children were held unconstitutional. A stay of judgment was granted on December 15, 1975 (423 U.S. 1028 46 L.Ed. 402, 96 Sp. Ct.). On January 12, 1976, a motion to vacate the stay was denied.

[13]Edward D. Ohlbaum, "The Gates of Cerberus: Involuntary Civil Commitment in Philadelphia," Temple Law Quarterly 49 (1976):323-384.

[14]349 F.Supp. 1078 (E.D. Wisc., 1972).

[15]In fact, the OMH did not file for petitions. The petitioner in such cases was either the original applicant or the facility.

[16]Dixon v. Attorney General.

[17]U.S. ex Rel McGurrin v. Shovlin, 455 F.Supp. 2nd 1278 (3rd Cir. 1972) 407 U.S. 913.

[18]In re Gault, 387 U.S. 1, 1967.

[19]C.A. #75-791, M.D. Pa., 1976.

[20]Commonwealth ex Rel DiEmilio v. Shovlin, 295 A.2d., 320, 449, Pa., 177 (1972).

[21]See for example, Dixon v. Attorney General, supra note 8, and Baxtrom v. Herold, 383 U.S. 107 86 Sp. Ct. 760 (1966). Both cases dealt with persons incarcerated in institutions for the "criminally insane."

[22]Commonwealth of Pennsylvania v. McQuaid, 437 A.2d., 465 Pa. (1975).

[23]406 U.S. 715, 724, 92 Sp. Ct., 1845, 1851 (1972).

[24]Souder v. Maguire, 516 F.2d. 820 (3rd Cir., 1975) (on remand, pending).

[25]Commonwealth v. John Ronald Collello, 9 Mercer County Law J. 220 (1970).

[26]Baxtrom v. Herold and Dixon v. Attorney General.

[27]Ibid.

[28]#75-791, Civil, July 29, 1976.

[29]Miller v. Overholster, 206 F.2d. 415 (D.C. Cir., 1953); Burchett v. Bowser, 355 F.Supp. 1278 (D.C. Ariz., 1973); Davis v. Watkins, 384 F.Supp. 1196 (1974); Donaldson v. O'Connor, 493 F.2d. 507 (5th Cir., 1974).

[30]Covington v. Harris, 419 F.2d. 617 (D.C. Cir., 1969); Lake v. Cameron, 364 F.2d. 657 (D.C. Cir., 1966).

[31]Davis v. Watkins and Donaldson v. O'Connor, supra note 29.

[32]Lessard v. Schmidt, 349 F.Supp. 1978, 1089 (E.D. Wisc., 1972) vacated and remanded on other grounds, 414 U.S. 473 (1974), redecided, 379 F.Supp. 1376 (E.D. Wisc., 1974), vacated and remanded on other grounds, 421 U.S. 957 (1975). Heryford v. Parker, 396 F.2d. 393 (10th Cir., 1968); Donaldson v. O'Connor, supra note 29.

[33]Goldy v. Beal, U.S. Dist. Ct. M.D. Pa., C.A. #75-791 (1976).

[34]In re Ballay, 482 F.2d. 648 (D.C. Cir., 1973); Humphrey v. Cady, 405 U.S. 504, 509, 1972, Goldy v. Beal, supra note 33; Lessard v. Schmidt, supra note 32.

[35]Bolton v. Harris, 395 F.2d. 642 (1968); Dixon v. Attorney General, supra note 8; Baxtrom v. Herold, supra note 21; Jackson v. Indiana, 406 U.S. 715, 724, 92 Sp. Ct. 1845, 1851 (1972).

[36]See for example, Public Hearings on Act 143, Pennsylvania Senate, Harrisburg, March 25, 1977.

[37]The voluntary commitment with agreement of immediate release upon demand is similar to the informal commitment which exists in New York State and which is described in Ronald Leifer, In the Name of Mental Health: The Social Functions of Psychiatry (New York: Science House, 1969). In Chapter 6, Leifer says that the admitting staff in New York State hospitals try to avoid this procedure.

[38]Supra, note 12.

[39]Pennsylvania Juvenile Court Act.

[40]At the time of this writing, amendments have been introduced which would extend the period of this commitment to 180 days. See for example, S.B. 1076, introduced August 11, 1977.

[41]This step, obtaining a warrant from OMH has been the subject of dispute and confusion. The sequence of events is as follows: the petitioner contacts the facility with his complaint. The intake worker decides if the behaviors described fit the criteria of the act. If so, he calls OMH for a warrant to pick up the patient for examination. At this point, the OMH delegate makes his own decision regarding the appropriateness of detention. He reviews the decision of the intake workers, many of whom are doctors who object to the questioning of their decisions by a social worker. The Secretary of the Department of Public Welfare has expressed the opinion that the job of the OMH worker is merely to grant the warrant and record the information, and allow the propriety of the initial three-day detention to be tested at the three-day hearing (remarks made at the Fall meeting of the Pennsylvania

Psychiatric Society, November 5, 1976, Hershey, Pa.). However, the OMH maintains its right to refuse to grant warrants. At the time of this writing, an uneasy compromise had been reached in which the OMH had agreed to refuse less warrants, but still maintained its right to review decisions.

[42]In practice, the County Administrator never initiates petitions.

[43]At first it was not clear how to "convert" a voluntary patient to involuntary status, and the three-day emergency hold was used in many cases. Eventually it became clear that the correct procedure was to file a petition for a hearing under Section 304 while the patient was still in the facility. This requires some clerical speed, as the maximum period that the voluntary patient can be held against his will is three days. There are thus some instances where the facility will use the emergency procedures which involve less paper work.

[44]Dixon v. Attorney General, Baxtrom v. Herold, and Jackson v. Indiana, supra notes 8, 21, and 35.

[45]Philadelphia Inquirer, October 10, 1976.

[46]It should be noted that the only legal difference in the status of this group of persons is the requirement, under the 1976 act, of an annual review of the commitment. It was at this review that the hospital decided that the patient was no longer ill. It is possible to claim that this patient was released in order to publicize the unpopular act and as a function of the resentment felt toward it by the psychiatric profession.

CHAPTER 3. THE MENTALLY ILL--DANGEROUS OR NUISANCE?

Introduction

According to the new Pennsylvania law, the only permissable rationale for the involuntary commitment of the mentally ill is the dangerousness of the individual.[1] It follows, then, that if all mentally ill individuals are dangerous, all may be justifiably committed against their will, and they will cause no social problems. If, on the other hand, a substantial number of these individuals are not dangerous and cannot be involuntarily committed, they will be free to roam about in the community where their behaviors, though not dangerous, may be disturbing to others.[2]

In order to see whether this is a viable possibility, the issue of the dangerousness of the mentally ill is raised in this chapter. Current studies are reviewed. They indicate that most mentally ill persons are not dangerous, although their behaviors may well be disturbing and disruptive. These studies, therefore, support the hypothesis that the new legislation may divert substantial numbers of the non-dangerous mentally ill into the criminal justice system *via* arrests for petty offenses.

Rationales for Involuntary Commitment

There exist two main rationales for the involuntary commitment of the mentally ill. One, espoused mainly by psychiatrists, is the

need for care and treatment. In making this claim, the psychiatrist "second guesses" the individual and assumes that if he were in a "rational" state of mind he would voluntarily seek out the treatment being forced on him.[3] We can call this the therapeutic rationale.

The second, espoused mainly by lawyers and civil libertarians, is the dangerousness of the mentally ill individual. This rationale assumes thatthe "right to be different"[4] does exist and that the right is revoked only when the individual becomes dangerous to himself or others. This viewpoint echoes the sentiments expressed in John Stuart Mill's famous essay, "On Liberty," in which he states that

> As soon as any part of a person's conduct affects physically the interests of others, society has jurisdiction over it, and the question whether the general welfare will or will not be promoted by interfering with it becomes open to discussion. But there is no room for entertaining such question when a person's conduct affects the interests of no person besides himself, or needs not affect them unless they like (all persons concerned being of full age, and possessing the ordinary amount of understanding).[5]

The problem with the "dangerousness" rationale is contained in Mill's caveat--that all persons concerned possess the "ordinary amount of understanding." If the behavior does "physically affect the interests of others" and if the offender does not possess "the ordinary amount of understanding"--i.e., is mentally ill--does society have jurisdiction over the behavior and the actor? Mill does not say. A second problem connected with the "dangerousness" rationale is the issue of who decides whether the "ordinary amount of

understanding" is possessed by the offending person. Mill leaves this question open also.

While the therapeutic rationale was the dominant paradigm for the treatment of the mentally ill, these issues were not problematic. The first question--that of societal jurisdiction--did not arise, because the need for treatment of the offending individual was the sole concern. If the treatment also provided social control by isolating the offender, no problem was perceived (until the issue of the rights of the mentally ill was raised in the courts in the early 1960s). The second issue--who decides the state of mind of the offending individual--was not problematic. The psychiatric profession was given full authority to answer such questions (except where the behavior also constituted a serious criminal offense, in which case the psychiatric profession was bound to state its decision within the awkward framework of the legal definition of insanity. This legal imposition related only to the way in which the decision would be stated and not to whom the decision maker would be).[6]

Now that the legislature has forcibly replaced the therapeutic with the dangerousness rationale, the problems connected with the latter rationale come to the fore. In order to see how they will be overcome, it is necessary to consider the actual reason--as distinct from the rationale--for involuntary commitment of the mentally ill.

The reason for involuntary commitment does not necessarily correspond with its stated rationale. In the area of criminal justice, for example, Sellin points out that the reason for punishment has always

been social control, although the stated rationale has differed from time to time.[7] Previously, Hume had recognized justice as an "artificial virtue which comes into existence as a consequence of certain social and political institutions whose utility depends on the uniformity of human conduct."[8]

It will be argued here that the reason for involuntary commitment has always been the social control of the mentally ill, both dangerous and non-dangerous, so that the reduction of the control function to only the dangerous mentally ill creates a gap in the total social control system. This argument will be examined in more detail in the next chapter.

The need for conformity in society was recognized by Mill[9] and has been restated by the structural-functional school of sociology.[10] The sources of conformity in complex society are multiple. Socialization to value consensus[11] is a major source, but other, coercive, sources are necessary. Durkheim was concerned with the source of conforming behavior.[12] He concluded that as society became progressively more complex, mechanical solidarity (or conformity through similarity) would be replaced by organic solidarity--conformity through functional interdependence.[13] His point that the source of control would become increasingly more externalized (to the individual and to the community) seems to have been borne out.[14] However, his prediction that the institution through which organic solidarity would be maintained would be the law of contract appears to have been not incorrect, but rather too narrow. The function of social control in

modern society is carried out by a number of institutions, not all of which carry out this function overtly or explicitly. It has been argued that among those institutions which function covertly to induce conformity through social control are the educational system,[15] the economy,[16] the welfare system,[17] and the mental health system.[18]

The institution whose explicit function has always been social control is, of course, the criminal justice system. Its role is to control behavior which seriously offends the majority of the people and which is forbidden by law. Ideally, then, the sole concern of criminal justice should be whether acts are rightfully forbidden by law.[19] However, shortly after the formulation of the goals and scope of criminal justice by Beccaria in 1764, a problem arose directly out of the legal philosophy which holds that punishment is rightfully applied only to persons who are responsible for their acts. That is to say, if an individual is not responsible and cannot intend his acts, he may not be punished. (In such cases, punishment cannot deter, and is simply the infliction of hardship to no purpose.) Thus, at an early state in its development, the criminal justice system lost jurisdiction over those who were held to be incapable of forming intent--the very young and the insane.[20]

Jurisdiction over the criminally insane was delegated by the criminal justice system to the mental health system via the creation of institutions for the criminally insane. The "therapeutic rationale" which held sway over the mental health system permitted the control of the non-criminally insane by involuntary commitment.

Under this system, in which the criminal justice system deals with the dangerous and the mental health system deals with those who "need treatment," regardless of whether they are dangerous, there should be no problem of the control of the mentally ill. Now, however, the legislation under consideration here has imposed the "dangerousness rationale" upon the mental health system which now has jurisdiction only over the dangerous mentally ill. There remains no institution of control of the non-dangerous mentally ill (unless, as we will argue later, this function is taken over by the criminal justice system).

It is first necessary to determine whether most of the mentally ill are dangerous. If this is the case, they will continue to be controlled by the mental health system by involuntary commitment, and no problem of social control will arise.

The Dangerousness of the Mentally Ill

The dangerousness of the mentally ill is not a new issue. It was first raised in the United States in 1845 in relation to the issue of the justification for involuntary commitment.[21] There are two ways to approach the problem. The polemical approach often cites data but makes no attempt to base its conclusions on the data. The scientific approach uses data collected with as much methodological sophistication as possible, and bases its conclusions on these data. However, a review of existing studies indicates that neither approach has succeeded in providing a definitive answer to the question of whether the mentally ill are dangerous.

Typical of the polemical approach is the report of the California Legislature Committee which stated that, according to "surveys," nine out of ten state hospital residents in California were not dangerous.[22] The nature of the surveys cited are not reported, nor are the criteria used to define dangerousness. An additional problem with such a conclusion is the nature of the environment in which the subjects were studied: viz., a restrained and guarded one, in which the subjects were probably chemically tranquilized. Little weight can be given to the above conclusion, nor to the further conclusion of the committee that, of persons brought to the commitment court, only 8 per cent seemed dangerous.[23] The key word is, of course, "seemed." If 8 per cent "seemed" dangerous to one group of observers, then more or less may have "seemed" dangerous to a different group of observers. The committee's report is, then, not conclusive.

Another polemical report was made following New York City's policy change which reduced the number of involuntary commitments to state and city mental hospitals by excluding the non-dangerous mentally ill. The report stated that "New York's street crime scene found a grim addition in the senseless violence of many released mental patients."[24] Another report concluded that the addition of released mental patients to the population of the Bowery in Manhattan caused a situation of such dangerousness that the ex-patients had to be removed from the scene.[25] Neither report presented supporting data.

No further studies of this type will be presented, because it is not possible to evaluate studies which present no data. The studies

which use the second, or scientific, approach are of more value, but are nonetheless difficult to compare and evaluate because the operational definition of "dangerous" and the methods used differ widely.

One group of studies looks at violence within the mental hospital as an indicator of dangerousness.[26] A problem common to these studies is that the data base comprises hospital records, so that what is actually being measured in the hospital staff's perception of events, rather than the events themselves. Goffman has criticized this type of study by implication by his observation that violence may be an artificial creation within a restrained and repressive environment, and may even be in response to "cues" given by the hospital staff.[27] For these reasons, this type of study will not be examined here.

There exists another group of studies which focuses on the behavior of the mental patient in the community. A common research design is to define dangerousness as arrest and/or conviction, and to follow the patient's career in the community for some time after release. Some of the studies allow for time spent back in the institution when computing the rates of arrest, and others do not. These studies can be divided into two groups--those which compare the rates obtained with rates in the general population, and those which do not. A further subdivision may be made according to the types of subjects: the civilly committed and the criminally insane.[28]

Although we are concerned here with patients who are civilly committed, four studies concerning the criminally insane will be

included.[29] Three of the studies concerning the criminally insane took advantage of judicial orders resulting in the release to the community of substantial numbers of the criminally insane.[30] The fourth (McGarry, 1971) took advantage of an administrative decision to return to trial as many incompetent defendants as possible being held in Massachusetts hospitals for the criminally insane. These studies have been included because their subjects comprise very few persons whose dangerousness had actually been shown to have caused their criminal behavior (that is to say, persons found not guilty by reason of insanity).[31]

Eight studies deal with the question of the dangerousness of the civilly committed mentally ill. The first study was carried out in 1922 and the latest in 1976. For the sake of convenience, all of the studies are presented summarily in Table 3-1, in chronological order. The studies concerning the criminally insane found rates of dangerousness ranging from 10 to 15 per cent (these are rates based on dangerous offenders, not offenses in the subject populations). Given that the expected rate of dangerousness, according to the psychiatric and administrative decisions to incarcerate the subjects was 100 per cent, we can agree with Steadman that "these patients were not very dangerous."[32]

A problem arises in comparing the results of these studies with those concerning civilly committed patients. The studies concerning the criminally insane present the proportion of dangerous individuals within the subject population in order to indicate the overprediction

Table 3-1 Studies Evaluating the Dangerousness of Released Mental Patients

Author & Year	Population Studied	Definition of Dangerousness	Follow-Up Period in Years	Allowance for Time in Institution
Ashley, 1922[33]	1000 men paroled over 10 years from Middletown Homeopathic Hospital	arrest, all offenses	unknown	unknown
Pollock, 1938[34]	5092 men and 4471 women released from New York state hospitals in 1934	arrests, all offenses	unknown	unknown
Cohen & Freeman, 1945[35]	1676 patients discharged from a Connecticut state hospital 1940-44	arrests, felonies	2	unknown
Brill & Malzberg, 1962[36]	10,247 men over 16 discharged from New York state hospitals in 1947	arrests, all offenses	5.6	unknown
Rappeport & Lassen, 1965[37]	men over 16 in Maryland state hospitals in 1947: N = 708 1955: N = 2152	arrests for homicide, rape, robbery, and aggravated assault	5 pre- and post-hospitalization	no
Rappeport & Lassen, 1966[38]	females over 16 in Maryland state hospitals in 1947: N = 693 1955: N = 2219	as above	as above	no
Giovannoni, 1967[39]	1142 psychotic men under 60 without organic problems	all criminal behavior	4	yes

Table 3-1 (cont.)

Author & Year	Population Studied	Definition of Dangerousness	Follow-Up Period in Years	Allowance for Time in Institution
Zitrin, 1976[40]	867 admissions to Bellevue, 1969-71	arrest, rape, burglary, and aggravated assault	2 pre- and post-hospitalization	no
McGarry, 1971[41]	50 incompetent male defendants released from Massachusetts state hospitals in 1964-65 and reaching the community	all criminal offenses	5-6	yes
McGarry & Parker, 1974[42]	234 men discharged from Massachusetts state hospitals in 1968-69; average age of 60.4 years	court appearance	3	unknown
Steadman & Cocozza, 1974[43]	98 men released from New York state hospitals in 1964-65; average age of 51.6 years	violent behavior causing arrest or rehospitalization	5	yes
Jacoby, 1976[44]	432 men released from Pennsylvania state hospitals in 1969-71; average age of 42.6 years	behavior constituting violent crime	2-4	no

Table 3-1 (cont.)

Author & Year	Dangerousness Rate of Mentally Ill	Dangerousness Rate of General Population	Source of Rate of General Population
Ashley, 1922	1.2/1000	unknown	unknown
Pollock, 1938	6.9/1000	99.7/1000	New York Department of Corrections
Cohen & Freeman, 1945	4.2/1000	27/1000	unknown
Brill & Malzberg, 1962	12.2/1000	49.1/1000	unknown
Rappeport & Lassen, 1965	robbery significantly higher; rape and aggravated assault higher but not significant		Uniform Crime Reports
Rappeport & Lassen, 1966	aggravated assault significantly higher; homicide and robbery less but not significant		Uniform Crime Reports
	rate for males and females falls after peaking at 2 years after release		
Giovannoni, 1967	higher for aggravated assault, murder and robbery (3 murders)		Uniform Crime Reports
Zitrin, 1976	rates for rape, aggravated assault and burglary higher than for general population		
McGarry, 1971	48% of sample	59.8% (recidivism rate of released prisoners)	Massachusetts Department of Correction
McGarry & Parker, 1974	14% of sample	———	———
Steadman & Cocozza, 1974	15% of sample	———	———
Jacoby, 1976	14% of sample	———	———

of dangerousness of this class of persons. On the other hand, the studies on the civilly committed mentally ill compare rates of dangerous individuals in the subject population with the rates within the general population. There is no estimate of the numbers of dangerous individuals within the total population of the civilly committed mentally ill.

A superficial overview of the studies on the civilly committed mentally ill gives rise to the alarming conclusion that they are becoming more dangerous as time passes. The first study, that by Ashley in 1922, gives a low rate of dangerousness--1.2--although it gives no comparable rate for the general population. In 1934 Pollock found that the ratio of dangerous persons amongst ex-patients compared to the general population was 6.9/99.7. In 1945, Cohen and Freeman found the ratio to be 4.2/27; and in 1962, Brill and Malzberg calculated it to be 12.2/49.1. In other words, the ratio increased from .07 in 1938 to 1.55 in 1945, and decreased to .25 in 1962. Despite the fluctuating rates and the differing methods of study, the conclusion that ex-patients are less dangerous than the general population appears inevitable. This pattern changes with later studies.

In 1966, Rappeport and Lassen found that male ex-patients had significantly higher rates than the general population for robbery and that they committed more (although not significantly more) rapes and aggravated assaults than the general population. The same authors found that female ex-patients committed more aggravated assault than

the general population. In 1967, Giovannoni found that male ex-patients committed more robbery, aggravated assault and homcide than the general population.[45] It could be argued that Giovannoni's findings of greater criminality on the part of the mentally ill could be due to her data collection methods. Unlike the other studies discussed here, Giovannoni used not only official records, but also self-report and observation. The rate for the general population was taken from official records only. However, in 1976, Zitrin, using the narrower data base of official records, confirmed that male ex-patients have higher rates than the general population for aggravated assault, rape, and burglary.

Giovannoni points out that her results do not indicate an all-time high in the increasing dangerousness of the mentally ill, but rather reflect the increasing leniency of release policies of mental institutions. At the time of the first study in the series under discussion, release policies were exceedingly conservative, leading Giovannoni to conclude that

> it is primarily the way that mental hospitals are utilized by the community that one is likely to find the major sources of variation in the ex-patient crime rate. For example, we can assume two persons with essentially similar, non-florid psychiatric symptom pictures and/or criminal activity. If the civic machinery of a community channels the one to a jail and the other to a mental hospital, then such a hospital will inevitably show a low rate of ex-patient social disruption--the more so if the particular hospital should compound the felony by also having a conservative release policy.[46]

If any conclusion can be reached from studies as diverse as these,

it is that a possibility exists that the mental patient may commit more offenses against the person and property than the typical member of the general population. The rate of dangerous behavior of the mentally ill, as measured by the crime rate of released patients, will depend not only on innate tendencies to crime but also on the release policies of the institutions and on community policy and law regarding criteria for admission to mental hospitals. The research to date has not managed to devise a design which separates all of these factors. It is not, therefore, surprising that the issue of the dangerousness of the mentally ill as compared to the general population remains unresolved.

The problem which concerns us most here is that the studies on the civilly committed mentally ill do not give any indication of the proportion of dangerous individuals within the total population of mentally ill persons. The best estimate of that proportion that we have is that of the studies on the criminally insane, viz., from 10 to 15 per cent.

As mentioned before, the situation in Pennsylvania regarding the involuntary commitment of the mentally ill is that, after September 1976, only those mentally ill with demonstrably dangerous tendencies may be committed against their will. Extrapolating from the studies on the criminally insane, we can estimate that about 10 to 15 per cent of the total population of the mentally ill can be controlled in this way by the mental health system. (It is necessary to assume that the decisions made by the commitment court will utilize a definition of

dangerousness similar to that used by the studies discussed above.)

The act excludes from involuntary commitment all of those mentally ill persons whose behavior is not dangerous: that is, according to our estimate, from 85 to 90 per cent. Opponents of the legislation have claimed that it will result in the arrest and imprisonment of many of the non-dangerous mentally ill.[47]

The Mentally Ill as Misdemeanants

The objective of this section is to see whether the behavior of a substantial number of the non-dangerous mentally ill can be classified as misdemeanors. Before looking at the studies themselves, it is necessary to examine the criminal code, because the existence of criminal offenses of a minor and general nature underlies the proposition that the non-dangerous mentally ill are potential misdemeanants. Harassment, for example, is defined as:

> A person commits a summary offense when, with intent to harass, annoy or alarm another person:
>
> (1) he strikes, shoves, kicks, or otherwise subjects him to physical contact, or attempts to threatens to do the same; or
> (2) he follows a person in or about a public place or places; or
> (3) he engages in a course of conduct or repeatedly commits acts which alarm or seriously annoy such other person and which serve no legitimate purpose.[48]

A person is guilty of disorderly conduct if

> with intent to cause public inconvenience, annoyance or alarm, or recklessly creating a risk thereof, he:

(1) engages in fighting, or threatening, or in violent or tumultuous behavior;
(2) makes unreasonable noise;
(3) uses obscene language, or makes an obscene gesture; or
(4) creates a hazardous or physically offensive condition by any act which serves no legitimate purpose of the actor.[49]

These and similar offenses (see Chapter 5) are broadly phrased and can be used to cover a wide range of behaviors. The next question which arises is the degree to which the police actually use these codes. The police do not always arrest all individuals who behave in ways which could be interpreted as falling within the range of prohibited behavior.[50] First, they are not always requested to do so, nor do they always observe the behavior. Second, it has been shown that when the offending individual is perceived as being mentally ill, the police often choose not to arrest.[51] In fact, the stated policy of the Philadelphia Police Department had been (up to the enactment of the legislation in question) to take disturbed persons directly to mental health facilities in the case of "police personnel observing a person on the highway acting in such a violent, unruly and disorganized manner, so as to constitute a danger to himself or others."[52] In order to be strictly within the law (the Mental Health Law of 1966), the police could not remove a person to a mental health facility against his will unless his behavior "constituted danger to himself or others." In fact, the actual police behavior appears to have been to refer disturbed people to the mental health system even when the behavior was not in fact dangerous. This conclusion can be implied from the policy which was drawn up to supercede the one quoted

above. It states that

> Persons who, by their actions, are unruly or disorganized but do not present a danger to themselves, or to any person present, may no longer be taken into custody under the provisions of the Mental Health Act of 1976 [emphasis added].[53]

The studies quoted earlier indicate a general reluctance of police to arrest persons who are obviously mentally disturbed. The issue of police behavior is central to the hypothesis of diversion and will be raised again in Chapter 6.

It now remains to be seen whether the behavior of substantial proportions of the mentally ill can indeed by classified as non-serious offenses.

There exists a prevalent belief that the behavior of all mentally ill persons constitutes, in the least case, a public nuisance and is, therefore, in breach of the law. The protests of neighbors of proposed half-way houses for ex-mental patients is one fairly common manifestation of this belief.[54] Such complaints are impressionistic, non-specific, and are not based on any empirical proof. One element of the protest is undoubtedly the belief that the mentally ill constitute a public nuisance. Scheff ascribes the prevalence of this belief in a large part to the media and its biased reporting.[55] Morgan sees the origin of the belief in the need to explain behavior which is anti-normative and non-instrumental.[56]

Morgan also points out that the referent of mental illness is bizarre behavior. The ascription of mental illness provides a

satisfactory explanation for the behavior. The illness is then perceived as the cause of the behavior.[57] Other theorists argue in a similar way. Lemert, for example, feels that the basis for involuntary commitment is "the deviations of the psychotic persons from customary role expectancies which increase his social visibility and put strains on others."[58] Mechanic adds to this formulation the existence of alternative interpretations of the behavior. It may be perceived as either "bad" or "sick" depending on whether it is instrumental or not.[59] McHugh's formulation is similar. He points out that behavior which is both bizarre and illegal will be perceived as either mental illness or criminality depending on the perception of its being goal-directed and rational; or irrational and non-goal-directed.[60]

The conclusion that can be reached from the theoretical formulations is that mental illness is equated with bizarre behavior. The illness becomes, in the mind of the observer, both cause and explanation of the behavior. The behavior, in turn, is perceived as a necessary element of mental illness. It is, therefore, not surprising that the mentally ill are generally perceived as persons whose behavior is bizarre, frightening, and easily fits one of the descriptions of legally proscribed behaviors in breach of public order.

The question still remains: how much actual behavior of mentally ill persons actually fits the above description? The theoretical formulations outlined above indicate that the popular conception

of the mentally ill person is of someone who constantly engages in bizarre behavior.

Studies which look at the behavior of the mentally ill are usually directed to the behavior of the ex-patients, and attempt to discover the degree to which their subjects engage in criminal or anti-social behavior. Four groups of studies can be distinguished.

One group of studies concentrates on the disposition of the mentally ill within the criminal justice system. Eizenstat concluded that the police and courts used the incompetency procedure to remove the mentally ill person from the community, because this process was easier than civil commitment to a mental hospital.[61] A further finding is that

> The research on competency indicates that a primary reason that the right to trial is denied to these individuals is that this might be the most organizationally convenient way to process them through a complicated system.[62]

On the same point, Langsley and Barter quote a survey of mental health professions carried out by Assemblyman Frank Lanterman which focused on the reactions of law enforcement personnel to California legislation which prevented the involuntary hospitalization of the non-dangerous mentally ill. They conclude that

> L-P-S (the legislation in question) had deprived law enforcement groups of easy disposition (indefinite commitment in a state mental hospital) for patients who were a nuisance. In fact, law enforcement groups are probably quite concerned about behavior that many mental health professionals would terms a nuisance but not especially dangerous.[63]

We can conclude from these studies that an unknown number of mentally ill persons who committed minor offenses were processed through the criminal justice system in order to provide a "short cut" to treatment in the mental health system. It may also be concluded that the offenses in question were minor, in that prosecution was not carried out.

A second group of studies comprises those carried out in California following the enactment of L-P-S. The California legislature studied the situation regarding state hospital patients released under the new legislation.[64] Among its conclusions concerning ex-patients now residing in the community in boarding homes was that

> in this setting, patients are inactive, bored, tranquilized and vulnerable to exploitation. Without adequate supervision, they are too often arrested for being a nuisance and put in the county jail or are admitted to a local hospital, to be released and rearrested or readmitted in a costly and indefensible revolving door cycle.[65]

The committee also found that

> because of law enforcement personnel's lack of experience in identifying mental illness, they find themselves forced to book many of the individuals. . . . the same people come to the attention of the police repeatedly.[66]

Finally, the committee reported a study which found that former patients were being jailed "for a variety of offenses." However, there was no way of discovering the frequency of imprisonment.[67]

The impact of L-P-S was the subject of a study by the American Federation of State, County and Municipal Employees, which concluded that

> Following (L-P-S) the Los Angeles Police Department reported that, 200 times a month, officers were arresting former patients for bizarre behavior and public nuisances, such as trespassing, exhibitionism, loitering, or wandering along the freeways.[68]

A similar study carried out by the California State Employees' Association concluded that "some law enforcement agencies have experienced an abrupt increase in the number of incidents involving former mental patients."[69]

These studies must be evaluated in light of their obvious interest to prove that L-P-S did not work. The final report was concerned to ensure that the threatened closure of California state hospitals would not occur, and the employees' associations had the same goal, because of the resulting lack of employment for their members.

Nonetheless, three points are made clear from the studies considered here. First, a substantial but unknown amount of the behavior of mentally ill persons can be categorized as against the law. Second, this behavior may be controlled by either the menthal health or the criminal justice systems; and third, discretion and policy, which vary greatly, will decide which institution will take control of the disturbing individual.

It is the immeasurable effect of policy which hinders the

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1 OF 3

evaluation of the actual amounts of behavior which are against the law, as Giovannoni has pointed out.[70] The effect of policy is illustrated by the findings of ENKI,[71] a six-month follow-up of the effects of L-P-S. They found that the number of mentally ill persons picked up by the police following the enactment of L-P-S did increase substantially (by 50 per cent in the first year following the enactment of L-P-S and by 19 per cent the following year), while the number of mentally ill individuals actually booked and imprisoned decreased. The increase in police intervention was felt to be due to the "reaction of the community to its inability to rely on commitment."[72] The study does not attempt to explain the decrease in bookings and jailings, but we can attribute this to the reluctance of the police to process individuals whom they believe to be mentally ill.[73]

ENKI also substantiates the first point; that is, that much of the observed behavior of the mentally ill in the community constitutes misdemeanors. Stone, citing ENKI, lists the main charges against them as "disturbing the peace, vagrancy, and other quasi-offenses."[74]

These studies do not, however, indicate what amount of behavior of the mentally ill constitutes misdemeanors. A third group of studies which does throw some light on the question comprises those dealing with the criminal behavior of the released mental patient. The question of the types of offenses committed by the mentally ill can be only partially answered by these studies for two reasons, both deriving from the fact that the subject populations are all persons

released from mental institutions. First, as already stated, the data measure, to an unknown extent, the effect of release policies of the institutions. The second problem is that the total number of mentally ill at large in the community is made up of releasees and persons never institutionalized. The ratio of releasees to never institutionalized is unknown. The measured rate of offenses committed is the rate of releasees. Thus we cannot estimate the "true rate" of crime of the total population of the mentally ill.

Two of the studies on the civilly committed, discussed previously in the section on dangerousness, are relevant here. Pollock, in 1938, found that the released mental patient was typically guilty of vagrancy, assault, forgery, swindling and profiteering. These are predominantly misdemeanors (assuming that the assaults were simple and not aggravated). Pollock does not give exact numbers. Giovannoni's results were recategorized according to the felony/misdemeanor dichotomy. Her subjects committed a total of 165 offenses, of which 63, or 32.2 per cent, were felonies, and 102, or 61.8 per cent, were misdemeanors.[75] She found that "aside from arrests for intoxication, the most common offense was simple assult."[76] Three of the studies dealing with the criminally insane substantiate the conclusion that the mentally ill tend to commit more misdemeanors than felonies.

Steadman and Cocozza found that of the 98 patients who were eventually released into the community, 20 per cent were arrested for a total of 45 offenses. Of these, 22, or 31.1 per cent, were felonies, and 31, or 68.9 per cent, were misdemeanors. When the

total convictions (N = 11) were analyzed, "in most of the cases, conviction was for minor offenses, such as public intoxication, disorderly conduct, or vagrancy. Two of the convictions involved felonies."[77] Jacoby's study found that of 223 known offenses committed by 137 individuals, 106, or 47.5 per cent, were felonies, and 117, or 52.8 per cent, were misdemeanors.[78] McGarry studied 50 individuals released to the community. During the five-to-six-year follow-up period 24 subjects were accused of a total of 114 offenses of which 103, or 90.4 per cent were misdemeanors, and 11, or 9.6 per cent, were felonies.[79] Thornberry and Jacoby found that victimless offenses and offenses against the public order predominated among offenses committed by their subjects.[80] All of these studies agree that the criminally insane released to the community commit more misdemeanors than felonies. However, no study estimates the total amount of misdemeanors committed by the total mentally ill population for the reasons stated above.

This estimate is provided by two studies, the subjects of which were persons entering the system. The effect of release policy is thus not a factor, although admission policies may have influenced the results. However, according to Goffman,[81], once the institutional process has reached the hospital itself, few patients are refused admission. Levine randomly selected 100 state hospital patients and analyzed the records of their admissions. He found that the behavior initiating the hospitalization constituted an offense in 71 per cent of all cases. Twenty-four behaviors, or 15 per cent,

constituted felonies, and 130, or 84 per cent, constituted misdemeanors. Over half of the misdemeanors could be categorized as assaults, batteries, or disorderly conduct.[82]

Fox and Erikson analyzed the behavioral content of police-initiated admissions to Toronto mental hospitals.[83] Of 679 admissions, charges could have been brought in only 39 per cent of the cases. However, this analysis is based only on those 337 cases in which the behavior was recorded. Those cases were divided into six misdemeanors, distributed as follows:[84]

	Per Cent
drug or alcohol intoxication	6.2
disorderly conduct	5.8
aggression against self	5.0
destruction/theft of property	4.4
no means of support/fixed address	5.2
aggressive behavior to others	9.6
threats	2.9
	39.1

In summary, there are four groups of studies which shed light on the issue of the mentally ill as misdemeanants. The first group looks at mentally ill persons who enter the criminal justice system and are diverted into the mental health system by the incompetency procedure. The implication from these studies is that the behavior in question constitutes minor offenses (assuming that if the behavior were felonious, prosecution would be carried out). The second group of studies looked at the rates of arrests of non-dangerous mentally ill persons following the enactment of L-P-S in California. These studies conclude that much of the behavior of released patients

constituted minor offenses and that the persons concerned were diverted into the criminal justice system. The drawback to this group of studies is that all were carried out by interest groups. Neither group of studies provides an estimate of the degree to which mentally ill people engage in illegal behavior.

A third group of studies looks at the behavior of the released civilly committed patient. It can be concluded that of all offenses committed by the subjects, misdemeanors prevail over felonies. However, this finding could well be a consequence of releasing only those patients who constitute "good risks." A fourth group of studies which examines patients released from institutions for the criminally insane does not suffer this problem, because the release in all cases was the result of judicial order rather than of institutional policy. We have, then, a total of four estimates of the proportions of misdemeanors (as opposed to felonies) committed by ex-patients:

61.8%	Giovannoni
68.8%	Steadman and Cocozza
52.5%	Jacoby
90.4%	McGarry

Finally, two studies which dealt with patients entering the system gave different estimates of both the total numbers of behaviors which constitute:

(a) total criminal offenses--71%, Levine; 39%, Fox and Erikson

(b) misdemeanors--80% Levine; 100%, Fox and Erikson.

The differences are not surprising in view of the different research designs. Levine's subjects had already been admitted and hence his results reflect the admission policy of the institution, which probably explains why his sample contained no drug or alcohol intoxication. Fox and Erikson's study reflects police policy and their perceptions of behavior, which probably explains why there were no felonious behaviors in their sample.

This section attempted to show that the behavior of a substantial proportion of the mentally ill in the community could be classified as in breach of the law and as misdemeanors or summary offenses. At this point, then, it is sufficient to say that the studies support the proposition that a substantial although unknown proportion of the mentally ill population behaves in ways which could be categorized as constituting a summary offense or misdemeanor. Although the exact proportion remains unknown, there exists support for the argument that it is great enough to cause considerable system problems were all of the mentally ill misdemeanants to be diverted into the criminal justice system.

Footnotes to Chapter 3

[1]Pennsylvania Mental Health Procedures Act, #142 of 1976, Section 301.

[2]Many persons are concerned about the failure of the system under the new legislation to provide treatment for the non-dangerous mentally ill. "What we need is an act . . . that's oriented toward letting people who need treatment get it, rather than excluding people who can't meet the narrow criteria of being dangerous." Dr. Erwin R. Smarr, quoted in the Philadelphia Inquirer, June 26, 1977. This research does not deal with the issue of the "right to treatment," but rather addresses itself to the question of social control of the non-commitable mentally ill.

[3]Many psychiatrists have expressed this view to the author, citing as proof of its validity cases of patients who, having recovered from their illnesses, thanked the psychiatrist for coercing them into treatment.

[4]Nicholas Kittrie, The Right to be Different; Deviance and Enforced Therapy (Baltimore: Penguin Books, 1971).

[5]Quoted in Karl Britton, John Stuart Mill (London: Penguin Books, 1953), p. 103.

[6]For a discussion of the problem of the legal definition of criminal insanity, see Herbert Fingarette, The Meaning of Criminal Insanity (Berkeley: University of California Press, 1972).

[7]Introduction to G. Rusche and O. Kirchenheimer, Punishment and Social Structure (New York: Russell and Russell, 1968).

[8]Britton, p. 55.

[9]Ibid.

[10]Talcott Parsons and Edward A. Shils, eds., Toward a General Theory of Action (New York: Harper Torchbooks, 1962), especially Part 2, Chapter 4.

[11]Ibid., Part 2, Chapter 2.

[12]Emile Durkheim, The Division of Labor in Society (New York: Macmillan, 1933).

[13]Ibid.

[14]David Reisman, with Nathan Glazer and Reuel Denney, The Lonely Crowd (New Haven: Yale University Press, 1950).

[15]Joel Spring, "Education as Social Control," in Clarence J. Karier, Paul Violas, and Joel Spring, eds., Roots of Crisis: American Education in the Twentieth Century (Chicago: Rand-McNally, 1973), pp. 30-39.

[16]Michael Harrington, The Other America (Baltimore: Penguine Books, 1963).

[17]Frances Fox Piven and Richard A. Cloward, Regulating the Poor: the Functions of Public Welfare (New York: Vintage Books, 1971).

[18]Bruce Ennis, Prisoners of Psychiatry (New York: Harcourt, Brace, 1972).

[19]Cesare Beccaria, On Crimes and Punishments (1764), reprinted in George Killinger and Paul Cromwell, Jr., eds., Penology: the Evolution of Corrections in America (St. Paul: West, 1973).

[20]Edwin Sutherland and Donald Cressey, Criminology, 8th ed. (Philadelphia: Lippincott, 1970), p. 302.

[21]"The Matter of Josiah Oakes," 1845, 8 Law Reports 123 (Mass.)

[22]California Legislative Assembly, "The Dilemma of Mental Commitments in California," The Assembly Ways and Means Subcommittee of Mental Health Services, Sacramento, California, 1966.

[23]Ibid., Chapter 1.

[24]Henry Santiestevan, "Deinstitutionalization: Out of Their Beds and into the Streets," American Federation of State, County, and Municipal Employees, Washington, D.C., December, 1976, p. 32.

[25]Robert Reich and Lloyd Siegel, "Psychiatry under Seige: the Mentally Ill Shuffle to Oblivion," Psychiatric Annals 3 (November, 1973):35-55.

[26]See Joseph E. Jacoby, "The Dangerousness of the Criminally Insane," unpublished Ph.D. dissertation, Sociology Department, University of Pennsylvania, 1976. In Chapter II Jacoby reviews these studies exhaustively.

[27]Erving Goffman, Asylums: Essays of the Social Situation of Mental Patients and Other Inmates (New York: Anchor Books, 1961), pp. 177-188. See also B. M. Braginsky et al., Methods of Madness: the Mental Hospital as a Last Resort (New York: Holt, Rinehart and Winston, 1969).

[28]This category includes the mentally ill prisoner, the individual committed in lieu of sentence, the incompetent defendant and persons transferred from civil hospitals for security reasons.

[29]A. Louis McGarry, "The Fate of Psychotic Offenders Returned for Trial," American Journal of Psychiatry 127 (1971):1181-84; A. Louis McGarry and Laurence L. Parker, "Massachusetts' Operation Baxtrom: a Follow-up," Massachusetts Journal of Mental Health 4 (Spring 1974): 27-41; Henry J. Steadman and Joseph J. Cocozza, Careers of the Criminally Insane: Excessive Social Control of Deviance (Lexington, Mass.: Lexington Books, 1974); Jacoby, note 26.

[30]Baxtrom v. Herold 383 U.S. 107 86 S.C-. 760 (1966) led to the release of patients studied by Steadman and Cocozza, McGarry, and McGarry and Parker. Dixon v. Attorney General of Pennsylvania 325 F.Supp. 966, 974 (M.D. Pa., 1971) led to the release of patients studied by Jacoby.

[31]McGarry had none; Steadman and Cocozza had under 10 per cent; McGarry and Parker, unknown; and Jacoby had 1.7 per cent.

[32]Steadman and Cocozza, p. 129.

[33]Maurice C. Ashley, "Outcome of 1,000 Cases Paroled from Middletown State Hospital," State Hospital Quarterly 8 (November 1922):64.

[34]Horatio M. Pollock, "Is the Paroled Patient a Menace to the Community?" Psychiatric Quarterly 12 (April 1938):236.

[35]Louis H. Cohen and Henry Freeman, "How Dangerous to the Community are State Hospital Patients?" Connecticut State Medical Journal 9 (1945):694.

[36]H. Brill and B. Malzberg, "Criminal Acts of Ex-Mental Patients," American Psychiatric Association, Mental Hospital Service, Supplemental Mailing #153, August, 1962.

[37]Jonas M. Rappeport and George Lassen, "Dangerousness--Arrest Rate Comparisons of Discharged Patients and the General Population," American Journal of Psychiatry 121 (1965):776-783.

[38]Jonas M. Rappeport and George Lassen, "The Dangerousness of Female Patients: a Comparison of the Arrest Rate of Discharged Psychiatric Patients and the General Population," American Journal of Psychiatry 123 (1966):413-419.

[39]Jeanne M. Giovannoni and Lee Gurel, "Socially Disruptive Behavior of Ex-Mental Patients," Archives of General Psychiatry 17 (1967):146.

[40]Arthur Zitrin, Ann S. Hardesty, Eugene I. Burdock, and Ann K. Drossman, "Crime and Violence among Mental Patients," American Journal of Psychiatry 133 (February 1976):142-149.

[41]McGarry, note 29.

[42]McGarry and Parker, note 29.

[43]Steadman and Cocozza, note 29.

[44]Jacoby, note 29.

[45]The total number of homicides was three.

[46]Giovannoni, p. 139.

[47]For example, the Philadelphia Bulletin, Sunday, September 26, 1976, reported that in the opinion of Drs. Jonas R. Rappeport and Jonas Robitscher, "it [the Act] could result in needy persons being deprived of treatment or eventually winding up in jail."

[48]Title 18, Crimes and Offenses, Commonwealth of Pennsylvania, Act #334, 1972, Section 2709 (Chapter 27).

[49]Ibid., Section 5503 (Chapter 55).

[50]Herbert Packer, "Two Models of the Criminal Process," University of Pennsylvania Law Review 113 (1964):1-68.

[51]Richard G. Fox and Patricia G. Erikson, "Research Report: Apparently Suffering from Mental Disorder--an Examination of the Exercise of Police Power under S.10 of the Mental Health Act of Ontario," University of Toronto, Centre of Criminology, 1972 (mimeo); and Egon Bittner, "Police Discretion in the Apprehension of Mentally Ill Persons," Social Problems 14 (1966-67):278.

[52]Philadelphia Police Department, Directive 136 (April 21, 1971).

[53]Philadelphia Police Department, Directive 136 (June 10, 1977).

[54]Otto Friedrich, Going Crazy: an Inquiry into Madness in Our Time (New York: Simon and Schuster, 1972), reports the protests of New Yorkers. See also University City Newspaper (Philadelphia) 6 (January 1977).

[55]Thomas J. Scheff, Being Mentally Ill (Chicago: Aldine, 1966).

[56]David Morgan, "Explaining Mental Illness," European Journal of Sociology 16 (1975):262-280.

[57]Ibid.

[58]Edwin E. Lemert, "Legal Commitment and Social Control," Sociology and Social Research 30 (1946):370-378.

[59]David Mechanic, Mental Health and Social Policy (Englewood Cliffs: Prentice-Hall, 1969), Chapter 2.

[60]Peter McHugh, "A Commonsense Perception of Deviance," in Hans Peter Dreitzel, ed., Recent Sociology #2: Patterns of Communicative Behavior (New York: Macmillan, 1970), pp. 151-180.

[61]S. Eizenstat, "Mental Competency to Stand Trial," Harvard Civil Rights-Civil Liberties Law Review 4 (1968):379-413.

[62]Henry J. Steadman and Geraldine Braff, "Incompetency to Stand Trial: the Easy Way in?" in Marc Riedel and Terence P. Thornberry, eds., Crime and Delinquency: Dimensions of Deviance (New York: Praeger, 1974), pp. 178-190.

[63]D. Langsley and J. Barter, "Treatment in the Community or State Hospital: an Evaluation," Psychiatric Annals 5 (1975):163-170.

[64]Final Report, California Legislature, Senate Select Committee of State Hospital Service, Alfred E. Alquist, Chairman, Sacramento, California, 1974.

[65]Ibid., p. 17.

[66]Ibid., p. 18.

[67]Ibid., p. 44.

[68]Santiestevan, p. 28.

[69]California State Employees Association (CSEA), "Where Have All the Patients Gone: a CSEA Report on the Crisis of Mental Health Care in California," Sacramento, California, January, 1972.

[70]Giovannoni, op. cit.

[71]ENKI, "A Study of California's New Mental Health Law," ENKI Research Institute, Chatsworth, California, 1972.

[72]Ibid., Chapter 12.

[73]Fox and Erikson, op. cit.; Bittner, op. cit.; and Alan Stone, Mental Health and Law: a System in Transition (Rockville, Md.: NIMH, 1975), Chapter 4.

[74]Stone, p. 63.

[75]Adapted from Giovannoni, p. 149.

[76]Ibid., p. 151.

[77]Steadman and Cocozza, Chapter 8.

[78]Adapted from Jacoby, Table 9-4. Auto theft (N = 11) was categorized as a misdemeanor.

[79]McGarry, op. cit.

[80]Terence P. Thornberry and Joseph E. Jacoby, The Criminally Insane: a Community Follow-Up of Mentally Ill Offenders (in press, 1978).

[81]Goffman, op. cit.

[82]David Levine, "Criminal Behavior and Mental Institutionalization," Journal of Clinical Psychology 26 (1970):279-284.

[83]Fox and Erikson, op. cit.

[84]Ibid., Table 5.10, p. 93.

CHAPTER 4. THE INTERFACE OF THE MENTAL HEALTH AND CRIMINAL JUSTICE SYSTEMS: DEVELOPMENT OF AN HYPOTHESIS

1. Introduction

In this chapter we shall develop the hypothesis of "diversion," that is to say, that when the numbers of persons involuntarily committed to mental hospitals decreases, the number of arrests of these same individuals will increase. We have already concluded (Chapter 3) that the observed behavior of an unknown proportion of mentally ill persons can be conceptually redefined in terms of summary offenses. It now remains to consider the question of whether this redefinition will, in fact, take place and will result in diversion of mentally ill persons into the criminal justice system.

2. The Principles of Treatment

Clear principles regarding the disposition of the criminal and the insane exist in American society and state that the criminal should be punished and the sick treated.[1] Criminality can be defined as deviation from the legal standard, and psychopathology as a deviation from the mental health standard.[2] The overlap--i.e., behavior which deviates from both standards--"has historically been cautious and restrained"[3] and comprises those individuals known as the criminally insane.[4]

Generally speaking, an individual must commit a fairly serious crime in order to be classified as criminally insane. Exceptions to this unstated rule are generally regarded as abuses[5] in light of

the prevailing ideology which prescribes treatment rather than punishment for the sick. As shown above in Chapter 3, much behavior which precipitates a petition for involuntary commitment can be classified as a misdemeanor and, therefore, the behavioral overlap between criminality and mental illness is much greater than the officially recognized overlap (whose referent is the size of the population of the criminally insane). In fact, the majority of mentally ill people whose behavior constitutes, strictly speaking, a breach of law, are dealt with by the mental health system rather than the criminal justice system. Much of the screening into what is perceived as the appropriate system is carried out by the police who are reluctant to press charges against a person whose actions are perceived as determined by mental illness.[6,7] This initial decision is reinforced by mental health workers who continue the commitment process and do not take advantage of the alternative of pressing criminal charges.

Is there any reason to believe that, following the passage of the new law, police and mental health workers will change their long-standing practices and policies which are based on a clear set of ideological principles, and suddenly begin to prosecute the newly freed mentally ill for non-serious offenses? After all, criminal charges are not the inevitable alternative to commitment. One prevalent belief is that the mentally ill will be let free to roam in the community and will form "ghettoes" in substandard board and care homes located in deteriorating areas of the city.

> Some California groups believe that such patients have been removed from the back wards of hospitals and placed in back rooms of board and care homes where they are less visible than in the hospital.[8]

It has been established that the reduction of the population of state hospitals does result in the growth of board and care homes,[9] and that these homes tend to be situated in low-income areas where the community is powerless to protest them.[10] Further, the lack of licensing requirements leads to the low visibility of these establishments and the consequent difficulty in estimating the size of their population.[11] It has not been established, however, that residence in a board and care home precludes diversion into the criminal justice system (unless, of course, the board and care home resident is physically or chemically restrained. There are claims that such treatment is used, but its incidence is unknown). Some reports claim that residents of board and care homes are among those ex-mental patients who come into contact with the criminal justice system.[12]

The fact of residence in a board and care home does not, then, rule out the possibility of diversion into the criminal justice system. However, would not the treatment ideology referred to above prevail to the extent that the non-serious offenses of the mentally disturbed would be overlooked? The answer to this question centers around the reason (as opposed to the rationale) for involuntary commitment for the mentally ill. If, as we will argue below, involuntary commitment is a convenient means of social control, it is

reasonable to suppose that if it is removed by legislation, the alternative means--the criminal justice system--will be used.

3. The Asylum as a Social Control Institution

A review of the history of involuntary commitment reveals that it arose out of a need for social control of deviants. We shall see that it continues to fulfill this function today. There is general agreement that before the eighteenth century the three major forms of deviance--crime, poverty and mental illness--posed no great threat to rural society,[13] and mechanisms for their control were informal, centering largely around the family.[14] The notion is that of an amorphous "pool of deviants" whose numbers were suddenly and greatly increased by the breakdown of the feudal system and the development of capitalism.[15] It was during this time that institutions of formal control developed. There is agreement that these institutions developed out of a need for social control of deviants,[16] particularly the need to manipulate the work force. The manpower most easily controlled by the state was the "pool of deviants"--beggars, prostitutes, widows, lunatics and orphans.[17] Consequently, the first institutions did not differentiate between classes of deviants.[18] The development of the lunatic asylum can be most accurately described as an evolution, the cause of which has been claimed to be: the rise of the psychiatric profession and difficulties in dealing with the insane within the workhouse or house of correction,[19] humane and ideological reasons,[20] industrialization and the need for social order,[21] and the demands of

the market system.[22] These factors are, of course, related and the origin of the asylum must be attributed to the complex interrelationships between them all. The fact remains, however, that the asylum evolved from institutions which were themselves established because of the need to control deviant behavior, and the asylum continued to fulfill this function: "The hospital treatment of the mentally ill in America, as in Europe, developed in the context of the social control of the deviant and the poor."[23] "For all the criticisms which could be made of them [nineteenth century] asylums were still a convenient way of getting rid of inconvenient people."[24]

The differentiation of institutions according to the type of inmate was related more to the development of professions specialized to deal with different types of deviants than to a reduction in the need for social control. However, the social control function of the asylum was masked to a considerable extent by the growth of the treatment ideology. Scull claims that the custodial nature of asylums was legitimized by medical control and rhetoric concerning cure,[25] and Leifer analyzes in detail the manner in which the "treatment ideology" disguised the underlying control function of the asylum.[26] This thesis is also supported by Bardach who claims that

> Until recently, the effort to define mental disorder as a medical problem, rather than as a problem properly dealt with by law or other means of social control, was seen as an unqualifiedly progressive, humane, and liberal cause.[27]

The recent rediscovery of the social control function of institutions for the mentally ill by sociologists[28] has been implicitly recognized by the United States Supreme Court in the "right to treatment" cases in which preventive incarceration in mental hospitals has been found unconstitutional.[29] The "right to treatment" cases have, in effect, ordered the mental health administration to release patients if treatment cannot be provided. We can conclude that those patients released as a result of these cases had, indeed, been confined for purposes of social control only.[30]

Proof of the contention that incarceration in mental hospitals serves the purpose of social control is usually presented in the form of individual case histories.[31] One difficulty in proving the contention lies in the fact that treatment and social control are not mutually exclusive phenomena. Further, the goal of social control can be achieved by psychiatric means (usually in the form of psychotropic drugs). "The means are medical but the ends are social and political."[32] Proof must, therefore, be sought in the "ends," that is to say, in the motivation for the incarceration or treatment, and this factor is not easily measured.

Support for the contention that psychiatric treatment is used for purposes of social control abounds, but in non-empirical form. On the lowest level of validity, there are polemical statements which attribute motivation, an individual characteristic, to the mental health system, or to society as a whole. For example, Ennis contends that

> coercive psychiatry has found a comfortable niche in society. How would we tame our rebellious young, rid ourselves of doddering parents, or clear the streets of the offensive poor without it?[33]

Other statements not only imbue society with motivation, but characterize the motivation as malicious. "Society's unspoken goal is to remove most abnormal behavior to a place where it will not generally be seen."[34] Motivation, as mentioned earlier, is difficult to measure, particularly when its incumbent is a whole society or a complex system.

The contention is better borne out by statements concerning the function of the mental health system (in particular, the state hospital), for function can be imputed, observed, and explained. Thus the statement that the function of the mental health system includes that of relieving society "of the trouble of accomodating persons who, though not dangerous, are bothersome"[35] is borne out by the observation that there is a large group of persons confined in mental institutions "for whom no rationale can be advanced"; they "are simply bothersome or troublesome to their families or to society."[36] The social control function can be inferred from observations of this type[37] and also from legislative restrictions on the release of violent, dangerous, or troublesome patients. Commitment statutes in particular reveal the social control function of involuntary commitment.[38]

The explanation of the contemporary social control function of involuntary commitment is based on the behavioral overlap of criminal and psychotic behavior. We have indicated that this overlap is

wide-spread, particularly when one includes misdemeanors in the category of criminal behavior.[39] "Both systems can and do frequently try to handle the same human problems."[40] It should be emphasized here that we are not dealing with the voluntary patient, who may recognize within himself unpleasant feelings for which he actively seeks help. The focus of concern is rather with the involuntary patient who is brought against his will into the mental health system, because his overt behavior has caused distress to others, and of whom it may be said that the basis of commitment is not illness but "the deviations of the psychotic person from customary role expectancies which increase his social visibility and put strain on others."[41] The referent of illness is thus behavior.[42] If the behavior is seen out of context, as pure action, so to speak, one may well claim that "the menace [of the behavior] is precisely that posed by any criminal activity."[43] The point is, however, that the behavior is seen in context, and it is within this context that the behavior is judged to be illness or criminality. "The extent to which mental illness is seen to exist depends on the perspectives taken and the criteria used to identify its presence. In this area it is not too difficult to play a numbers game which either maximizes or minimizes the amount of alleged mental illness by changing the criteria used."[44]

There exists a considerable body of literature concerning the perception of behavior and the attribution of illness or criminality.[45] We are not concerned here with the processes of perception and definition of behavior. Our intention is to emphasize the fact that the referent

of illness is behavior[46] and that the behavior is interpreted as either illness or criminality before action is taken. The criteria for interpretation are cultural and are interpreted by individuals so that a situation exists where

> there is . . . between madness and badness a large gray area which, depending on cultural values and administrative practice, might be labelled as criminal or mental. The major legal difficulty, of course, is that in the gray area it may be possible to confine someone simply by changing his label to conform to whichever allows the easier route to confinement.[47]

This behavioral overlap and the amorphous and flexible criteria for allotting behavior to the appropriate system are necessary preconditions for the systemic overlap which contributes to the blurring of the distinction between illness and criminality. This systemic overlap comprises two areas--the control of deviants by the mental health system and the treatment of the mentally ill within the criminal justice system, but it is the former which constitutes the basis of the claim that a major function of the mental health ystem is that of social control. There have been two contemporary movements which have contributed to the control function of the mental health system. One is the "decriminalization" of victimless crimes such as alcoholism and drug addiction, as well as some offenses against the person, particularly within the area of sex offenses. The perpetrators of these offenses are turned over to the mental health system.[48] A concomitant movement has been the growth of the community mental health system[49] which has been described as a "boundaryless and boundary-busting system":[50] boundaryless because of the very

general nature of its goals and boundary-busting partly by definition as boundaryless[51] and partly because of the decriminalization movement which provides input. It is this extension of psychiatry which led Zola to claim that "medicine is becoming a major instrument of social control."[52] This movement, together with the historically created social control function leads to the conclusion that a major contemporary function of the modern mental health system is "to protect the community from persons whose conduct is considered to be dangerous, threatening or bothersome."[53]

There exists some empirical proof for the proposition that a major function of the mental health system--particularly the mental hospital--is that of social control.[54] We have already mentioned that a major difficulty in proving this proposition is the co-existence in many cases of mental illness and criminality. The ideal methodology would, therefore, be to examine the system itself rather than the individuals within it. This was the method chosen by Penrose who hypothesized that each society contained a number of individuals whose behavior needed control and that the institution used for control could be either the prison or the mental hospital. The choice depends primarily on the availability of resources, so that "as a general rule, if the prison services are extensive, the asylum population is relatively small and the reverse also tends to be true."[55] In an extensive research in which the populations of prisons and asylums were compared in 18 countries, Penrose found that an inverse relationship did indeed exist. In 1968, Biles and Mulligan attempted

to replicate Penrose's findings, using a more sophisticated research design which took into account variables such as crime rates, probation rates and the ratio of police to public. The hypothesized inverse relationship between the prison and the asylum population did appear, but only weakly. The authors concluded that

> the data are consistent with the view . . . that the relative use of mental hospitals or prisons for the segregation of deviants reflects differnt styles of administration.[56]

These studies of the systems themselves are so wide in scope that the interpretation of their results is difficult, especially without controlling for the variable of administrative policy. However, the very fact that administrative policies can influence the rates of imprisonment and hospitalization indicates that the phenomena of illness and criminality are socially constructed, while the weak inverse relationship found supports the contention that they are in some instances alternative interpretations of the same behavior.

Other studies restrict themselves to one system only--the mental health system--and attempt to show that one of its major functions is social control by examining the behavior of individuals within the system. One way of drawing this conclusion is to examine the behavior of the patients themselves. We have already mentioned that the behavior which initiates the commitment process constitutes a disturbance and is often against the law.[57] Steadman and Cocozza[58] found that the 20 individuals in their sample who were arrested were also rehospitalized at some time during the follow-up, and that "whether a

violation of the law resulted in arrest or rehospitalization as the preferred mode of official response did not seem to be related to the type or severity of the offense."[59] We can conclude that administrative discretion produced this result. This study thus supports the findings of systems studies of Penrose and Biles and Mulligan in that hospitalization or imprisonment are alternative responses to the same behavior, and that the allocation of the behavior to one or the other system depends on administrative policy.

Other studies which concentrate on the administration within the mental health system also support the above conclusion. The commitment process begins with the disturbed person's family or community, or the police. Scheff, using observations and individual case studies, points out that the family does not initiate proceedings during the time that the patient suffers symptoms which cause distress only to himself, but rather waits until those symptoms manifest themselves in overt behavior which the family cannot control.[60] Rogler and Hollingshead, in an in-depth study of 20 Puerto Rican families with a schizophrenic member, also found that hospitalization is used only when the sick person's behavior cannot be controlled by the family.[61] Yarrow et al. found that among American families, a complex series of defensive definitions of behavior takes place before no more adaptations can be made, and the decision to hospitalize appears inevitable.[62] Smith et al. examined the hospitalization of 100 schizophrenic patients and found that of 100 precipitating incidents, only nine could be described as "illness requiring treatment." The remaining

incidents represented either a danger to self or others or socially unacceptable behavior.[63] (It should be noted that Gove's findings indicate that the reactions of the audience to psychiatric symptoms and behavior may be class-related.[64])

The sick person's perception of the family's reaction is exemplified by a patient in the case of Kremens v. Bartley[65]: "You're 14 years old and you don't like school. The juvenile court puts you on probation for truancy. When you cut school again, your parents sign you into a state mental hospital."[66]

If the initial petitioner is not the family, it is likely to be the police.[67] Rock et al. found that police in different states have very different methods of dealing with the mentally ill. They found, for example, that in Chicago the police preferred not to petition for commitment, but to arrest the disturbing individual and let the court initiate commitment proceedings if it wished. On the other hand, Los Angeles police took mentally ill persons directly to a mental health facility. Rock concludes, "That they did so is a product of legal environment, administrative policy and availability of resources for expeditious police referral of mental illness cases."[68] This finding supports the contention that mental illness and criminality are in many cases alternative explanations of the same phenomenon, and that the explanation chosen is determined to a large extent by the facilities which are available to control the disturbing individual.

The next step in the commitment procedure is the commitment court itself. (Even in jurisdictions in which commitment by medical certification exists, there is usually some judicial supervision and

ratification of the certification.) Observational studies confirm that the commitment hearing, although couched in medical/psychiatric terminology, fulfills the function of social control. The observers in one study "quickly realized that the judges' chamber had historically served as a crisis intervention center for the county."[69] Another study noted that the commitment court dealt with not only the mentally ill but also individuals who were, strictly speaking, mentally healthy although socially incompetent. These included the elderly and homeless persons. "The process engulfed a potpourri of other social problems."[70]

The ENKI report discussed the problem of the dual objectives--control and treatment--of the California mental health system and commented that "the conflict was carried over into the commitment court."[71] Later, the report concluded that

> most commitment procedures were found to be a ritual where legal and medical performers cooperated to remove the disturbed and disturbing patient from the community.[72]

Once committed and hospitalized, the patient comes in contact with the final link in the chain of social control--the psychiatrist. Despite the fact that the desired self-image of the psychiatrist is that of the agent of the patient, studies indicate that he is more accurately described as a mediator in the conflict between the patient and his family or community.[73] Further, he is a non-objective mediator:

> psychiatrists, so impressed with their legally conferred role in the commitment decision, seem to have been involved in making social dispositions rather than psychiatric or therapeutic decisions. Whether they perceived such pressure or not, physicians acts as though under pressure to satisfy the social control function.[74]

A local mental health worker has observed that "the family strongly influences the decision," at least at the point of initial contact.[75] Greenley has shown that this familial influence continues through to the treatment stages and is a strong determinant of the decision of the psychiatrist to release the patient.[76] The psychiatrist is, of course, acting within and as a part of the total complex system of institutions known as the mental health system, within which the mental hospital plays a central role. The fact that the hospital fulfills a social control function has been recognized by the Supreme Court in the "right to treatment" cases referred to earlier. Ennis describes Bellevue Hospital in New York as "a dumping ground for New York City's alcoholics, addicts and Bowery bums. It takes in runaway teenagers and students on 'bad trips,' old people who can no longer wash or feed themselves, troublemakers, demonstrators. . . ."[77]

4. Recent Changes in the Mental Health System

We have shown that the criminal justice and mental health systems originated together as one social control institution and that the separation of the two systems did not indicate a total separation of function. Rather, the mental health system continued to fulfill

the function of social control covertly in cases where the prevailing ideology dictated treatment rather than punishment. The social control function of the mental health system is best fulfilled by the mental hospital which provides physical restraint. However, the mental health system is undergoing drastic change in the form of a movement away from the mental hospital and towards community treatment.

The origin of the community mental health system has been referred to above. This movement of patients out of the hospital and into the community has been influenced by federal funding policy,[78] by the "right to treatment" cases, and by state legislation of the type under discussion here. The result has been the release into the community of many individuals who would previously been hospitalized.[79] The institution designated to care for them is the community mental health system. However, the clientele of the community mental health system does not necessarily include those persons who have avoided involuntary commitment. The community mental health system is designed to treat "the community"[80] and, although the numbers of social problems coming within its jurisdiction are increasing,[81] it has no way of coercively treating those who reject treatment. The involuntary patient who can no longer be committed under the new mental health act is no more likely to accept community care than he was to accept hospitalization. This problem has been recognized in California where a recent amendment to the Mental Health Services Act of 1969 has introduced the concept of involuntary out-patient treatment in an attempt to solve it.[82]

The result of the "decarceration" movement[83] of the last two decades has been to increase the number of deviants in the community.[84] (By "deviant," we mean persons who would, prior to the most recent developments in mental health law, have been hospitalized. It has been claimed that the mental hospital controls persons who are not, strictly speaking, mentally ill, but who can be best described as "social problems."[85] For this reason, we use the term "deviant" rather than "mentally ill" to describe this newly free population.) There has been some indication that the non-deviant population may become, as a result of new mental health law and policy, more tolerant of the deviants in their midst.[86] If this could be shown to be the case, it could be assumed that there would be no need to use alternative means of social control and that diversion into the criminal justice system would not occur. However, there are two reasons to believe that this increased tolerence has not occurred.

First, it is fairly well-established that the major causes of the community mental health movement were a mixture of humanitarian reform[87] and financial pressures.[88] There is a strong movement of civil libertarians who support civil rights for the mentally ill and who work actively for their freedom in the community. This group has also been actively involved in those judicial decisions which have awarded such rights (and which later have been the basis for legislation of the type under consideration here).[89] There is no reason to assume that this small body of civil libertarians represents the community at large, so that one commentator was moved to note

that while the result of the new mental health legislation is good law, the wisdom of the social policies involved is questionable.[90] Foley states flatly that

> the mental health ologopolists did not face the critical question of what would be the social costs for the community and family themselves when they assumed a greater responsibility for the care of the mentally ill.[91]

Mechanic cites two studies which indicate that such "decarceration" policies cause considerable strain on the families and communities of the mentally ill persons who were no longer commitable under new mental health laws[92] and concludes that "policy changes must be evaluated in terms of their behavioral consequences and problems."[93] It is thus not clear that any widespread increase in tolerance of deviant behavior existed before the community mental health system began.

Second, the community mental health movement has not been shown to have caused increased tolerance through increased exposure of the mentally ill to the community. Wolpert's documentation of community protests concerning the establishment of group homes for ex-patients in their midst[94] indicates that intolerance is widespread on the community level, and this is supported by the work of Aviram and Segal who describe the ways in which communities resist the establishment of residences for ex-patients.[95] Aviram and Segal also examined a number of social distance studies on the attitudes towards the mentally ill and concluded that although a slight increase in tolerance over the years is indicated,[96] this increase is hardly great enough

to effect a change in behavior, especially in light of their findings with regard to the community resistance towards homes for the mentally ill.[97]

There is, then, no reason to claim that public tolerance of the behavior of the mentally ill has changed significantly as a result of the community mental health movement. The need for social control can, therefore, be said to remain. We have already pointed out that the factor which activates the use of social control mechanisms is behavior and that when the person engaging in the disrupting or disturbing behavior is mentally ill, there exists a tendency to use the mental health system as social control because of the prevailing "treatment ideology." However, the behavior is open to redefinition and reinterpretation as criminality, thereby permitting the use of the criminal justice system as social control. We have raised the question whether, in cases where the mental health system can no longer be used as social control, this redefinition will in fact take place. The factors of "ghettoization" and of increased tolerance towards the mentally ill are not likely to prevent its occurring. Nonetheless, this does not prove that it will indeed occur. The desire for control over the mentally ill,[98] coupled with the culturally induced aversion to punishing them, raises a dilemma,[99] and it is difficult to predict how the community will resolve it.

5. Resolving the Dilemma--Non-Empirical Perspectives

We have already mentioned the central role played by the police in

dealing with the mentally ill. Bittner's work on police discretion, based on observation, indicates that the police are not confined to the alternatives of arrest or commitment when dealing with the mentally ill, but often find other informal ways of coping with the behavior of disturbed people.[100] It would seem, however, that police policy depends to a great extent on the type of police administration.[101] The policy of the Philadelphia Police Department was made clear in a directive dated June 10, 1977, following the new act, in which officers were informed that:

> Persons who, by their actions are unruly or disorganized but do not present a danger to themselves, or any person present, may no longer be taken into custody under the provisions of the Mental Health Act of 1976.
>
> However, persons who make unreasonable noise, use obscene language, make obscene gestures, engage in fighting or threatening, in violent or tumultuous behavior, create a hazardous or physically offensive condition by any act which serves no legitimate purpose to the actor, may be charged with violating Section 5505 of the Crimes Code, Disorderly Conduct.[102]

There is no reason to assume that police officers will not comply with this directive. Diversion would thus be avoided because of police activity.

Monahan has suggested that a possible reason for the failure of diversion to occur will be the manipulations of mental health personnel: "to the extent that the states tighten their criteria for involuntary civil commitment from 'need for treatment' to 'dangerous to others' one should expect predictions of dangerousness to increase."[103] There does not appear to be any study on this point,

so at this stage such manipulation remains an untested possibility. However, the legislative requirement in Pennsylvania that the dangerousness be proven by an overt act may overcome such manipulation.

There is not a great deal of evidence proving that diversion does not occur. There is, on the other hand, an indication that the community mental health system does not fulfill the control function of the state mental hospital, thus opening the way for the argument that diversion into the criminal justice system will occur. Senator Nicholas M. Petris, evaluating the effect of L-P-S, indicated the need for more control. "We found the need to strike a middle ground between involuntary commitment and no care at all."[104] The compromise suggested by Petris was a form of mandatory outpatient treatment. Although Petris phrases his remarks in terms of "care," we may assume the need for control from the necessity of some form of coercive treatment. A great deal of the problem with the community mental health system is that it is neither designed nor equipped to care for the discharged mental patient.[105] Thus the very fact that the individual is free in the community does not indicate that he is receiving care[106] or that he does not constitute a burden to his family or community.[107]

6. Resolving the Dilemma--Empirical Perspectives

It appears reasonable to hypothesize that diversion may result from such a situation. The precedents for the current situation in Pennsylvanis are California, whose Mental Health Services Act (known

as L-P-S) was passed in 1969, and New York, where a policy change brought about a similar situation in 1968.[108] The studies made on the newly freed mentally ill in these states do not provide a definitive answer to the question of the resolution of the dilemma referred to above.

Some studies indicate that there is no diversion into the criminal justice system, but present little support for the conclusion. For example, the report of a director of a community mental health center stated that "we have not seen evidence in our local area of mentally ill persons being diverted into the criminal justice system."[109] However, this is an impressionistic conclusion and cannot be regarded as conclusive evidence against diversion.

Some studies are polemical in nature and, as such, cannot be granted a great deal of validity. Santiestevan states that

> Following [L-P-S] . . . the Los Angeles Police Department reported that, 200 times a month, officers were arresting former patients for bizarre behavior and public nuisance, such as trespassing, exhibitionism, loitering, or wandering along the freeways[110]

but cites no source for this figure. His comment that "New York's street crime scene found a grim addition in the senseless violence of many released mental patients"[111] is typical of the journalistic type of "findings" which abound but which will not be further discussed here.

A second group of studies has more validity in that there appears to be an attempt at objective data-gathering and analysis. However,

the exact methodology is not presented, so that a critical valuation may not be made. A study by Lowry found that a number of former patients were indeed jailed for a variety of offenses following the enactment of L-P-S in California. However, it was not clear whether this number was more than the number arrested before the enactment of L-P-S.[112] The California State Employees' Association concluded that "some law enforcement agencies have experienced an abrupt increase in the number of incidents involving former mental patients."[113] The failure to state the source of this conclusion detracts from its validity. Bardach also notes that many mentally disturbed but non-commitable persons were diverted into the criminal justice system, and attributes this to the failure of any one institution within the mental health-welfare complex to accept and deal with this group of persons.[114] In this case, also, the validity of the conclusion is weakened by the failure to elucidate its source.

The conclusions of a third group of studies are based on official records and/or observations and are thus more acceptable. The studies fall into two categories. The first category concludes that diversion into the criminal justice system of non-commitable persons occurs. The second group finds that such diversion simply detours these people back into the mental health system using the incompetency procedure.

Among the first category is the report of the California Senate committee whose observations led it to the conclusion that "in this setting [the board care home] patients . . . are too often arrested

for being a nuisance and put in the county jail."[115] Rock et al. reached a similar conclusion. Their observations and investigations of records led to the conclusion that

> intervention by some agencies to initiate hospitalization is discouraged to such a degree that another basis for intervention, criminal arrest, is often substituted.[116]

The problem with these conclusions is that there is no pre-legislative rate of arrest with which to compare the post-legislative rates. There are two studies which partially solve this problem.

The California situation was examined by the ENKI Corporation, who compared arrests of persons defined by the Los Angeles police as mentally ill for the years immediately preceding and following L-P-S. They found a 50 per cent increase in arrests of mentally ill persons in the first year following the legislation. The increase continued in the second year but at a lesser rate (19 per cent over the previous year).[117] The rate of the mentally ill actually jailed for their offenses actually decreased, indicating that the increased arrest rate was

> a response by law enforcement to community pressures for processing the mentally disordered individual who manifested bizarre behavior but who was ineligible for involuntary hospitalization under L-P-S.[118]

There has been as yet no investigation of arrest rates of the mentally ill in Pennsylvania, but a study of mentally ill prisoners indicates that their numbers have increased following the new law. Guy compared the psychiatric caseload in the Philadelphia prison system during the

first quarter of 1977 (post-legislation) with the first quarter in 1976 (pre-legislation) and found a 51 per cent increase in psychiatric hospitalization rates (101 in 1976 to 153 in 1977). The total prison population remained constant during this time. Along with the total increase, Guy noted an increased number of patients charged with non-violent offenses, including several misdemeanors. The post-legislation group contained six prisoners whose arrests were family-initiated, while the pre-legislation group contained no such admissions.[119] Guy concludes tentatively that these changes may be the result of the new legislation.[120]

The evidence from California indicates that the effect of the new mental health law was the arrest, booking, and subsequent release of mentally disturbed persons, whereas the evidence from Pennsylvania indicates their entry into the prison psychiatric services. A third possibility--that of entry into the mental health system via the criminal justice system--is raised in three studies, two of which were carried out in California and one in New York. Steadman, in a follow-up study of patients released from New York state hospitals for the criminally insane, mentions the use of the incompetency procedure in order to hospitalize the non-dangerous mentally ill, but does not estimate its prevalence.[121] Abrahamson observed the San Mateo County jail, court and probation system and concluded that "as a result of L-P-S, mentally disordered persons are being increasingly subjected to arrest and criminal prosecution" on summary charges.[122] He also compared commitments via the incompetency procedure before

and after L-P-S and found that its use had increased considerably.[123] The California Department of Mental Hygiene found that the numbers of persons entering the mental health system via the criminal code had increased since L-P-S, but was cautious in inferring a causal relationship.[124]

7. Summary

If the evidence is not sufficient to prove that legislative restrictions on involuntary commitment will result in diversion into the criminal justice system, it does at least suffice to raise the hypothesis that this may well be the case. The theoretical basis for the hypothesis is the functional reciprocity of the systems of mental health and criminal justice, and the perception of mental illness as behavior which needs control. The empirical basis comprises the studies cited above. Stone summarizes the California situation as follows: "While some who would formerly have been committed are undergoing outpatient care, a significant number have refused referral and have found their way into the criminal system."[125] The next chapter will discuss the methodology used to test the hypothesis and will present the findings.

Footnotes to Chapter 4

[1]Allan A. Stone, Mental Health and Law: a System in Transition (Rockville, Md.: National Institute of Mental Health, Monograph #HSM-42-73-249, 1975).

[2]Simon Dinitz, "Policy Implications of an Experimental Study in the Home Care of Schizophrenics," Sociological Forces 1 (Winter 1967): 1-19.

[3]Ibid., p. 103.

[4]The concept of "criminally insane" has been examined in Chapter 3.

[5]Henry J. Steadman and Joseph J. Cocozza, Careers of the Criminally Insane: Excessive Social Control of Deviance (Lexington, Mass.: Lexington Books, 1974).

[6]Richard G. Fox and Patricia G. Erikson, "Apparently Suffering from Mental Disorder: an Examination of the Exercise of Police Power under S.10 of the Mental Health Act of Ontario," Research Report, Centre of Criminology, University of Toronto, 1972 (mimeo).

[7]Egon Bittner, "Police Discretion in the Apprehension of Mentally Ill Persons," Social Problems 14 (1966-67):278.

[8]D. Langsley and J. Barter, "Treatment in the Community or State Hospital: an Evaluation," Psychiatric Annals 5 (May 1975): 163-170. For further discussion of board and care homes in California, see Henry Santiestevan, Deinstitutionalization: Out of their Beds and into the Streets (Washington, D.C.: American Federation of State, County and Municipal Employees, 1976); ENKI, A Study of California's New Mental Health Law, 1969-1971 (Chatsworth, Calif.: ENKI Corporation, 1972). For a discussion of the board and care situation in New York, see Otto Friedrich, Going Crazy: an Inquiry into Madness in Our Time (New York: Simon and Schuster, 1976); Robert Reich and Lloyd Siegal, "Psychiatry under Siege: the Mentally Ill Shuffle to Oblivion," Psychiatric Annals 3 (November 1973):35-55. The situation in Pennsylvania is discussed by Gretchen Niedermayer, "Boarding Homes are Seen as Warehouses of the Helpless," Region, October, 1976, pp. 12-15; Center for Social Policy and Community Development, "Boarding Homes in Philadelphia," Temple University, 1978 (mimeo).

[9]Eileen and Julian Wolpert, "The Relocation of Released Mental Hospital Patients into Residential Communities," Princeton University, 1974 (mimeo).

[10]Uri Aviram and Stevan P. Segal, "Exclusion of the Mentally Ill," Archives of General Psychiatry 29 (July 1973):126-131 and "Community-Based Sheltered Care," in Paul I. Ahmed and Stanley G. Plog, eds., State Mental Hospitals (New York: Plenum Publishers, 1976).

[11]Center for Studies in Social Policy and Community Development, op. cit.; and Aviram and Segal, Archives of General Psychiatry.

[12]Santiestevan, op. cit.

[13]Reich and Siegal, op. cit. It should be noted that before goal-oriented institutions were created for deviance management, this function was fulfilled by a private police force employed by wealthy urban dwellers. Andrew T. Scull and Steven Spitzer, "Social Control in Historical Perspective: from Private to Public Response to Crime," in David Greenberg, ed., Corrections and Punishment (Beverly Hills: Sage, 1974).

[14]Andrew T. Scull, "The Decarceration of the Mentally Ill: a Critical View," Politics and Society 6, Summer 1976 and Decarceration: Community Treatment and the Deviant, a Radical View (Englewood Cliffs: Prentice-Hall, 1977); David Rothman, The Discovery of the Asylum: Social Order and Disorder in the New Republic (Boston: Little, Brown & Co., 1971); Ronald Leifer, In the Name of Mental Health: the Social Functions of Psychiatry (New York: Science House, 1969); Michael A. Peszke and Ronald Wintrob, "Emergency Commitments: a Transcultural Study," American Journal of Psychiatry 131 (1974):36-40.

[15]Ibid. See also George Rusche and Otto Kirchenheimer, Punishment and Social Structure (New York: Russell and Russell, 1968).

[16]Rothman claims that the social control hypothesis is too narrow and attributes the origin of the institution to society's need for social order. There are two problems with this thesis. One is that it is difficult to see the substantive difference between social control and social order. The other is that Rothman negates the social control theory on the grounds that it "makes every spokesman and leader of movements a tool, conscious or not, or the economic system." Many theorists agree that this is, in fact, the case. See, for example, Herbert Marcuse, One Dimensional Man (Boston: Beacon, 1964).

[17]Rusche and Kirchenheimer, chapter 2.

[18]Scull, Decarceration, chapter 4.

[19]Scull, "Decarceration," and Leifer, op. cit.

[20]Leifer, chapter 4.

[21]David Mechanic, Mental Health and Social Policy (Englewood Cliffs: Prentice-Hall, 1969); and Rothman, op. cit.

[22]Scull, Decarceration; and Rusche and Kirchenheimer, op. cit.

[23]Leifer, p. 215.

[24]Scull, Decarceration, p. 128.

[25]Ibid., chapter 7.

[26]Leifer, chapter 7.

[27]Eugene Bardach, The Skill Factor in Politics: Repealing the Mental Commitment Laws in California (Berkeley: University of California Press, 1972), p. 70.

[28]Saleem A. Shah, "Community Mental Health and the Criminal Justice System: Some Issues and Problems," in John Monahan, ed., Community Mental Health and the Criminal Justice System (New York: Pergamon Press, 1976), pp. 279-292.

[29]See, for example, Wyatt v. Stickney 325 F.Supp. 781 (M.D. Ala. 1971).

[30]National Institute of Mental Health, Statistical Note #60, "Provisional Patient Movement and Administrative Data, State and County Mental Hospital Inpatient Services, July 1, 1970-June 30, 1971, Washington, D.C., Department of Health, Education and Welfare, Office of Planning and Evaluation, Survey and Reports Sections, January, 1972.

[31]See, for example, David Ferleger,"Loosing the Chains: In-Hospital Civil Liberties of Mental Patients," Santa Clara Lawyer 13 (1973):447-500.

[32]Leifer, p. 45.

[33]Bruce Ennis, Prisoners of Psychiatry (New York: Harcourt, Brace, 1972), p. 230.

[34]American Bar Association, Mental Health and Retardation Services Project, "Handbook: Legal Principles for Representing the Mentally Different," Seattle, 1975, p. 58 (mimeo).

[35]Stone, p. 45.

[36]Ibid., p. 46.

[37]California Legislative Assembly, "The Dilemma of Mental Commitments in California," Sacramento, 1966 (the conclusion reached --that California's mental health system had dual goals of treatment and custody--was based on observations).

[38]Bardach, op. cit.

[39]See studies cited in Chapter 3, especially David Levine, "Criminal Behavior and Mental Institutionalization," Hospital and Community Psychiatry 27 (1976):716-719.

[40]Herbert C. Modlin, J. Porter, and Richard E. Benson, "Mental Health Centers and the Criminal Justice System," Hospital and Community Psychiatry 27 (1976):716-719.

[41]Edwin Lemert, "Legal Commitment and Social Control," Sociology and Social Research 30 (1946):371.

[42]D. Mechanic, op. cit.; Leifer, op. cit.; David Morgan, "Explaining Mental Illness," European Journal of Sociology 16 (1975): 262-280.

[43]Julian Friedman and Robert W. Daly, "Civil Commitment and the Doctrine of Balance: a Critical Analysis," Santa Clara Lawyer 13 (1973):503-536.

[44]Mechanic, p. 65.

[45]Ibid.; Morgan, op. cit.; Peter McHugh, "A Common Sense Perception of Deviance," in Hans Peter Dreitzel, ed., Recent Sociology #2: Patterns of Communicative Behavior (New York: Macmillan, 1970), pp. 151-180.

[46]Morgan, op. cit.; Leifer, op. cit.

[47]Stone, p. 6.

[48]An exhaustive analysis of the decriminalization phenomenon is presented in Nicholas Kittrie, The Right to be Different: Deviance and Enforced Therapy (Baltimore, Md.: Penguin, 1973).

[49]Leifer, op. cit., and Mechanic, op. cit., both describe the history of the community mental health system.

[50]Simon Dinitz and Nancy Beran, "Community Mental Health as a Boundaryless and Boundary Busting System," Journal of Health and Social Behavior 12 (June 1971):99-107.

[51]Ibid.

[52]I. Zola, "Medicine as an Institution of Social Control," The Sociological Review, 1972, p. 487. This thesis has been shown to be empirically true, at least in one California jurisdiction. See Thomas Blomberg, "Diversion and Accelerated Social Control," Journal of Criminal Law and Criminology 68 (1977).

[53]Leifer, p. 138.

[54]See L. S. Penrose, "Mental Disease and Crime: Outline of a Comparative Study of European Statistics," British Journal of Medical Psychology 28 (1939); and David Biles and Glen Mulligan, "Mad or Bad?--The Enduring Dilemma," British Journal of Criminology 13 (1973):275-279.

[55]Penrose, p. 3.

[56]Biles and Mulligan, p. 278.

[57]Levine, op. cit.

[58]Steadman and Cocozza, op. cit.

[59]Joseph E. Jacoby, "The Dangerousness of the Criminally Insane," unpublished Ph.D. dissertation, Sociology Department, University of Pennsylvania, 1976. Jacoby summarizes the findings of Steadman and Cocozza at p. 32.

[60]Thomas J. Scheff, ed., Mental Illness and Social Processes (New York: Harper and Row, 1967), introduction.

[61]Lloyd H. Rogler and August B. Hollingshead, Trapped: Families and Schizophrenia (New York: Wiley, 1965).

[62]Marian Radke Yarrow et al., "The Psychological Meaning of Mental Illness in the Family," in Thomas Scheff, ed., Mental Illness and Social Processes, op. cit., pp. 32-48.

[63]Kathleen Smith, Muriel W. Pumphrey, and J. C. Hall, "The 'Last Straw'; the Decisive Incident Resulting in the Request for Hospitalization in 100 Schizophrenic Patients," American Journal of Psychiatry 120 (1963):228-233.

[64]Walter R. Gove and Patrick Howell, "Individual Resources and Mental Hospitalization," American Sociological Review 39 (1974):86-100.

[65]402 F.Supp. 1039 (E.D. Pa. 1975)

[66]Ferleger, op. cit.

[67]Ronald S. Rock, Marcus A. Jacobsen, and Richard M. Janopaul, Hospitalization and Discharge of the Mentally Ill (Chicago: University of Chicago Press, 1968).

[68]Ibid., p. 98.

[69]Virginia Frederick, Frances P. Coltrane, and Lewis Griffin, "Developing a Partnership between a Court and Community Agencies to Reduce Involuntary Commitments," Hospital and Community Psychiatry 27 (1976):689.

[70]Grant H. Morris and Elliot D. Luby, "Civil Commitment in a Suburban County: an Investigation by Law Students," Santa Clara Lawyer 13 (1973):518-536.

[71]ENKI, p. 13.

[72]Ibid., chapter 4, p. 17.

[73]James R. Greenely, "Alternative Views of the Psychiatrist's Role," Social Problems 20 (1972):252-262.

[74]Stone, p. 51.

[75]Myron McLaughlin, Coordinator, Emergency Services, West Philadelphia Mental Health Consortium.

[76]Greenely, op. cit.

[77]Ennis, p. 189.

[78]H. Foley, Community Mental Health Legislation: the Formative Process (Lexington, Mass.: Lexington Books, 1975); Bernard L. Bloom, Changing Patterns of Psychiatric Care (New York: Human Sciences Press, 1975).

[79]Mechanic, op. cit.; and National Institute of Mental Health, Statistical Note #97, "Changes in the Age, Sex and Diagnostic Composition of First Admissions to State and County Mental Hospitals, United States, 1962-1972," Washington, D.C., Department of Health, Education and Welfare, September, 1973.

[80]Mechanic, chapter 4.

[81]Dinitz and Beran, op. cit.; Allan Beigel, "Law Enforcement, the Judiciary and Mental Health: a Growing Partnership," in John Monahan, op. cit., pp. 140-150.

[82]California Legislature, Final Report, Senate Select Committee on Proposed Phaseout of State Hospital Services, Sacramento, 1974.

[83]Scull, Decarceration, op. cit.

[84]Ibid.; see also Santiestevan, op. cit., and Reich and Siegel, op. cit.

[85]Ennis, op. cit.

[86]ENKI, p. 15; interview with Senator W. Louis Coppersmith, principal author of Act 143.

[87]Bardach, p. 23.

[88]Scull, Decarceration, op. cit.

[89]See, for example, American Bar Association, op. cit.

[90]Stone, op. cit.

[91]Foley, p. 44.

[92]Mechanic cites the following studies in chapter 6: G. Brown, Schizophrenia and Social Care (London: Oxford University Press, 1966); and J. Grad, "A Two-Year Follow-Up," in R. H. Williams and L. D. Ozarin, eds., Community Mental Health: an International Perspective (San Francisco: Jossey-Bass, 1970).

[93]Mechanic, p. 85.

[94]Wolpert and Wolpert, op. cit.

[95]Aviram and Segal, "Exclusion of the Mentally Ill," op. cit.

[96]Ibid.

[97]Ibid., p. 127.

[98]Mechanic, chapter 8; Scull, Decarceration, op. cit.; Leifer, chapter 2.

[99]Mechanic, op. cit.

[100]Bittner, op. cit.

[101]James Q. Wilson, Varieties of Police Behavior: the Management of Law and Order in Eight Communities (New York: Atheneum, 1971).

[102]Philadelphia Police Department, Directive 136, June 10, 1977.

[103]John Monahan, "The Prevention of Violence," in Monahan, p. 23.

[104]Nicholas C. Petris, "The Impact of L-P-S on the Patient," paper prepared for the National Institute of Mental Health (n.d.).

[105]California Legislature, Final Report, op. cit.

[106]Reich and Siegal, op. cit.

[107]Mechanic, op. cit.

[108]Santiestevan, p. 30.

[109]California Conference of Local Mental Health Directors, papers prepared for the meeting of June 15-16, 1972, Santa Barbara, California, on "L-P-S Really Works," presentation of Gerald E. Maguire, p. 21.

[110]Santiesteven, p. 28.

[111]Ibid., p. 32.

[112]Cited in California Legislature, Final Report, p. 47. No reference given.

[113]California State Employees' Association, "What have all the Patients Gone?" report presented on the crisis of mental health care in California, Sacramento, January, 1972.

[114]Eugene Bardach, The Implementation Game: What Happens after a Bill Becomes a Law (Cambridge: MIT Press, 1977).

[115]California Legislature, Final Report, p. 17.

[116]Rock, pp. 253-254.

[117]ENKI, chapter 12.

[118]Ibid., p. 188.

[119]Edward B. Guy, "The Impact of New Legislation on Mentally Ill Offenders Entering the Philadelphia Prison System," paper presented at the Third Annual Conference, Mental Health Evaluation, Philadelphia, May 20, 1977.

[120]Ibid., p. 5.

[121]Henry Steadman, "The Psychiatrist as a Conservative Agent of Social Control," Social Problems 20 (1972):263-270.

[122]Marc F. Abramson, "The Criminalization of Mentally Disordered Behavior," Hospital and Community Psychiatry 23 (1972):101-105.

[123]Ibid.

[124]California Department of Mental Hygiene, Statistical Bulletin, "The Impact of the L-P-S Act on the Number of Admissions by Penal Code Commitment to State Hospitals for the Mentally Ill," Bureau of Biostatistics, Sacramento, vol. 13, no. 12, June, 1970.

[125]Stone, p. 61.

CHAPTER 5. METHODS AND FINDINGS

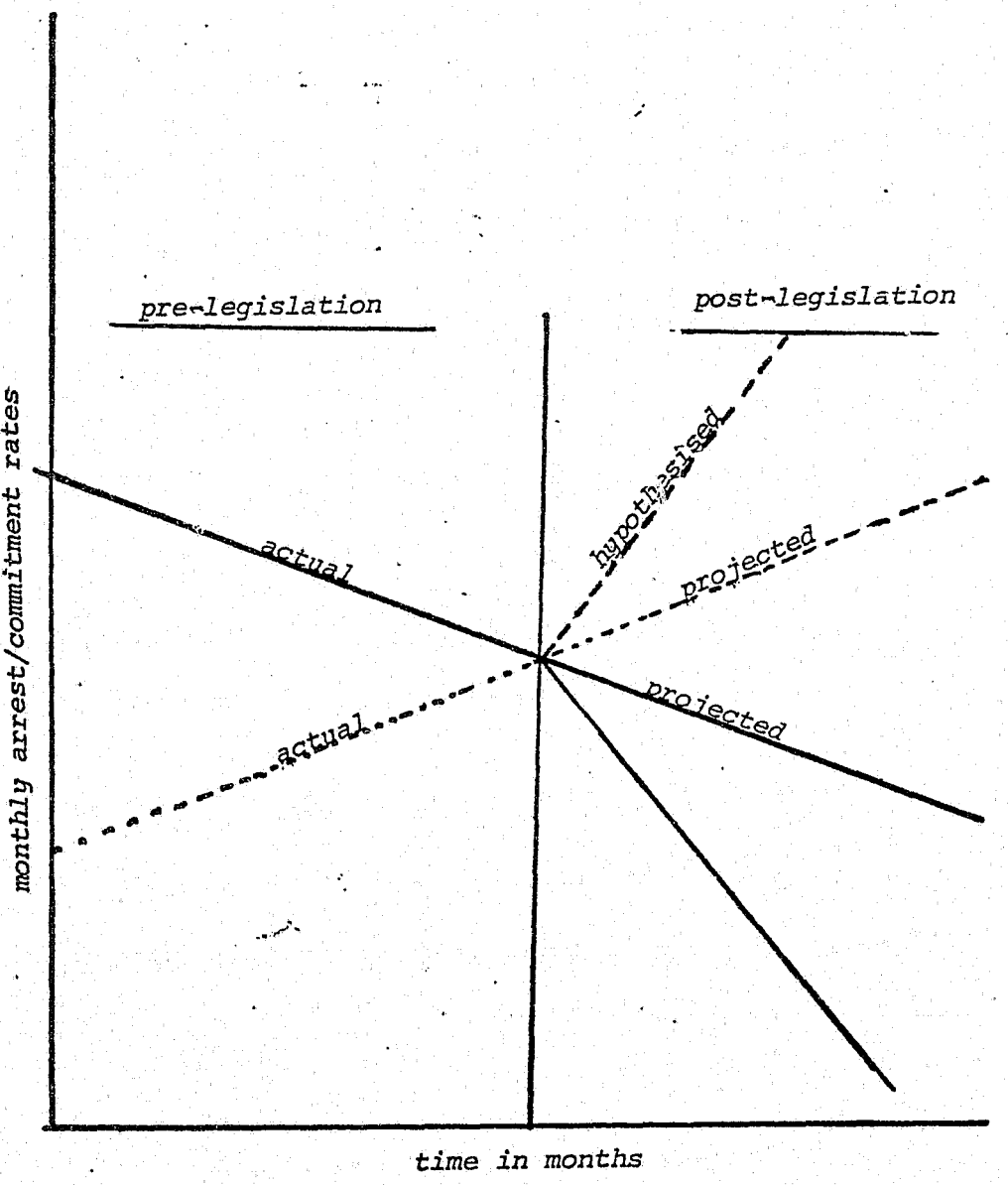
1. Research Methodology

The hypothesis implies that the new legislation will cause a sudden and substantial increase of mentally ill persons in the community. This should occur through the reduction of input into the mental health system--that is, the reduction of incoming long-term, involuntary commitments. It should also occur through the deinstitutionalization of patients who were already hospitalized at the time of the legislation and who will be released when the new criteria are applied to them. The hypothesis implies also that these people will be diverted into the criminal justice system via arrests for petty offenses against the public order.

The analysis was carried out on two levels: a county-wide, or macro-level, analysis; and a micro-level analysis of a sample of ex-patients. The first, or macro-level, analysis looked at county-wide arrest and commitment trends. Time series analyses were used in order to see whether the hypothesized deviations from current trends actually occurred. Had diversion indeed occurred as a result of the new legislation, the deviations from existing trends would resemble those sketched in Figure 5-1. It will be seen from this figure that the established pre-legislative trend was used as a basis for the projection of the post-legislative trend as if no change had occurred. The actual post-legislative trend was compared with the projection in

Figure 5-1

Hypothesized Trend Deviations,
Arrest and Commitment Rates, Philadelphia County



The arrest rate is represented by the broken line.
The commitment rate is represented by the unbroken line.

order to see whether the hypothesized deviation from trend actually occurred.

If the two hypothesized deviations from the projected trend were shown to occur (that is, if arrests increased and commitments decreased), it becomes necessary to prove a causal relationship between the two phenomena. The ideal method would be to compare the number of mentally ill arrestees before and after the legislation to see whether their numbers had significantly increased after the legislation. This was not feasible, because arrest records do not state whether the offender has a history of mental illness or not.

The method chosen to indicate a causal link was to sample persons who had been "rejected" from the mental health system after the legislation and to compare the proportions of arrests in this sample before and after the legislative change in order to see whether the arrest rate increased significantly following the change. A "rejectee" is an individual for whom an unsuccessful petition had been made after the act. In order to qualify as a "rejectee," the behavior which led to the petition had to be of a type which could have led to commitment before the new act. The assumption was made that the petitioner, having failed in his attempt to control the behavior by committing the source of the problem, would then turn to the criminal justice system for relief. Single sample tests of significance were used, and diversion will be defined as significantly more arrests after the act than before for offenses against the public order.

The follow-up period throughout the analysis was one year. The pre-legislative period from which projections were made in the macro-analysis was three years. There are four possible combinations of results possible from the two levels of analysis. These are shown in Figure 5-2.

Figure 5-2

Relationship between Macro and Micro Levels of Analysis

Micro \ Macro	Diversion	No Diversion
Diversion	hypothesis supported	diversion occurs but on a small extent so that county-wide data are not affected
No Diversion	increase in arrests due to causes other than deinstitution-alization or sample is not representa-tive	hypothesis not supported

2. Macro-Level Analysis--Involuntary Commitments

(a) Summary

In this section the data source is first described. The establishment of the pre-legislative trend in involuntary commitments is then described. The projection of post-legislation commitment rates is made and is compared with the actual post-legislative commitment trend.

(b) Data Source

The source of the data was the records kept by the Office of Mental Health of the dispositions of court hearings. The number of involuntary, long-term commitments made by the court for the pre-legislative period--January 1, 1973 to August 31, 1976--were counted. The reason for choosing this 44-month period is the pragmatic one that the Office of Mental Health began keeping formal records in January, 1973. Beginning the count at this time has the added advantage that the commitment by medical certification was, by that time, no longer being used, so that the OMH records, which consist of a daily log of court dispositions, may be regarded as complete.

Court proceedings during this period (as well as during the post-legislative period) were held by a special commitment court known as the "Master's Court," which was presided over by an appointee of the court of common pleas.

There were three sources of input into the Master's Court. First, there was the emergency ten-day commitment which the facility or the patient's family wished to extend. The second source was the commitment initiated in the court itself. In this latter case, the patient was "at large" in the community, and his family or friends petitioned directly to the court for his long-term commitment; or the patient was in the hospital on a voluntary commitment which he wished to terminate, and the facility petitioned to change his status to involuntary. Third were petitions which originated in a

criminal action by the patient and an informal agreement between the public defender and the district attorney.[1]

The data for the period preceding the legislation do not permit a breakdown of the sources of input into the Master's Court. However, when the new legislation went into effect, the recordkeeping at OMH changed, permitting this breakdown. There is reason to believe that the same proportions or input existed prior to the new legislation.[2]

The sources of petitions for commitment during the year following the act are presented in Table 5-1. The percentages of the totals are presented in parentheses.

Table 5-1

Sources of Petitions for Commitment, September, 1976-August, 1977

Emergency Commitment Extended	Patient in Community	Patient Voluntarily in Hospital	Criminal Action	N
2102	42	62	92	2297
(91.5)	(1.8)	(2.6)	(4.0)	(100)

It is clear from this table that the major source of petitions for long-term commitment was the exention of the emergency commitment. As stated above, there is no reason to believe that these proportions differed before the new legislation. Therefore, when the data from both periods--before and after the legislation--were compared, all incoming petitions were used except those which originated in a criminal complaint and which did not reach the Master's Court. The reason for this exception is that of all such commitments after the legislation, only 5.5 per cent stayed in the hospital until the

scheduled hearing at the Master's Court. (They were either discharged or became voluntary before the data of the hearing.) Such commitments would not appear in the pre-legislation records and have been omitted in order to make the two sets of data comparable.

Before the new legislation, there were eight possible dispositions in the Master's Court. These are listed in Table 5-2.

Table 5-2

Possible Dispositions in Master's Court, Pre-Legislation

Disposition	Redefinition for Research Purposes (if necessary)
indefinite	6 months and over
limited commitment	1 to 6 months
commitment for evaluation	up to 1 month
outpatient commitment	
partial (day) commitment	
dismissal for lack of evidence	
continuance	
other[3]	

The continuance represents a methodological problem in that it constitutes an informal commitment of the patient who is already in custody. It is possible that a case will be continued for as long as six months, after which the patient will be discharged from the hospital, so that the recorded disposition will read "discharged" whereas in fact the patient has been incarcerated (in a manner whose legality is doubtful) for six months. As it is not known how many such de facto commitments have been lost to the data collection in

this way, it will be assumed that the proportions of such "lost commitments" vary consistently throughout the period studied.

(c) Establishing the Pre-Legislative Commitment Trend

As stated above, the purpose of counting the number of indefinite commitments during the pre-legislative period was to establish a trend from which the expected number of commitments could be projects as if no change had occurred.

At this point, it became necessary to choose what type of pre-legislative commitment would be used to establish the trend which would later be compared with the post-commitment trends. The maximum period of commitment during the post-legislative period was 90 days (this could be renewed if the court felt it necessary), and therefore long-term commitment, post-legislation, was defined for the purposes of the research as 90 days and over. A suitable pre-legislation basis of comparison was needed. The choice was between the indefinite commitment (over 6 months), limited commitment (1 to 6 months), or both. Neither of these periods is directly comparable to the 90-day post-legislative period. Ideally, the pre-legislative data should have been arranged in such a way that commitments of 90 days and over could have been counted. However, the court did not use this period, as was seen in Table 5-2.

If one were to compare one maximum period with another, the appropriate basis of comparison would have been the indefinite commitment. However, as the meaning of "maximum" changed so much after the

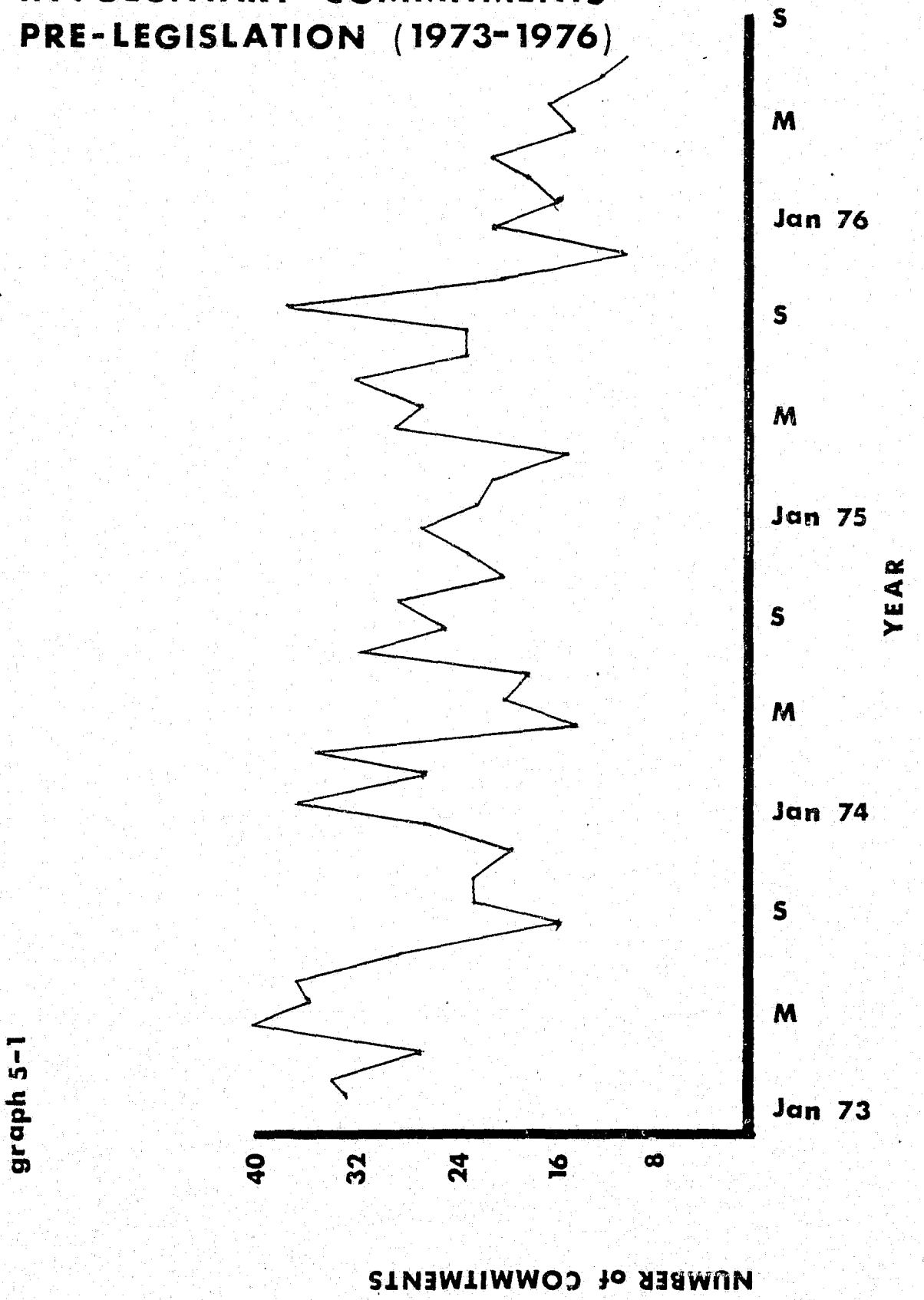
legislation, such a comparison would lack meaning. It was decided to use all commitments over one month as the pre-legislative basis of comparison in order to compute the pre-legislative commitment trend.

In order to establish this trend, the numbers of involuntary commitments during the pre-legislative period were plotted (Graph 5-1). A visual inspection of Graph 5-1 reveals a decreasing trend with consistent seasonality. There is a midsummer peak in 1973, 1974 and 1975,[4] and a midwinter peak in the same years.

There is, to our knowledge, no accepted explanation of the mid-summer peak. It is known, however, that crimes of violence tend to increase during the summer[5] and one may, therefore, speculate that the same factors which underly the increase in violent crime also contribute to the higher commitment rate. Wirth notes the strain caused by the multiple relations of urban life.[6] These strains may well be increased during the summer because of the greater numbers of interactions, particularly in the inner city. Another possible explanation for the mid-summer peak is the positive relationship between unemployment rates and hospitalization rates found by Brenner.[7] In the summer, teenagers are released from school and add to the numbers of the unemployed.

The characteristic mid-winter peak[8] can be explained in two ways. First, it is known that festive periods intensify feelings of loneliness and depression.[9] Second, in the winter, many homeless "street people" become committable as dangerous to themselves, because their exposure to the cold weather renders them liable to freeze to death.

INVOLUNTARY COMMITMENTS PRE-LEGISLATION (1973-1976)



graph 5-1

The trend of the rate of commitment would appear, from Graph 5-1, to be decreasing, but the trend is partly obscured by the seasonal variation. Before removing the seasonality to clarify the trend, the original data were tested for linearity, using Kendall's Tau.[10] A value of -.874 was obtained, which indicates that the trend was decreasing. This value when transformed to Z[11] was not significant (Z = 2.414), so that it cannot be said that the decreasing trend was linear. This result was to be expected, because any projection into the future from a linear trend would eventually fall below zero--an impossible outcome in the case of involuntary commitments.

The raw data could not be used as a basis for projecting the future because the seasonality obscured the shape of the trend curve. Before smoothing the curve by removing the seasonality, it was necessary to decide whether the relationship between time and commitments was additive or multiplicative, because different formulae are needed in each case.[12] It was found that the standard deviations (of time and of commitments) were not directly proportional to the means (of time and of commitments), and therefore an additive model was assumed.[13] The form of the model is

$$u_t = m_t + s_t + e_t$$

where u_t is the value of commitments at time t; m_t is the trend value of commitments at time t; s_t is the seasonality and e_t comprises other sources of variation.[14]

The seasonal component was then removed by transforming the data using a moving average.[15] The formula used was

$$\text{m.a.} = \frac{1}{24}(t_1 + 2t_2 + 2t_3 \ldots 2t_{12} + t_{13}).$$

The moving average of the pre-legislative series, presented in Graph 5-2, was used to make the projection. The formula used has the disadvantage that the first and last six points of the series are lost, so that the transformed series consists of 32 points--from July, 1973, to February, 1976.

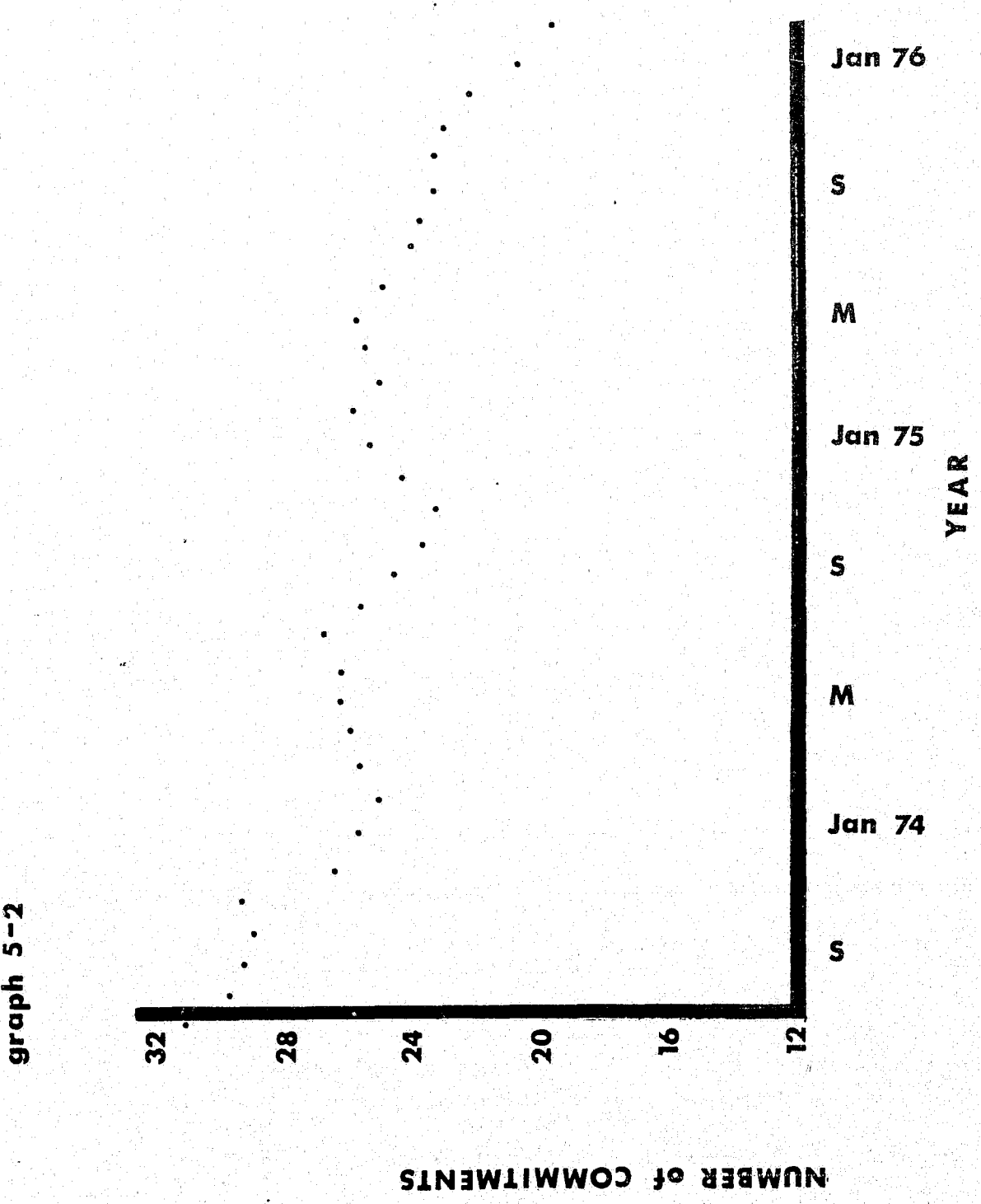
(d) Projecting the Post-Legislative Trend

In order to project the post-legislative commitment trend, a curve must be fit to the existing (pre-legislative) trend. In the ideal situation, the existing data resemble a known curve which is then simply extended into the period for which the projection is required. However, visual inspection of Graph 5-2 does not reveal a curve of recognizable shape. A decreasing trend is evident, but the unwieldy shape of the curve makes a simple visual projection difficult, particularly because it is not possible to know whether the "bumps" in the curve are remains of seasonal peaks or whether they indicate a true temporal relationship.[16]

A stepwise regression was performed on the data in order to see whether the appropriate curve was a polynomial.[17] The dependent variable was the moving average of commitments, and "dummy" independent variables of time raised to the first, second, third and fourth powers were included. A separate regression was carried out using the log of time as the "dummy" independent variable.

The multiple regression indicated that the polynomial which best

MOVING AVERAGE of INVOLUNTARY COMMITMENTS, PRE-LEGISLATION (1973-1976)



graph 5-2

described the curve was

$$y = a + b_1x + b_2x^2 + b_3x^3$$

where y is the moving average of commitments and x is time. The values obtained from this polynomial resembled the actual post-legislative numbers of commitments quite closely until January, 1977, when the projected values decreased below zero--a result which is impossible. The values obtained using the polynomial were thus not acceptable as a basis with which to compare the actual post-legislative values. The drawbacks of using an atheoretical model are thereby illustrated.[18]

The values for post-legislative commitments obtained from the regression of commitments on the log of time were similarly rejected as unrealistic. The semi-logarithmic projection showed a rate of decrease which was less than the pre-legislative rate. In reality, the post-legislative rate should have been greater or, at least, the same as the pre-legislative rate.

It was, therefore, decided to seek another method of projecting the expected values of commitments during the post-legislative period. This apparently "hit or miss" way of finding the appropriate method of projection is in accordance with Kendall's advice that "there is great scope--even a necessity--for personal judgment"[19] in trend estimation.

According to Pittenger,

> The quickest and simplest means of forecasting the total population of an area is to graph the historical population size data and then extend that line to represent the future.[20]

It seemed that this method of visual projection was the most suitable, particularly in the absence of a suitable mathematical model, despite the unwieldy shape of the curve mentioned above. It has the advantages that it involves no further distortion of the data by mathematical transformation; it permits the inclusion of existing information about the population in question (i.e., it is not atheoretical); and it demands no assumptions about the form of the data. Its disadvantage is that it is a subjective and judgmental method, but according to Kendall subjective judgments are unavoidable when dealing with time series.

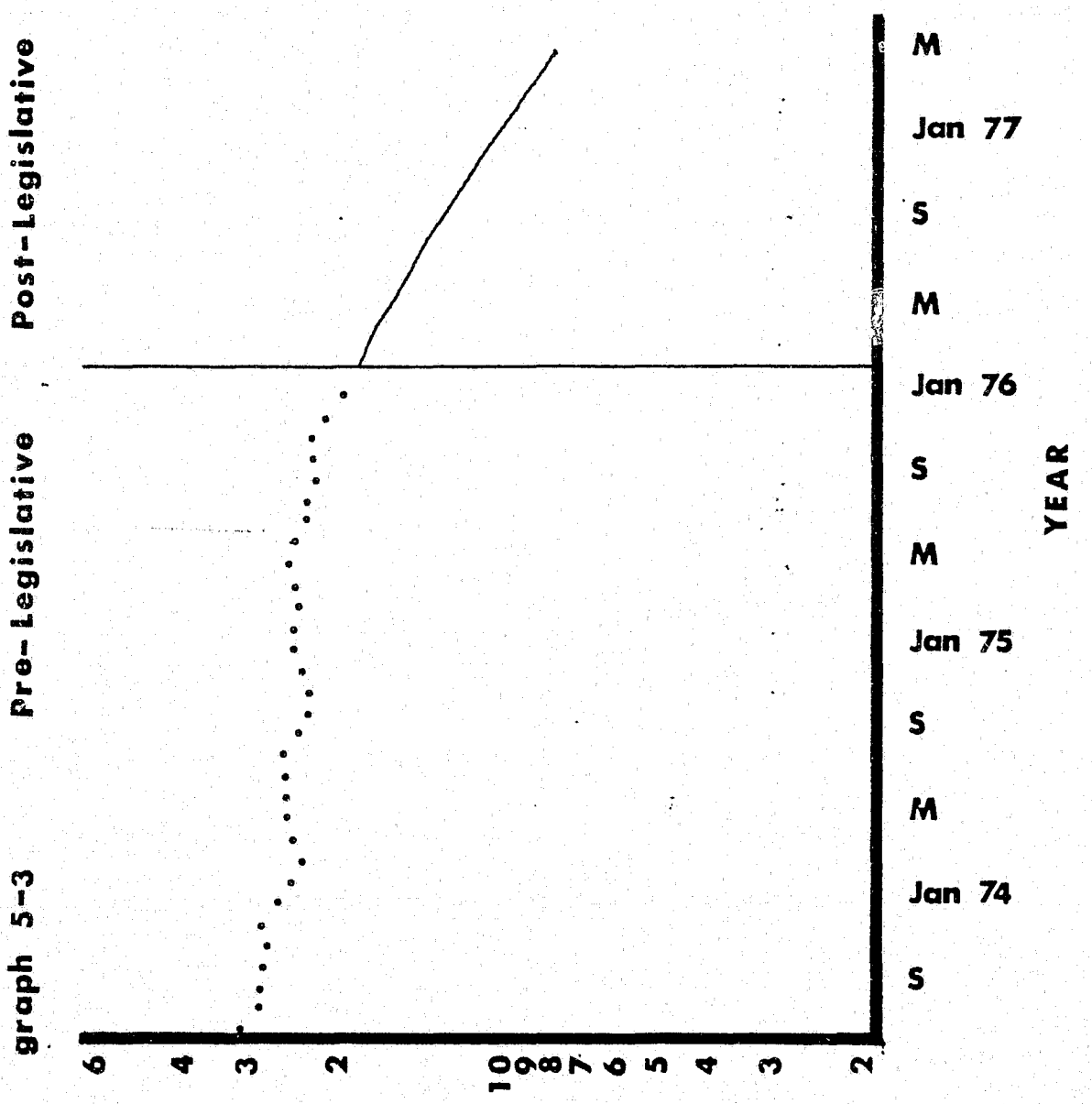
Accordingly, the moving average of the pre-legislative commitment data (Graph 5-2) was plotted on semi-log paper, a useful property of which is "that the slope of the line indicates the rate of growth."[21] The line obtained by connecting the points was extended visually. This is presented in Graph 5-3. The numbers of projected commitments for each month were obtained from Graph 5-3.

(e) Comparison of Post-Legislative Commitment Rates with Projected Rates

It remains to see how closely the actual rates of commitment after the legislation resemble the projected rates, in order to see whether the hypothesized downward deviation from the trend actually occurred.

MOVING AVERAGE of PRE-LEGISLATIVE COMMITMENT DATA and PROJECTION of POST-LEGISLATIVE DATA

actual data = ·
projected data = —



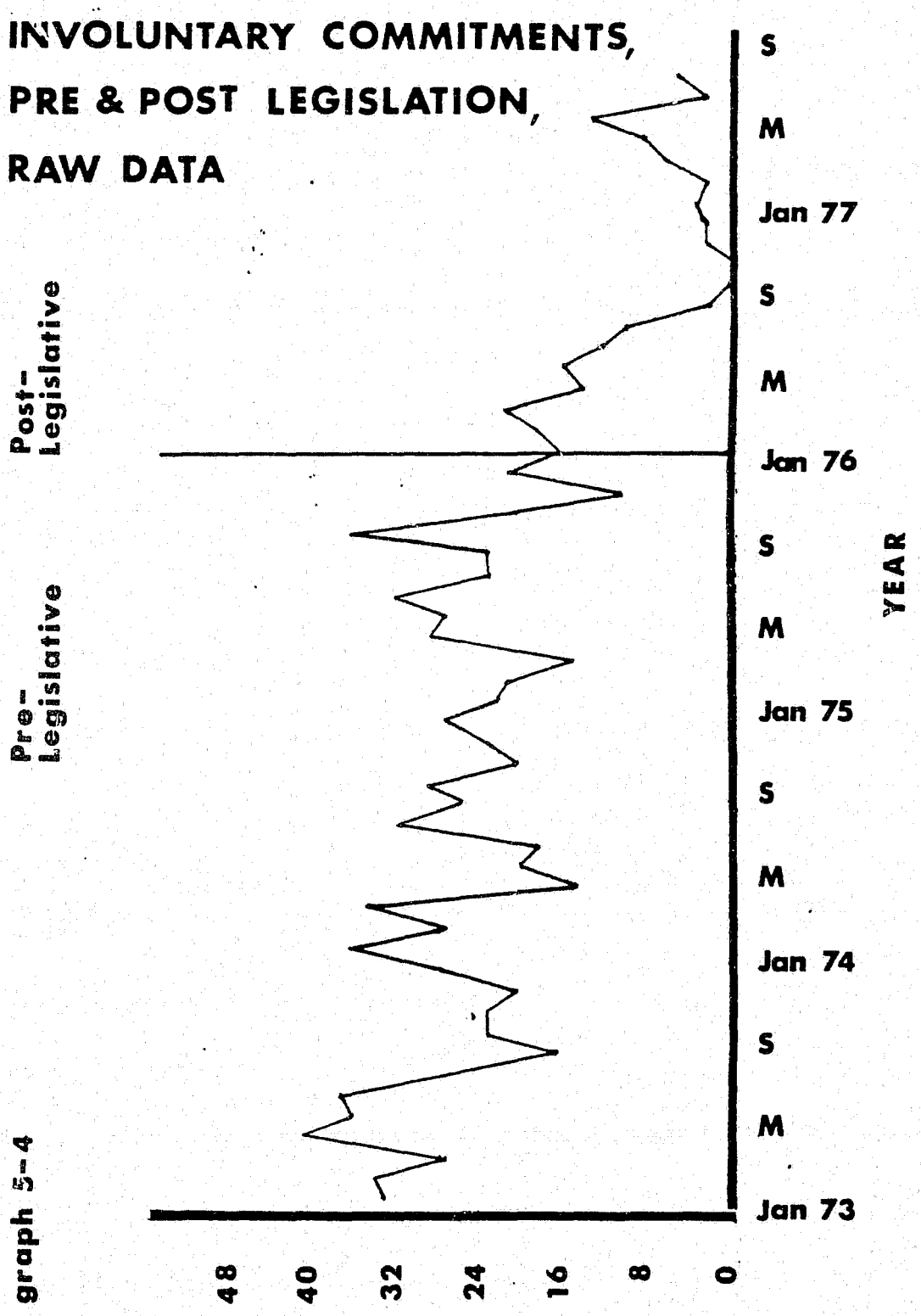
The total numbers of involuntary commitments for both periods were plotted on Graph 5-4. This graph reveals that the familiar mid-winter and mid-summer peaks continued to occur after the legislation which can thus not be said to have affected the seasonality of commitment trend. However, the seasonality continues to obscure the trend.

The raw commitment data were therefore transformed using the same formula for the 13-point moving average that was used for the pre-legislative data. These values are shown on Graph 5-5 and are compared with the projected values that were obtained from Graph 5-3. The same comparison is shown in tabular form in Table 5-3. Table 5-3 and Graph 5-5 indicate that the actual numbers of commitments are less than the predicted numbers, but that the maximum difference is only 5.84 commitments per month. It is perhaps more important to note that the predicted trend reflects the pattern of the actual trend quite accurately.

(f) Conclusions: Macro-Level Analysis of Commitment Rates

The comparison of the projected long-term involuntary commitments of the post-legislative period with the actual number of commitments during this period leads to the conclusion that the legislation did not, as hypothesized, result in the release of many persons who would otherwise have been committed.

However, although the hypothesized substantial decrease in the numbers of persons being committed did not occur, this finding does


INVOLUNTARY COMMITMENTS,
PRE & POST LEGISLATION,
RAW DATA
Post-
Legislative
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Jan 77
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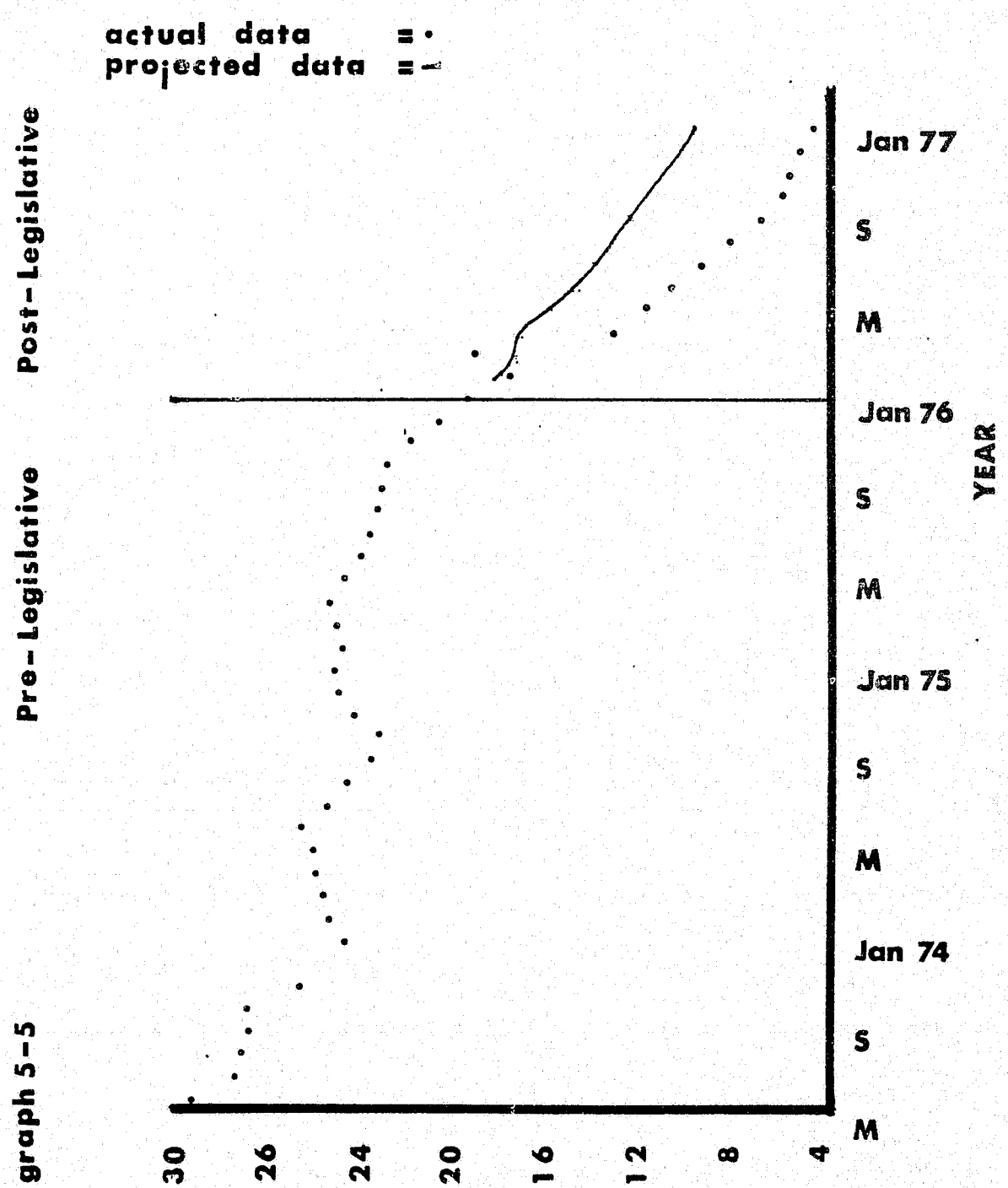
M
Jan 76
S
M
Jan 75
S
M
Jan 74
S
M
Jan 73
YEAR
48
40
32
24
16
8
0

graph 5-4

COMPARISON of ACTUAL WITH PROJECTED VALUES of COMMITMENTS



graph 5-5

Table 5-3

Numbers of Commitments, Post-Legislation (Transformed by Moving Average), Compared with Projected Values

Time	Actual Values	Predicted Values	Difference
33	18.29	18.50	-0.21
34	19.62	18.00	+1.62
35	13.46	17.60	-4.14
36	12.25	16.50	-4.25
37	11.25	15.50	-4.25
38	9.79	14.50	-4.71
39	8.58	13.70	-5.12
40	7.29	13.00	-5.71
41	6.41	12.25	-5.84
42	6.04	11.50	-5.46
43	5.50	10.90	-5.40
44	4.87	10.25	-5.38

not preclude the possibility of diversion into the criminal justice system. This is due to the fact that the time of incarceration decreased substantially from approximately three weeks per patient in the pre-legislative period[22] to three days during the post-legislative period.[23] The fact that the type of commitment changed to a shorter period of incarceration means that more mentally ill people are free in the community--not because they were not hospitalized at all, but because they were hospitalized for a short time only. The possibility of their being charged with minor crimes at greater rates than during the pre-legislative period, as hypothesized, is thus still a viable one.

3. Arrest Data--Macro-Level Analysis

(a) Summary

In this section, the offenses considered most typical of the non-dangerous mentally ill are analyzed as time series. Data for the three-year period preceding the legislation were used to project the expected arrest rates for the year following the legislation. These projections were compared with the actual rates during this period in order to see whether the hypothesized increase in rates occurred after the legislation.

(b) Data Source

First, 16 offenses were selected as most typically committed by the non-dangerous mentally ill offender. The selection of these offenses was based on the studies cited above in Chapter 3 and on conversations with the Philadelphia police, the public defender in charge of mental health, and the district attorney in charge of mental health. It should be noted that two of the behaviors listed below--minor disturbance inside and minor disturbance outside--are not offenses, but service codes for which no arrest can be made. According to the Philadelphia police, they are often used in cases of mental illness. The Philadelphia police supplied the total numbers of arrests, in monthly rates, for the offenses listed below from January 1, 1973 to September 30, 1977.

Table 5-4

Offenses Selected for Analysis

simple assault	resisting arrest
terroristic threats	embezzlement
indecent assault	public indecency
corner lounging	disorderly conduct
loitering and prowling	panhandling
trespassing	public drunkenness
minor disturbance outside	minor disturbance inside

(c) Establishing the Pre-Legislative Arrest Trend

Each offense was analyzed separately, because it appears from the data that they differ considerably in frequency of use by the police and in temporal pattern. Aggregation would therefore only obscure trends and patterns.

First, the yearly average for each offense for the pre-legislative period was plotted as a rough measure of trend.[24] The yearly averages indicate that there are five major patterns of arrest. The most common one (seven offenses) is an inverted parabola; which is to say that the arrest rate was decreasing before the legislative change. The second most common pattern is an approximately linear decrease. The three final categories comprise five offenses in which the pattern is unclear. Three offenses--loitering and prowling, indecent assault, and failure to pay transit fare--take a vaguely cubic form and appear to be increasing. One offense--resisting arrest--also takes a cubic form and appears to be decreasing. Trespass exhibits what appears to be a decreasing parabola. The arrest trends obtained from the annual averages are summarized in Table 5-5.

Table 5-5

Arrest Patterns during Pre-Legislative Period Based on Yearly Averages

Parabolic Decrease	Linear Increase	Cubic Decrease	Parabolic Decrease	Cubic Increase
simple assault	minor disturbance outside	resisting arrest	trespass	loitering & prowling
public drunkenness	minor disturbance inside			embezzlement
disorderly conduct	panhandling			failure to pay transit fare
indecent assault	corner lounging			
harassment				
terroristic threats				

It will be noted from Table 5-5 that the arrest rates of all but three offenses were decreasing at the time of the legislative change. What was sought, therefore, in order to support the hypothesis of diversion, was a substantial change in the rate of growth. In the case of the offenses whose rates were decreasing, a decrease in the decrease or else a change to an increasing rate was sought. In the case of the offenses which exhibted an increasing rate, a substantial increase in the increase was sought.

(d) Projecting Post-Legislative Arrest Trends and Comparison with Actual Rates

In order to see whether the arrest patterns changed substantially during the post-legislative period, the post-legislative trend was projected using the following method. The moving averages for the pre-legislative data were plotted and the resulting curve was used as a basis for a visual projection of the expected trend during the

post-legislative period. The actual data for the post-legislative period were transformed in the same way and were compared with the projected trend.[25] The graphs showing the projected and actual post-legislative trends are presented in Appendix 2.

Table 5-6 presents the results of this comparison. One offense --embezzlement--had such low arrest rates during the entire period that analysis was impossible (the arrest rate varied from 0 to 1.35 arrests per month). There are thus 15 offenses in Table 5-6. Of the 15 offenses analyzed, two--simple assault and public indecency--support the hypothesis clearly, three provide tentative support, and ten provide no support. The offenses which provided tentative support were disorderly conduct, harassment, and terroristic threats.

Disorderly conduct was the offense for which non-dangerous mentally ill persons were to have been arrested following the legislative change according to Philadelphia Police Department Directive #136 which was quoted in full in Chapter 3. Although the post-legislative trend indicates an increase in arrest rates (as opposed to the projected decrease), the increase occurred only during the last three months of the follow-up period and it was felt, therefore, that this finding could do no more than provide tentative support for the hypothesis.

In the case of harassment, the deviation from the projection occurred late in the follow-up period, and the range of arrests was small--between 7 and 12 arrests per month. For these reasons it was felt that only tentative support for the hypothesis could be claimed.

Table 5-6

Comparison of Projected Arrest Trends During the Post-Legislative Period with the Actual Trends

Offense	Pre-Legislative Trend	Projected Trend	Actual Trend	Hypothesis Supported
simple assault	decreasing	decreasing	marked increase	yes
public drunkenness	decreasing	slight increase	slight increase	no
public indecency	decreasing	decreasing	sharp increase	yes
disorderly conduct	decreasing	decreasing	decreasing with increase towards end of period	tentative
indecent assault	decreasing	decreasing	decreasing	no
harassment	decreasing	decreasing	slight increase at end of period	tentative
terroristic threats	decreasing	decreasing	increase	tentative
minor disturbance outside	decreasing	decreasing	decreases below projection	no
minor disturbance inside	decreasing	decreasing	decreases below projection	no
panhandling	decreasing	decreasing	decreasing	no
corner lounging	decreasing	slow decrease	slight increase	no
resisting arrest	decreasing	slow decrease	decreases below projection	no
trespassing	decreasing	slight decrease	decreases below projection	no
loitering & prowling	increasing	slight decrease	decrease	no
failure to pay transit fare	increasing	slight decrease	decrease	no

Similar reasoning applied in the case of terroristic threats where the actual post-legislative arrest rate deviated from the projected rate in the hypothesized direction but where the range of arrests was very small. In the case of corner lounging, the deviation from the projected trend took place only within the last two months of the follow-up period and the increase was within the range of one to two arrests per months. It was thus felt that no support for the hypothesis could be claimed.

(e) Conclusions--Macro-Level Analysis--Arrest Statistics

The findings of this part of the analysis provide no more than tentative support for the hypothesis. The fact that a one year follow-up was used can be only a disadvantage in this type of research. It was seen in Table 5-6 that four offenses began to show a deviation which would have supported the hypothesis, but as the deviation appeared toward the end of the follow-up period, only tentative support, if any, could be claimed for the hypothesis.

The findings, as they stand, could be interpreted in two ways. First, it could be claimed that diversion of the non-dangerous mentally ill into the criminal justice system did not occur at all and that the deviations from the expected trends were caused by factors other than the release of mental patients into the community. Alternatively, it could be claimed that diversion is occurring, but that the population of released mentally ill is so small in relation to the total arrested population that their arrests make no impact on the county-wide rates.

In the next section, the analysis of a small sample of released patients is carried out in order to see which, if either, of these two interpretations is correct.

4. Micro-Level Analysis

(a) Summary

The purpose of analyzing the numbers of arrests of a sample of mentally ill people before and after the legislation had been to provide a causal link between the decrease in commitments and the increase in arrests, if both of these phenomena had been shown to occur on the county-wide level. The analysis of released mentally ill persons would have shown whether the two events were related and that it was indeed the released mentally ill who contributed to the rise in arrests.

However, as the analysis of arrest rates on the county-wide level provided only tentative support for the hypothesis, the purpose of the micro-analysis became two-fold. First, it was carried out in order to see whether the relatively small increase in arrests was indeed caused by the released non-dangerous mentally ill--as originally intended. Second, it became necessary to see whether diversion of the non-dangerous mentally ill did indeed occur, but to such a small degree that it did not influence county-wide rates of arrest.

Accordingly, a sample was chosen and its arrest rates before and after the legislation were compared.

(b) Choosing the Sample

The sample consisted of 94 individuals for whom an unsuccessful petition for commitment had been made, following the legislation. The rationale behind the choice of sample was to see whether the frustrated petitioner would turn to the police for relief from his problem, as the hypothesis implied.

The West Philadelphia Mental Health Consortium, a local community mental health center, agreed to make its files available for the selection of the sample. The consortium serves a large catchment area which includes two major universities and a large ghetto, so that its clientele is quite varied in age, race, and socioeconomic status. The selection of the sample was made by the author and a worker at the consortium. We searched the files for cases which fit the following criteria:

1. The commitment attempt was made after the new legislation but before January 1, 1977. This restriction was made in order to allow the subjects one year during which they could be followed in police records, without postponing the analysis too long.

2. The age of the subject had to be over 18, as juvenile records were not available for the follow-up.

3. The diagnosis could be neither drug addiction nor alcoholism. The consortium will not attempt to commit people with these diagnoses,[26] so that their inclusion in the sample

would have represented the policy of the consortium rather than the effect of the new law.

4. The behavior of the person must be in breach of law and could have led to commitment under the old act but not under the new. This restriction was made in order to qualify the sample as potential arrestees.

Only 41 cases which fit the above criteria could be found at the consortium. The remainder of the sample was taken from OMH records of "warrants refused." The refusal of a warrant occurs when the mental health facility requests permission to hold an individual for the emergency three-day commitment. If the worker at the OMH feels that the criteria of the new act are not met, the warrant is rejected. We attempted to apply the same criteria for inclusion that were applied at the consortium. This was not possible in all cases, due to the paucity of recorded information at the OMH.

The final sample consisted of 94 persons whose characteristics are described in Table 5-7.

(c) Data Analysis

It has been found that among released mental patients[27] and also among the general criminal population[28] that both age and the number of prior arrests are highly correlated with the number of subsequent arrests. The relationship of age with arrests is often described as increasing up to a peak in the mid-twenties, and then levelling off.[29] However, the pattern described is not always found.

Table 5-7

Characteristics of Sample Selected for Follow-Up

Age	Total	Per Cent	Sex	Total	Per Cent	Race	Total	Per Cent
18-29	38	37.20	male	75	60.63	black	40	42.55
30-39	23	24.50	female	37	39.37	white	27	28.72
40-49	19	20.20				unknown	27	28.72
50+	17	18.10						
Total	94	100.00		94	100.00		94	100.00

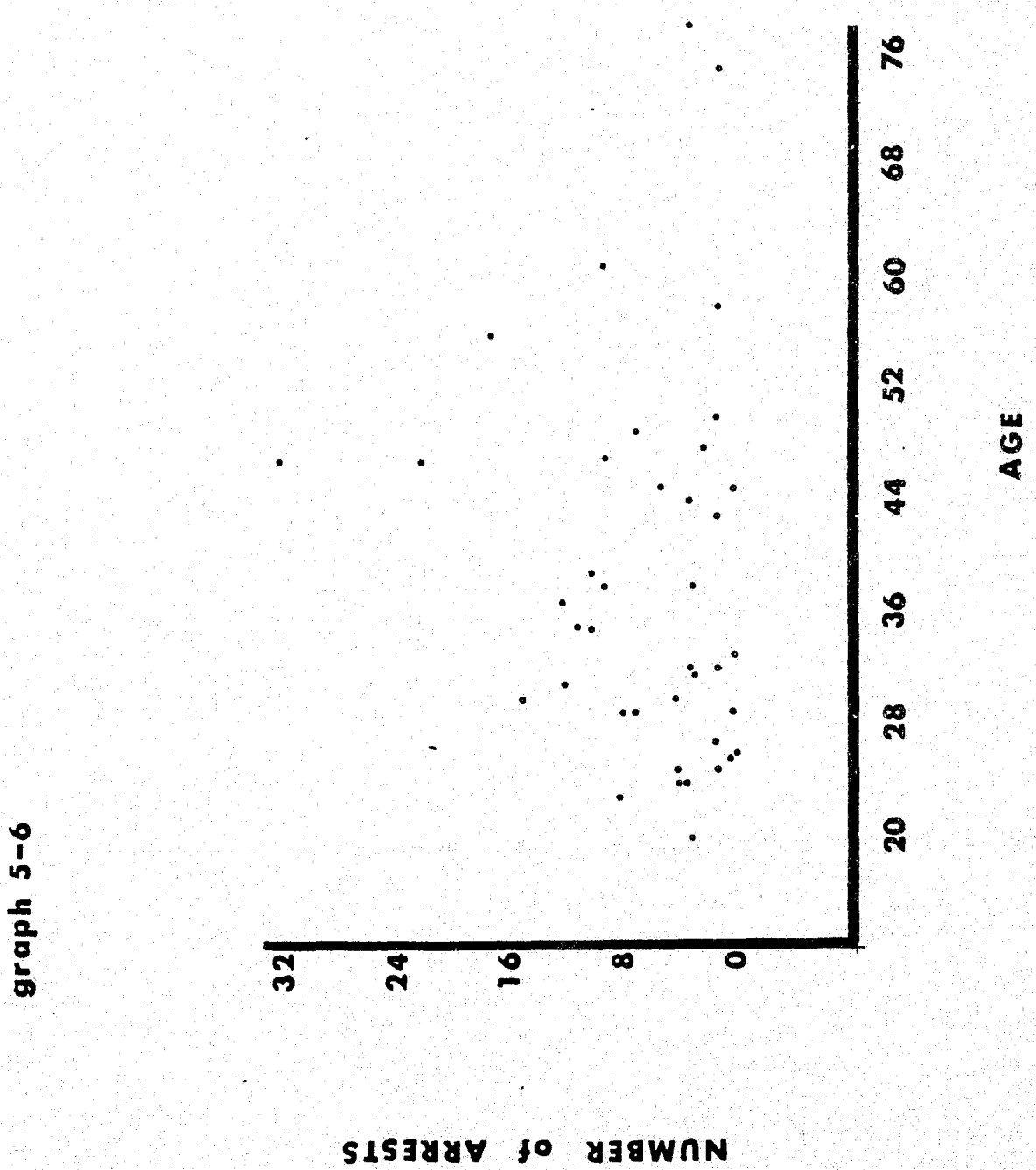
The Philadelphia Police Department provided arrest records for all subjects who were on file. Of the total sample, 40 (42.55 per cent) had been arrested. All but one had begun their arrest careers before the new legislation.

The 40 subjects who were on file were 85 per cent male, 62.5 per cent black, and the modal age category was 30-39 years. Most of the sample had been arrested before they were 30 years old. Forty per cent were under 20 at first arrest, and only 45 per cent were between 20 and 29 at first arrests. Only 5 per cent were over 30 at first arrest.

The relationship of age with arrests has been shown to vary with the type of offense.[30] It was necessary to examine the relationship of these two variables with the number of post-legislative arrests in the sample in order to see whether it was necessary to control for them in the analysis.

In the sample, age was not correlated with the number of arrests. The Pearsonian r of age on total number of arrests was not significant ($r = .0041095$, $F = .006384$, $DF = 1:38$). In order to see whether the relationship of age with arrests was curvilinear, a scatterplot of the number of offenses on age was made (Graph 5-6). The result

RELATIONSHIP of AGE WITH TOTAL NUMBER of ARRESTS



graph 5-6

was a random scatter, indicating that no curvilinear relationship exists. There was, therefore, no need to control for the variable of age.

The number of prior arrests, however, was highly correlated with the number of post-legislative arrests. The Pearsonian r (total arrests pre-legislation with total arrests post-legislation) was .3998, which was significant as expected ($F = 7.21711$, $DF = 1:38$, $p = .01$).

For reasons which will be stated shortly, it was not possible to carry out multivariate techniques on the sample. Therefore, in order to control for the relationship of prior arrest record with post-legislative arrests, a new variable was created. First, a yearly rate of arrest was calculated for each individual. The post-legislative rate was the same as the number of arrests, because the follow-up period was one year. The pre-legislative rate was calculated by dividing the total number of arrests by the period at which the individual had been "at risk," i.e., age at the time of analysis minus age at first arrest. The difference of arrest rates was calculated for each individual by subtracting his pre-legislative from his post-legislative rate.

This statistic was tested for significance using a single sample test which used the central limit theorem under which the assumption of normality may be relaxed if the sample size is large enough.[31] A sample size over 30 is sufficient for this purpose.[32]

The average number of arrests after the legislation exceeded

the average number of arrests before the legislation (0.65 arrests/year/individual compared with 0.54 arrests/year/individual). However, this difference could not be tested by a difference of means test due to the same restrictions inherent in the data that prevented the use of multivariate techniques to control for the effects of the number of prior arrests. First, only a single sample was used. It could not be treated as a repeated measures test because the lapse of time between the measures could not be controlled.[33] Correlative measures used on a single sample can result in spurious significant results. The second factor which required the use of a simple technique was the nature of the sample, which was purposive. The population tested could not, therefore, be assumed to be normal.[34]

Therefore, the analysis was restricted to testing the variable of difference of rates which had been constructed. A test statistic for the variable was computed using the formula

$$Z = \frac{\bar{D} - \mu}{SD/\sqrt{N}} \qquad \text{and } Ho: \mu = 0$$

D = difference of rates.

The value of Z was .4525, which is not significant.

(d) Conclusions--Micro-Level Analysis

The analysis of the pre- and post-legislative arrest rates of a sample of 94 people for whom an unsuccessful commitment attempt had been made indicated that although they were arrested more often after the legislation than before, this increase was not significant.

The results of this analysis did not indicate that the county-wide increase in arrests for simple assault and public indecency were caused by released mental patients, nor did they indicate that diversion of the mentally ill was taking place to an extent which was not great enough to influence the county-wide data.

The data from the micro-analysis showed that the best predictor of post-legislation rates of arrest was the number of prior arrests, as Steadman had found in New York[35] and as Sosowski found in California.[36] In the sample of 94 people, 40 had an arrest record. The total number of post-legislative arrests was 26, 18 of which (66.67 per cent) were accounted for by six people. All of these individuals had higher than average arrest rates, pre-legislation. It would appear, then, that the legislation in question did not cause the post-legislative increase in arrests.

(e) Micro-Level Analysis--Frequencies of Arrests

The analysis of the county-wide arrest rates was carried out on separate offenses, but the analysis on the micro-level was carried out on aggregated offenses. The possibility, therefore, existed that the arrest rates for specific offenses in the sample may have increased after the legislation but that the increase was not revealed due to large decreases in arrest rates for other offenses. In order to investigate this possibility, the frequencies of arrests, pre- and post-legislation were calculated.[37] Table 5-8 presents these frequencies which were divided into offense categories. The categories

Table 5-8

Frequencies of Arrests, Pre- and Post-Legislation

Order of Frequency	Pre-Legislation	Per Cent of Total	Order of Frequency	Post-Legislation	Per Cent of Total
1	Offenses against public order	20.67	1	Index against person	26.47
2	Non-index property	13.53	2	Non-index against property	20.58
3	Index against person	13.16	3	Law-enforcement related	14.71
4	Substance abuse	10.15	4	Index against property	8.80
5	Law-enforcement related	7.89	5	Substance abuse	8.22
6	Index against property	7.14	6	Against public order	5.88
7	Morals	6.39	6	Non-index against person	5.88
8	Auto theft	5.63	6	Morals	5.88
9	Non-index against person	5.26	7	Gambling	2.94
10	Traffic	4.51	7	Auto theft	2.94
11	Gambling	3.38	8	Miscellaneous	0.00
12	Miscellaneous	2.25	8	Traffic	0.00

and the total numbers of offenses are presented in Appendix III. Table 5-8 shows that those offenses which exhibited an unexpected increase on the county-wide level--simple assault and public indecency--decreased in frequency in the sample after the legislation, or at least did not increase in frequency.[38]

This finding further substantiates the conclusion which was already reached--that the post-legislative increase in arrests for a simple assault and public indecency which was found on the county-wide level was not caused by the released mentally ill.

Table 5-8 reveals an increase in the frequency of arrests for violent offenses against the person. These offenses were third in order of frequency before the legislation (13.16 per cent of total arrests) and rose to first in order of frequency after the legislation (26.47 per cent of total arrests). This percentage represents a total of nine offenses committed after the legislation by six offenders.

It was not possible to test this increase for significance because of the small sample size. However, the correlation of pre- and post-arrest rates for the six offenders was carried out in order to see whether the increase in the rate of arrest for violent crime could be accounted for by the previous criminality of the offenders. This proved not to be the case: the correlation was not only not significant but negative ($r = -.44285$, $F = -.97272$, $DF = 1:4$).

5. Conclusions

The analysis on the macro-level showed that the expected decrease in the numbers of involuntary commitments after the new legislation did not take place. This did not preclude the possibility of diversion into the criminal justice system, because the time spent in the hospital was considerably reduced after the legislation, thereby allowing the mentally ill to spend more time in the community.

The analysis of county-wide arrest rates provided only tentative support for the hypothesis of diversion. Of 16 offenses against the public order which were examined, only two exhibited the unexpected increase which had been hypothesized.

The micro-level analysis of a sample of 94 people who had been "rejected" from the mental health system following the legislation did not support the hypothesis. The analysis showed that the increased arrest rates which were found on the county-wide level could not be attributed to the released mentally ill. Although arrests for offenses against the public order were the most frequent before the legislation, their arrest rate decreased after the legislation. The overall rate of arrest for all offenses did increase after the legislation but not significantly, so that it cannot be said that diversion occurred to a degree too small to influence the county-wide data. The hypothesis of diversion was thus not supported.

The micro-level analysis revealed an increase in the frequency of arrests for violent offenses against the person after the

legislation. Similar findings have been made in states with similar legislation.[39] The significance of the increase could not be tested due to the small sample size.

The following chapter will deal with the question of why no diversion occurred and with the question of whether the increase in arrests for violent crimes can be attributed to the new legislation.

Footnotes to Chapter 5

[1]This agreement was as follows: if the public defender, the district attorney and the patient all agreed that hospitalization was preferable to criminal trial and detention, the negotiated position was stated to a judge of the court of common pleas. The common pleas judge committed the offender for a limited period and rescheduled a hearing in the Master's Court. The public defender waived the right to protest the commitment and the district attorney entered a plea of nolle prossequi. This type of commitment rests on a basic ideological agreement between the district attorney and the public defender and thus may be peculiar to Philadelphia County.

[2]Conversations with Ned Levine, Defenders' Association, and with social worker Barbara Young of the Office of Mental Health.

[3]The category of "other" includes the issue of a warrant for the individual who fails to appear and various forms of dismissal, the most common of which is the withdrawal of the petition by the petitioner.

[4]The mid-summer peak in 1976 is barely noticeable. The reason may have been the case of Goldy v. Beal (U.S. District Court, M.D. Pa. C.A. #75-791, 1976) which was decided on July 8, 1976, and which held Section 406 of the 1966 Mental Health Act unconstitutional. The 1966 act had been so eroded by judicial decisions that there now remained no legal standards of commitment (apart from the ten-day emergency commitment). The Supreme Court therefore issued a stay order on July 19, 1976, stating that the standards of the new act were to be used until it came into effect on September 7. It is probable, therefore, that the anticipation of the Goldy decision, together with concern about the forthcoming new legislation, accounted for the failure of the mid-summer peak to appear in 1976. We shall see later that it reappears in 1977.

[5]Marvin E. Wolfgang, Patterns in Criminal Homicide (Philadelphia: University of Pennsylvania Press, 1957).

[6]Louis Wirth, "Urbanism as a Way of Life," in Paul Hatt and Albert Reiss, Jr., eds., Cities and Society (Glencoe: The Free Press, 1951).

[7]Harvey M. Brenner, Mental Illness and the Economy (Cambridge: Harvard University Press, 1973).

[8]It should be noted that the court recesses during the Christmas-New Year holiday, so that the midwinter commitment peak lags behind the demand for commitment by about two weeks.

[9]Emile Durkheim, Suicide: a Study in Sociology (1897), John A. Spaulding and G. Simpson, trans. (New York: The Free Press, 1951).

[10]Maurice G. Kendall, Time Series (New York: Hafner Press, 1973), pp. 26-27.

[11]Hubert M. Blalock, Jr., Social Statistics, 2d ed. (New York: McGraw Hill, 1976).

[12]Kendall, op. cit.

[13]Ibid.

[14]Christopher Chatfield, The Analysis of Time Series: Theory and Practice (London: Chapman and Hall, 1975).

[15]Kendall, p. 56.

[16]It would have been possible to try to smooth the curve further by using a moving average of more than 13 points, but this process would lose a great deal of information. Given the relatively short period on which the projection had to be based, this would have been unfeasible.

[17]Blalock, pp. 408ff.

[18]Donald B. Pittenger, Projecting Local and State Populations (Cambridge: Ballinger, 1976), chapter 3.

[19]Kendall, p. 53.

[20]Pittenger, p. 30.

[21]Ibid., p. 39.

[22]This figure is an approximate estimate which was derived from court records.

[23]Charles Bernstein, "Client Flow in the County Mental Health System under Act 143," paper presented at the Third Annual Conference, Mental Health Evaluation, Philadelphia, May 20, 1977.

[24]The data for 1976 were computed on the first nine months of the year only, because the legislative change was instituted in the tenth month of that year. The graphs of the yearly averages are presented in Appendix I.

[25]The projection was made by visual means rather than mathe-

matical because the macro-level analysis had validated the use of the visual method and also because the object of this part of the analysis was only to see whether a deviation from the expected trend had occurred, rather than to make an exact estimate of the deviation. Therefore, the assumption was made that the existing trend would continue during the post-legislative period, and the visual projection is simply an extention of the existing trend.

[26]Conversation with Myron McLaughlin, Coordinator, Emergency Services, West Philadelphia Mental Health Consortium.

[27]Henry J. Steadman, Joseph J. Cocozza, and Mary Evans Melick, "Explaining the Increased Crime Rate of Mental Hospital Patients: the Changing Clientele of State Hospitals," American Journal of Psychiatry (forthcoming, 1978).

[28]Marvin E. Wolfgang, Robert M. Figlio, and Thorsten Sellin, Delinquency in a Birth Cohort (Chicago: University of Chicago Press, 1972); and Joan McCord, "Patterns of Deviance," paper presented at the 1976 Annual Meeting of the Society for Life History Research in Psychopathology, Forth Worth, Texas, October 1976.

[29]Sue Titus Reid, Crime and Criminology (Hinsdale, Ill.: Dryden Press, 1976), p. 58.

[30]Thorsten Sellin, "Recidivism and Maturation," National Probation and Parole Association Journal 4 (July 1958):241-250; and Wolfgang, op. cit.

[31]Blalock, p. 181.

[32]Ibid.

[33]R. L. D. Wright, Understanding Statistics: an Informal Introduction to the Behavioral Sciences (New York: Harcourt, Brace, 1976), p. 230.

[34]Ibid., p. 213.

[35]Steadman, Cocozza, and Melick, op. cit.

[36]Larry Sosowski, "Crime and Violence among Mental Patients Reconsidered in View of the New Legal Relationship between the State and the Mentally Ill," American Journal of Psychiatry 135 (1978):33-42. Terence P. Thornberry and Joseph Jacoby, in The Criminally Insane: a Community Follow-Up of Mentally Ill Offenders (forthcoming, 1978), found that subjects with long and serious offense careers tended to be arrested after release.

[37]The data were arranged into events for this section of the analysis. For the description of an event, see Thorsten Sellin and Marvin E. Wolfgang, The Measurement of Delinquency (New York: Wiley, 1964). An event represents a complete singular behavioral action. If an arrest comprised several charges which described the same behavior, only the one most serious behavior was recorded. On the other hand, if the charges represented separate behaviors, both were recorded.

[38]Public indecency is included in the category of offenses against the public order which was first in frequency before the legisaltion, but which decreased to sixth place after the legislation. Simple assault was included in the category of non-index offenses against the person. This category rose after the legislation from ninth to sixth place, but this apparent rise in frequency is due to the fact that three offenses had the same post-legislative frequency. The percentage of these offenses stayed about the same (5.26 before the legislation and 5.88 after the legislation).

[39]Steadman, op. cit., note 27; Sosowski, op. cit.

CHAPTER 6. DISCUSSION AND CONCLUSIONS

1. The Mystery of the Dog in the Night

The results presented above in chapter 5 indicate that the hypothesis was not supported--the non-commitable mentally ill were not "diverted" into the criminal justice system via arrests for petty offenses. The data from California[1] and New York[2] indicate that such diversion is to be expected to some extent following a change in law or policy similar to that which took place in Pennsylvania. Why, then, did this study find that no diversion took place?

The most logical explanation would be that the behavior initiating arrest did not occur. This hardly seems likely, given the finding that the mentally ill spent more time in the community after the legislation. If we ask who of the mentally ill are spending more time in the community, we may find an answer to the problem of the failure of diversion to occur.

2. Selective Decarceration: the Reasons Why it Took Place

The legislation appears to have intended a two-pronged movement of patients out of the hospital and into the community. First, the new procedures for involuntary commitment were designed to prevent all but the dangerous mentally ill from entering the mental health system on a long-term basis. The data presented in chapter 5 indicate that this goal was achieved.[3]

Second, the hospitals were given 180 days from the implementation of the legislation to hold hearings on those patients already resident in the hospitals and to apply to them the criteria of the new legislation.[4] Application of these criteria would have meant the release of many long-term chronic and senile patients, thereby accelerating the deinstitutionalization movement of hospitalized patients which has already been documented in chapter 4. This movement occurred in California[5] and in New York[6] following legislative and policy change, respectively.

There are two indications that this second deinstitutionalization movement--of chronic and senile patients--did not take place in Philadelphia County. First, a study carried out in Philadelphia by Temple University[7] states that the deinstitutionalization movement slowed down in Pennsylvania after 1973. The proportion of old people in the total inpatient population in Pennsylvania increased from 30 per cent in 1969 to 34 per cent in 1974.[8] During the same period, we find that the percentage of old people hospitalized throughout the United States decreased (from 32 per cent in 1969 to 25 per cent in 1974).[9] It can, therefore, be concluded that, at least up to and including 1974, elderly patients in Pennsylvania were not being released at the same rate as their national counterparts.

The second indication of the failure to deinstitutionalize the elderly and the chronic in Philadelphia County comes from observations made during the current research. These observations concern the application of the new legislative criteria to patients hospitalized under the previous Mental Health Act.

There are three bureaucratic organizations in charge of implementing the legislation in Philadelphia County--the County Office of Mental Health (OMH), the hospitals themselves, and the commitment court. All three disapproved of the new legislation, and all played a part in the way in which it was implemented.

The main function of the OMH is administrative, even though its senior executives are psychiatrists. The additional paper-work load required by the new legislation was one source of negative feeling against it, and the "treatment" orientation of the chief executives was another. Both workers and executives had previously been dissatisfied for another reason. The OMH employes a number of psychiatric social workers whose original function had been to supply therapy to those people to whom no community mental health center was available. As the network of community mental health centers expanded, the therapeutic skills of these workers became redundant, and they took on administrative tasks with which they were dissatisfied. Most of these workers had by now accumulated so much time towards their pension and retirement benefits that it was economically unfeasible for them to seek work elsewhere, and their presence was a source of annoyance for the executives who had to find tasks for them. The workers and executives of the OMH were already in a state of precarious balance, and the legislative change was not seen by them as advantageous. It confused the established routine, provided no new tasks for the social workers but added more paper work for the clerical workers. There was, thus, no impetus to welcome a change from the status quo at the OMH.

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(The problem of the redundant social workers was solved by the expansion of the prison psychiatric services in early 1977. Most of them transferred to prison services without loss of pension benefits. This expansion of prison services probably explains Guy's findings that more prisoners were referred to prison psychiatric services post-legislation.[10] "There is a well-known trend in service delivery. The availability of services increases their use."[11])

The institutions themselves did not welcome the change. One psychiatrist attached to a large community mental health center conducted a study among center personnel and found unanimous objection to the legislation.[12] Another local psychiatrist conducted a survey of the reactions of the staff of a local mental hospital, with identical results, and also found that patients were not staying "long enough to be cured."[13] The animosity of the psychiatric profession towards the legislation can be seen in testimony given at public hearings held on proposed amendments to the act. The issue addressed with greatest frequency was that of the chronically ill.[14] Five psychiatrists, three lawyers and one politician addressed the issue. Four psychiatrists and one lawyer wanted the commitment period extended to six months (instead of three months). One psychiatrist felt that the act did not recognize the existence of "untreatables" or chronically disabled persons and felt that, in the absence of a suitable institution for their care, it was not feasible to exclude them from care by legislation. This testimony indicates the very negative attitudes to the legislation held by psychiatrists who hold executive positions in mental institutions.

The commitment court comprises a small group of members who meet nearly every day. The solidarity of the group is indicated by their continuing to address the presiding lawyer by his pre-legislative title of "Master" rather than his post-legislative designation of "Mental Health Review Officer." Although the court is a branch of the court of common pleas and, as such, a public office, its doors are guarded by personnel of the various hospitals and facilities where it holds its hearings. The court's membership, which seldom varies, consists of the Master--a lawyer appointed by the court of common pleas--a public defender,[15] a city solicitor who represents the petitioner, and two social workers, one from the public defender's office and one from the OMH.

The Master's Court, as it is known, is a small social system resembling that described by Blumberg.[16] The continuity of personnel, the semi-private nature of the hearings, the involvement with the personal tragedies of the patients and petitioners all combine to enhance an informal decision-making process which is based on a common goal--the good of the patient. It is this goal which lies behind the lack of expected conflict between the public defender and the city solicitor. One observer commented that "the informality of procedure and blatant disregard of the rules of evidence are common occurrences in Philadelphia."[17] In conversation, members of the court explain that the informality is for the patient's good.[18] In a letter to the senior author of the legislation, the Master complained that, because of the new Act, the non-dangerous mentally ill "are not re-

ceiving treatment in Philadelphia although they are sorely in need of it."[19] The "treatment orientation" of the court is evident in this statement and in that of the public defender who explained to us that he will defer to psychiatric opinion if he feels that it is for the good of the patient.[20] The distaste with which the court regards the new legislation may thus be attributed to the treatment orientation which predominates among the members of the court.

3. The Results of Selective Decarceration

The three major organizations in charge of implementing the new legislation agreed that their task was a misguided one. As mentioned earlier, the institutions had been given six months during which to apply the criteria of the new legislation to the already incarcerated population. Ideally, then, the deinstitutionalization of the non-commitable--the senile, the chronic, and the retarded--would have ended in March, 1977. In fact, this did not happen.

In the case of the retarded, it soon became clear that the planned new legislation concerning involuntary commitment and care of retarded persons was going to be delayed and, as an interim solution, indefinite commitment of retarded persons under the 1966 Mental Health Act was permitted by executive order.[21] This interim solution was still in use when we finished collecting data in December, 1977.

In the case of other long-term patients, a "conversion" form was drafted by the State for use of the Master's court. Although the

conversion form contained space for the registration of the dangerousness criteria that would permit the continued incarceration of the patient under the requirements of the new act, this space was more often than not filled by psychiatric diagnoses. The hearing was seldom a full evidential inquiry but consisted of the bureaucratic conversion of the commitment from the old to the new section and the automatic scheduling of a hearing in 90 days' time. We saw few of these "conversion" cases result in a finding of not mentally ill, or even in a commitment to outpatient care. In some cases, the case was continued--that is, was held in abeyance, often for months--during which the patient was being held in confinement with no legal status whatsoever.

The result of selective decarceration was thus to maintain in custody most of the resident hospital population who are retarded, chronically ill, or senile. There is some indication that the senile and the chronically ill are the most "arrest-prone" of the released mental patients.[22] Whether or not this is the case, it is clear that in Philadelphia County the legislation was implemented in a way that prevented the deinstitutionalization of large numbers of mentally ill people. Therefore, diversion into the criminal justice system was a possibility only for those who avoided entering the mental health system. It was shown above in Chapter 5 that there was no substantial decrease in the numbers of persons entering the mental health system, and it was pointed out above that patients already in residence were not released in large numbers. One major reason, then,

for the failure of diversion to occur was simply that there were not enough potential "divertees."

However, it was also shown in Chapter 5 that those people who did enter the mental health system after the new legislation spent substantially less time in the institution than they did before the legislation. This finding led to the conclusion that some diversion into the criminal justice system was to be expected because of the greater amount of time spent by the mentally ill in the community. It is, therefore, necessary to consider the reasons why these potential "divertees" did not, in fact, come into contact with the criminal justice system.

4. Alternative Means of Controlling Behavior

As mentioned earlier, in Chapter 1, diversion into the criminal justice system is not the only means of coping with unwanted behavior, although it is often assumed that the mental health system and the criminal justice system are the sole alternative means of social control.[23] Four alternative coping methods will be described here in order to see whether they could have explained the failure of diversion to occur.

a. Accepting Deviant Behavior

The first method of coping is simply to do nothing at all. Wolfgang has recently suggested that "we are currently experiencing in America . . . an expansion of acceptability of deviance."[24] The

declining arrest rates for "nuisance offenses" documented in Chapter 5 could be cited in support of this thesis. ENKI's finding that the police picked up mentally ill people but did not book them[25] is indicative of the reluctance of officials to take action against the mentally ill. This reluctance has been documented in other studies.[26] ENKI found also that the numbers of mentally ill persons picked up by the Los Angeles Police Department dropped by 31 per cent in the second year following L-P-S.[27] This decrease could indicate a growing acceptance by the public of the mentally ill in their midst.

This is not to say that the general public enjoys their new neighbors: in fact it protests their presence, often vehemently.[28] For example:

> "We will not continue to be a dumping ground," Collins said flatly, and added that he was ready to do something about it. Without such action, he said, the city will face "a constant deluge of erratic people," some of whom "beg nickels, dimes and quarters from people," and "urinate in the parks or alleys."[29]

The angry citizen in this case was prepared to demand but not to initiate action, like the writer of a letter to the senior author of the new legislation, who stated, inter alia, "My objection, Senator . . . is that for whatever reason . . . the law is not working on the street level, where the problems with mental health are happening."[30]

It would appear from these examples that the general public prefers to appeal to the administration and the legislature to "do something," rather than using the criminal law to cope with the problem

directly. This conclusion is not in conflict with the studies cited in Chapter 4 which found that the general public has not become more tolerant of deviant behavior since the deinstitutionalization movement began. It means simply that the public is not prepared--or does not know how--to act upon its dissatisfaction.

b. Hiding Deviant Behavior

It is clear that the deinstitutionalization movement of mental patients has encouraged the growth of privately-owned board and care homes.[31] These homes care not only for ex-mental patients but also for other socially marginal individuals, such as the elderly, the homeless and the physically disabled,[32] so that they have been compared with the poorhouse of colonial times.[33] The main difference between today's board and care home and the poorhouse is that the responsibility for payment lies not with the local community but with the federal government, in the form of Social Security, SSI and welfare payments. Not only does the board and care home remove from the community the financial responsibility for its marginal residents, but it also serves to contain their behavior within its walls. It provides a focus for complaints of neighbors. These complaints, not being officially recorded, maintain the appearance of public acceptance of deviance. If the residents behave in undesirable ways outside the board and care home, this behavior is limited to the lower-class neighborhood where many such homes are located.[34] The low visibility of the board and care home (and hence of its residents) is indicated

by the difficulties encountered by researchers in locating them.[35] By rendering much of the anti-normative behavior of the ex-patient invisible and by absorbing complaints which would otherwise come to public notice, the board and care home maintains the apparent acceptance of the general public of higher rates of minor forms of deviance.

c. Maintenance of the Sickness Label

According to current philosophy, the sick are not to be blamed and punished for their acts.[36] Whereas previously the label of sickness could be maintained by virtue of a person's residence in a mental institution,[37] it is now maintained by virtue of his receiving gratuities from the federal government. In fact, in order to receive some of these gratuities, the person is forced to admit officially that he is mentally disabled.[38]

In this way, the "sick and helpless" label is maintained, and so is the concomitant reluctance to apply penal sanctions to persons so labeled. Some feel that this newly labeled (or relabeled) population is growing and becoming more diversified, to include other socially marginal people.[39] Concomitant with the growth of this population is a new institution that has developed to serve it--the Community Mental Health System.[40] The problem with the Community Mental Health System is that it does not physically contain the population it serves. The visibility of this population causes distress to the community which is faced with the continuing dilemma that one should not punish the sick and blameless.

d. The Private Criminal Complaint

Nonetheless, the behavior of some mentally disturbed people causes others to seek relief. In Philadelphia, the victim is often referred by the police or by mental health workers (neither of whom feel that the situation lies within their domain) to the District Attorney's office where a private criminal complaint may be issued. The case is then investigated, the offender summoned to appear, and both plaintiff and defendent state their cases in the court of first arraignment. In many cases, mental illness is involved, and in many cases the judge presides upon the parties to settle their problem peacefully without need of further legal action.[41]

The number of cases heard in the year following the new legislation increased by 23 per cent. Data for previous years are unavailable and, therefore, it cannot be said with certainty that this increase was unexpected and was caused by the new legislation. However, the monthly pattern of complaints also differs in the year following the act. In 1976, the number of complaints peaked in the summer (June, July, and August); but in 1977 this peak was obscured by a long peak which ran from April through to October. This would indicate that factors other than "the long, hot summer" influenced the number of complaints.[42] Such factors could have included the influence of mentally ill people in the community; but, as mentioned above, the data do not permit the analysis required to state this conclusion with certainty.

5. Summary--Why No Diversion Appeared

It seems that the major reason for the failure of diversion of the type hypothesized here to appear was the relatively small number of mentally ill persons released to the community, especially as this number contained few chronically ill or senile persons. The factors of public acceptance of deviance, the use of board and care homes, maintenance of the sickness label and the use of the private criminal complaint all contributed to the failure of the relatively few "releasees" to be diverted into the criminal justice system in substantive numbers.

6. Conclusions--The Future of Decarceration in Pennsylvania

The importance of the implementation of legislated change has been well documented. Meisel, concentrating on mental health law, points out the "before becoming too complacent with the great progress made by the courts and the legislatures in the past few years, we should realize that their ability to implement their pronouncements is quite limited."[43] Meisel feels that the role of the mental health worker is the most important factor involved in the implementation of the rights of the mentally ill.[44] Bardach[45] takes a wider view, looking at varied types of legislated social change and various implementing organizations. He concludes that "the character and degree of many implementation programs are inherently unpredictable."[46]

Bardach gives as one example the post-L-P-S growth of board and

care homes in California. Their administration was eventually taken over by the Welfare Department, by default. No other body in the health and welfare complex wanted to assume responsibility for the task. The Welfare Department was not prepared or the task which was, therefore, carried out in a chaotic and unplanned manner.[47] Aviram et al. examined the rates of release of mental patients in states which had similar mental health laws. They found widely differing rates and concluded that this was due to the differential implementation of the laws.[48] They, therefore, supported Bardach's claim of the inability to predict the character and degree of many implementation programs. Bardach also found substantial county-wide differences in the implementation of L-P-S in California.[49]

Given this bureaucratic autonomy, it is pertinent to ask whether the "organizational rebellion" in Philadelphia will continue to prevent the further decarceration of the mentally ill. The balance between the makers of law and the implementors of law is not static. For example, in Pennsylvania, pressure has been placed on the implementors by a recent court order demanding the closure of Pennhurst (a large state institution for the retarded) and the placement of its residents in group community homes.[50] In California, pressure on the law makers recently resulted in an amendment to L-P-S which permitted the 90-day commitment of a person who is "considered an imminent danger" (as opposed to a person who had acted in a dangerous way).[51]

In order to predict the future of a dynamic and complex organizational relationship, it is necessary to search for and find a basic

imperative which transcends the varied goals of both the law makers and the law implementors. In the case of the decarceration of both the mentally ill and the criminal, this imperative is financial.[52] The financial imperative, however, does not exist in a vacuum. "The organization of psychiatric care was responsive to social, economic and ideological influences in society at large."[53] It can, however, be shown that these other influences are related to and influenced by the economic factor. Social influences are to a large extent dependent on economic influences[54] at least in a capitalistic society,[55] and ideological influences are strongly related to social and economic influences,[56] so that the economic factor appears focal.

The central part played by the economic factor is further demonstrated by three studies of admissions to mental hospitals during the Great Depression.[57] All three studies expected to find an increase in mental illness followed by hospitalization during the Great Depression because of the strains it caused. All found instead that hospitalization rates decreased. The authors offer no explanation for their contradictory findings but they are consistent with the thesis that long-term (as opposed to seasonal) trends in hospitalization populations are influenced by the economy and that the relationship is positive.[58]

Brenner's findings[59] are also consistent with this thesis. He found that economic depression (measured by the rate of unemployment in the manufacturing industry) caused an increase in hospital admissions in some patients--specifically the functional disorders--

but only on a short-term (seasonal) basis. Brenner did not find any long-term increases in the resident populations of mental hospitals which correlated with economic slumps. This is consistent with the thesis that, in the long run, the economic imperative on the state and national level will determine the rate of the hospitalized population (as distinct from short-term admissions).[60]

In a later work, Brenner found that indices of economic distress correlated positively with imprisonment rates.[61] This finding is also consistent with the thesis that financial imperatives influence incarceration rates. He found also that mental hospitalization admissions increased as economic indices decreased.[62] However, as hospital releases were not correlated with economic indices, the proposition of financial imperative is not disproved.

As the financial dilemma of the states shows no sign of melioration, it is logical to conclude that the pressure from the legislature and the administration to continue the deinstitutionalization of mental patients will not abate. It is logical also to conclude that the implementors will in time be forced to carry out the deinstitutionalization programs, although this implementation will by no means occur rapidly nor without resistance.

Given that the decarceration movement of the mentally ill will continue (albeit slowly and unevenly) the question arises: will the eventual deinstitutionalization of large numbers of non-dangerous mentally ill result in diversion to the criminal justice system? In order to answer this question, it is necessary to look at the total formal control system--the criminal justice system and the mental

health system--and to analyze the changes which are taking place in both systems.

Within the criminal justice system, two mutually reinforcing movements have been taking place. The decarceration of non-serious offenders into the community has been taking place over the last few years, with juvenile offenders predominating. At about the same time, disillusionment with the ideal of rehabilitation[63] has led to the reduction of the use of parole and to the use of the mandatory sentence[64] so that the resident prison population is beginning to resemble a core of serious, recidivist offenders.[65]

The mental hospital population has undergone a similar change as a result of deinstitutionalization policies. Its population consists more and more of the dangerously ill and less of the chronic, non-dangerous ill. The result of this changing clientele of the mental hospital in the direction of the dangerous patient has been the increasing rates of violent crime of the released patient. The present research, as well as that of Steadman in New York[66] and Sosnowsky in California[67] has shown that the offenses committed by ex-patients have become more serious since the deinstitutionalization movement has been accelerated by legislation and by policy. Both Steadman and Sosowsky explain this result by the increasing number of the population of mental hospitals who have a prior offense record.[68]

This change in population derives from two sources. First, there is what Steadman refers to as "diversion in reverse"[69]: that is, the movement of people from the criminal justice system into the mental health system. Our data bear this out. During the year following the

new act there were 194 applications for long-term commitment directly from the community (i.e., applications that did not begin with the emergency commitment). Of these, 91--or 46.9 per cent--came from the District Attorney's office. These were persons who had been arrested but whom the District Attorney and the public defender felt needed treatment for mental illness (this procedure is described in detail in Chapter 5). Most of the chsrges were not specified, but of the 44 charges that were known, 21 (47 per cent) were for violent offenses against the person, 4 (9 per cent) were serious offenses against property, 6 (13.63 per cent) were non-serious personal offenses, 7 (15.9 per cent) were non-serious property offenses, and 6 (13.63 per cent) were misdemeanors. Thus, the most frequent charge was for a serious offense against the person.[70]

The second source of the accumulation within the mental hospital of serious and dangerously ill persons is the legal fiat that only the dangerous may be committed against their wills.

These two movements represent a polarization of deviants, both the sick and the well, according to the categories of dangerous or not dangerous. They also represent a change in the function of the mental hospital and the prison. Both have become more the custodian of the dangerous (as opposed to the treater/rehabilitator of the sick/unsocialized). Both systems release their non-dangerous deviants to the community where they should be cared for, ideally, by the community mental health centers and the federal government (for their emotional and financial well-being, respectively). Some of these "rejectees" will remain in the community. They may cause minor disturbances but will not be reinstitutionalized unless they commit a dangerous act because

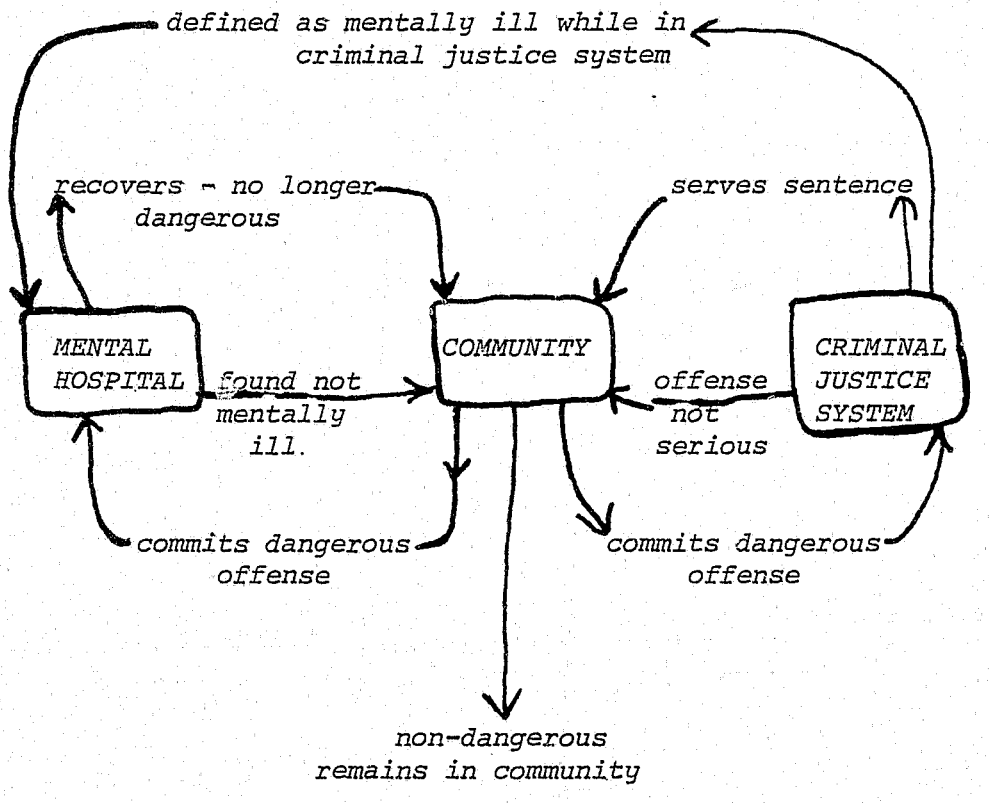
neither of the traditional social control systems will accept them, according to their newly-emerging functions as custodian of the dangerous.

If a dangerous act should be committed, the offender will be institutionalized, either in the criminal justice system or in the mental health system, according to the sick/well criterion. This is to say, the reciprocity of the two systems has not been reduced by recent developments, but has rather been concentrated on a smaller population of persons already classified as dangerous. The process is represented diagramatically in Figure 6-1 which indicates that the reciprocity of the two formal systems of social control still exists. The change in the nature of the clientele of both systems can be described as a concentration of a pool of dangerous deviants, both sick and well. Figure 6-1 does not indicate the proportions of the dangerous in prison, the dangerous in the hospital, and the non-dangerous in the community. It appears, however, from studies already examined, that the majority of the mentally ill are not dangerous,[71] so that the numbers of the mentally ill in the community should outnumber those incarcerated. As the decarceration movement from mental hospitals seems to outpace the decarceration movement from prisons, because of legislative and judicial orders, the numbers of mentally ill in prison should eventually outnumber those in hospitals, according to the flow outlined in Figure 6-1.

This tendency indicates that the dangerously mentally ill offender is being punished in the criminal justice system for what he has done, rather than being detained in the hospital for what he might do. This is undoubtedly constitutionally valid, but the question is:

Figure 6-1

Relationship between the Criminal Justice System, the Mental Health System, and the Community Mental Health System



has constitutionality been gained at the cost of public safety and convenience?[72]

There exists a solution for the problem of public safety and convenience, and this is to relabel the deviant as "ill" and to invoke preventative incarceration in mental hospitals. The recent amendment to L-P-S in which "mental illness" was redefined to mean a person who is "considered an imminent danger" indicates that this solution has been used, at least partially, in California.[73]

The right of the mentally ill person not to be incarcerated against his will has been advanced considerably by recent judicial decisions and legislation of the type which has been examined here. The concomitant occurrence has been the polarization of deviants into two categories: the dangerous and the non-dangerous. The non-dangerous--both sick and well--are moving into the community and the dangerous are either being punished in the criminal justice system or treated in the mental health system. The distinction between the sick and the well within the category of dangerous is much more difficult than the simple sick-well dichotomy, because the commission of a dangerous act has been used as one criterion for the existence of mental illness. The result is the continued mutuality and overlap of the criminal justice and mental health systems. This mutuality is enhanced by the changing function of both systems in the direction of custodian of the dangerous.

At the same time, the pool of non-dangerous individuals, both criminal and mentally ill, has been released into the community where

they are "dealt with" by the community mental health network, the welfare system, and private organizations, together with other socially marginal individuals. The community has not, as yet, organized any substantial protest about their new neighbors.

The question of whether this trend will continue depends on policy and its implementation. The major determinants of policy are economic and ideological considerations. At the beginning of the change in mental health care, the ideology was in agreement with the economic pressures to reduce the population of mental hospitals (and of juvenile institutions). However, the growing public protest concerning the number of deviants in the community and the protests of interest groups (such as the CSEA in California) together with the growing awareness and resentment of the large numbers of people being supported by federal welfare money may remove the ideological support from the decarceration movement.[74]

It is clear that the new legislation has not caused diversion of the non-dangerous mentally ill into the criminal justice system in any major proportions. Its major effect has been to change the population of the mental hospital to a core of dangerous individuals, at least in states where the legislation was implemented more fully. The problem to be expected, therefore, in the future is the increasing crime rate of these patients when released, at a time when the criminal justice system is also experiencing financial difficulties, re-evaluating its goals, and diverting as many people as possible into the community. The possible outcomes are an increase of crime and deviance in the

community, or a return to the previous situation. The factors which will influence the outcomes are financial, ideological, and political.

Footnotes to Chapter 6

[1]ENKI, A Study of California's New Mental Health Law, 1969-71 (Chatsworth, Calif.: ENKI Corp., 1972), chap. 12; Eugene Bardach, The Implementation Game: What Happens after a Bill Becomes Law (Cambridge, Mass.: MIT Press, 1977), chap. 6.

[2]Ivan Peterson, "Former Mental Patients a Source of Pity and Anger on Long Island," New York Times, January 8, 1978.

[3]The number of admissions increased during the year following the act (172 admissions per month in 1977 compared with 123.5 admissions per month in 1976) but the time spent in the hospital decreased from approximately three weeks per patient in 1976 to two days in 1977.

[4]Pennsylvania Department of Welfare, Memorandum, December 16, 1976.

[5]Steven P. Segal and Uri Aviram, The Mentally Ill in Community-Based Sheltered Care (New York: Wiley, 1978).

[6]Peterson, op. cit.; Robert Reich and Lloyd Segal, "Psychiatry under Siege: the Mentally Ill Shuffle to Oblivion," Psychiatric Annals 3 (1973):35.

[7]Temple University, Center for Social Policy and Community Development, "Boarding Homes in Philadelphia," Philadelphia, 1978 (mimeo).

[8]Ibid., p. 33.

[9]Ibid.

[10]Edward B. Guy, "The Impact of New Legislation on Mentally Ill Offenders Entering the Philadelphia Prison System," paper presented at the 3rd annual conference on Mental Health Evaluation, Philadelphia, May 20, 1977.

[11]Segal and Aviram, p. 10.

[12]Jerome J. Platt, "Staff Perceptions of the Impact of Act 143 upon Clinical Service Delivery in a Community Mental Health Center," paper presented at the 3rd annual conference on Mental Health Evaluation, Philadelphia, May 20, 1977.

[13]Thomas Steinberg, "The Effects of Act 143 upon Philadelphia State Hospital: a First Look," paper presented at the 3rd annual conference on Mental Health Evaluation, Philadelphia, May 20, 1977.

[14]The following is based on testimony presented at public hearings on Act 143, Pennsylvania Senate, Harrisburg, March 25, 1977.

[15]The proportion of patients represented by a private solicitor is so small that it may be disregarded for these purposes. In the course of our research we found two patients who retained private lawyers. Both were found not mentally ill.

[16]Abraham S. Blumberg, "The Practice of Law as Confidence Game: Organizational Cooptation of a Profession," Law and Society Review 1 (1967):15-39.

[17]Ohlbaum, Edward D. "The Gates of Cerberus: Involuntary Civil Commitment in Philadelphia," Temple Law Quarterly 49 (1976):328, note 18.

[18]Conversation with Mr. A. Ciparillo, Public Defender, November 18, 1976.

[19]Letter from the Master to W. Louis Coppersmith, November 30, 1976.

[20]Conversation with Public Defender.

[21]By order of October 28, 1976, U.S. District Court (M.D. Pa.) (staying its previous order of July 8, 1976, in the matter of Goldy v. Beal).

[22]Reich and Segal, op. cit.; Peterson, op. cit.

[23]See, for example, Alan A. Stone, Mental Health and Law: a System in Transition (Rockville, Md.: NIMH Monograph, 1975).

[24]Marvin E. Wolfgang, "Real and Perceived Changes of Crime and Punishment," Daedalus 107 (1978):143-158.

[25]ENKI, chap. 12.

[26]Egon Bittner, "Police Discretion in the Apprehension of Mentally Ill Persons," Social Problems 14 (1966); Richard G. Fox and Patricia G. Erikson, "Research Report: Apparently Suffering from Mental Disorder: an Examination of the Exercise of Police Power under S.10 of the Mental Health Act of Ontario," Centre of Criminology, University of Toronto, 1972.

[27]ENKI, op. cit.

[28]Julian Wolpert and Eileen Wolpert, "The Relocation of Released Mental Hospital Patients into Residential Communities," Princeton University, 1974 (mimeo).

[29]"A Town Impatient of Former Patients," Philadelphia Inquirer, March 5, 1978.

[30]"Problems Arise with Pennsylvania Rights for Mental Patients," Philadelphia Bulletin, January 2, 1977.

[31]Segal and Aviram, op. cit.; Temple University, op. cit.

[32]Ibid.

[33]Segal and Aviram, op. cit.

[34]Temple University, op. cit.

[35]Ibid.

[36]David Morgan, "Explaining Mental Illness," European Journal of Sociology 16 (1975):262-280; see also Peter McHugh, "A Commonsense Perception of Deviance," in Hans Peter Dreitzel, ed., Recent Sociology #2 (New York: Macmillan, 1970), pp. 151-180.

[37]Erving Goffman, Asylums (New York: Doubleday Anchor, 1961).

[38]Steven P. Segal, Jim Baumohl, and Elsie Johnson, "Falling through the Cracks: Mental Disorder and Social Margin in a Young Vagrant Population," Social Problems 24 (1977):387-400.

[39]Segal and Aviram, op. cit.; Andrew T. Scull, Decarceration: Community Treatment and the Deviant: a Radical View (Englewood Cliffs: Prentice-Hall, 1977).

[40]Morgan, op. cit.; S. Dinitz and N. Beran, "Community Mental Health as a Boundaryless and Boundary Busting System," Journal of Health and Social Behavior 12 (1971):99-108.

[41]Conversations with District Attorneys Elsie Heard and Alan Smuckler, January, 1977. Data from the District Attorney's office is not broken down in a way which would permit the estimation of the number of cases in which mental illness is involved.

[42]These figures were taken from the District Attorney's office, Division of Private Criminal Complaints, Philadelphia.

[43]Alan Meisel, "The Rights of the Mentally Ill: the Gulf Between Theory and Reality," Hospital and Community Psychiatry 26 (1975):352.

[44]Ibid.

[45]Bardach, op. cit.

[46]Ibid., p. 5.

[47]Ibid., chap. 6.

[48]Uri Aviram, S. Leonard Syme, and Judith B. Cohen, "The Effects of Policies and Programs on Reduction in Mental Hospitalization," Social Science and Medicine 10 (1976):571-577.

[49]Bardach, op. cit.; Appendix I.

[50]Halderman v. Pennhurst 74-1345 (M.D. Pa. Filed March 17, 1978) (now on appeal).

[51]California State AB 1228 and 1229, 1975, quoted in Segal and Aviram, p. 76.

[52]Eugene Bardach, The Skill Factor in Politics: Repealing the Mental Commitment Laws in California (Berkeley: University of California Press, 1972); see also Scull, op. cit.; and G. Rusche and O. Kirchheimer, Punishment and Social Structure (New York: Russell and Russell, 1968).

[53]David Mechanic, Mental Health and Social Policy (Englewood Cliffs: Prentice-Hall, 1969), p. 54.

[54]Rusche and Kirchheimer, op. cit.

[55]Max Weber, On Law in Economy and Society (New York: Simon and Schuster, 1967).

[56]See, for example, Anthony Platt, The Child Savers: the Invention of Delinquency (Chicago: University of Chicago Press, 1969).

[57]Harvey M. Brenner, Mental Illness and the Economy (Cambridge, Mass.: Harvard University Press, 1973). The studies cited by Brenner are: P. Komora and M. Clark, "Mental Disease and the Crisis," Mental Hygiene 19 (1935):289-301; Horatio M. Pollock, "The Depression and Mental Disease in New York State," American Journal of Psychiatry 91 (1935):736-771; Ernest R. Mowerer, "A Study of Personal Disintegration," American Sociological Review 4 (1938):475-487.

[58]We are not attempting to disprove Durkheim's theory that in times of shared crisis, suicide rates and other indicators of social stress are reduced (Emile Durkheim, Suicide: a Study in Sociology, trans. by John Spaulding and G. Simpson [New York: Free Press, 1951]. There are two operative trends: a long-term trend of hospital population which decreases as the economy decreases and a short-term or seasonal trend. The seasonal trend may obscure or be obscured by the long-term trend

depending upon the relative magnitudes of the numbers making up each trend. In the studies cited above, the results are consistent with both the Durkheimian (seasonal explanation) and the financial (long-term explanation).

[59]Brenner, op. cit.

[60]Conversation with Dr. Brenner, April 2, 1978.

[61]Harvey Brenner, "Estimating the Social Costs of National Economic Policy: Implications for Mental and Physical Health and Criminal Aggression," U.S. Congress, Joint Economic Committee, Washington, D.C., 1976.

[62]Ibid.

[63]See, for example, R. Martinson, T. Palmer, and S. Adams, "Rehabilitation, Recidivism, and Research," National Council on Crime and Delinquency, 1976.

[64]Wolfgang, op. cit.

[65]Brenner found an inverse relationship between economic distress and diversion from the criminal justice system; see Brenner, "Estimating the Social Costs," op. cit.

[66]Henry J. Steadman, Joseph J. Cocozza, and Mary Melick, "Explaining the Increased Crime Rate of Mental Patients: the Changing Clientele of State Hospitals," American Journal of Psychiatry (forthcoming, 1978).

[67]Larry Sosowsky, "Crime and Violence among Mental Patients Reconsidered in View of the new Legal Relationship between the State and the Mentally Ill," American Journal of Psychiatry 135 (1978)L33-42.

[68]Steadman, Cocozza, and Melick, op. cit.; see also Terence Thornberry and Joseph E. Jacoby, The Criminally Insane: a Community Follow-up of Mentally Ill Offenders (forthcoming, 1978).

[69]Steadman, Cocozza, and Melick, op. cit.

[70]Violent offenses comprised five homicides, eight aggravated assaults, seven robberies and one rape. Serious offenses against property were two burglaries and two auto thefts. The nonserious personal offense comprised three simple assaults, one indecent assault, one harrassment. The nonserious property offenses were six thefts, one theft of services; and the misdemeanors comprised two probation violation, two controlled substance, and two false fire alarms.

[71]See studies cited earlier in Chapter 4.

[72]The second issue which should be raised here is the well-being of the non-dangerous mentally ill in the community and the dangerous mentally ill in prison. This issue cannot be discussed here because of space limitations.

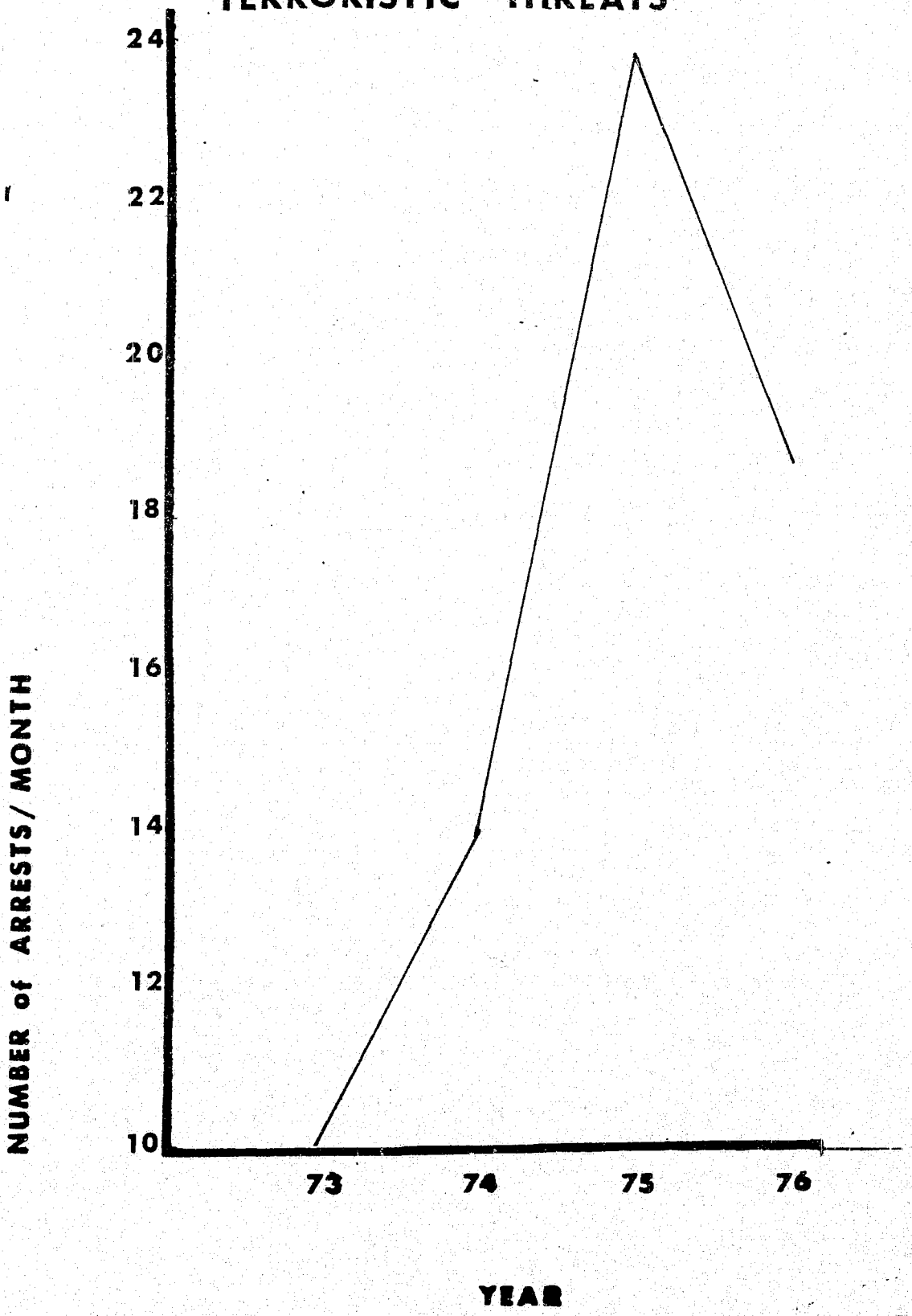
[73]It also indicates a return to power of the psychiatric profession, for who but a psychiatrist can say that a person is imminently dangerous?

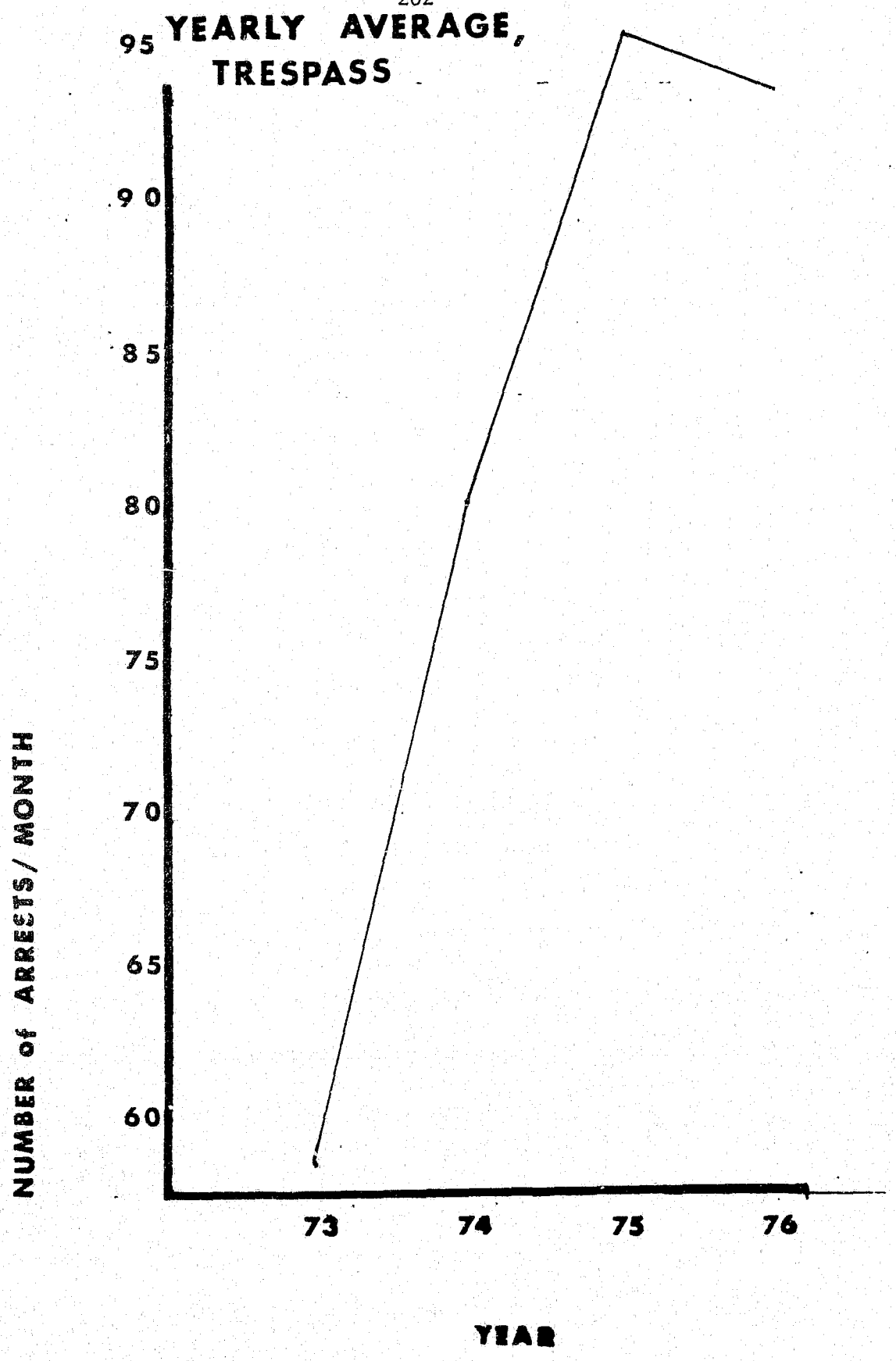
[74]It is significant that the recent amendment to L-P-S occurred during the Brown administration; that is, at a time when Reagan's strict budgetary restrictions on mental hospitals had been lifted, and also at a time when the newspapers were supporting the efforts of the CSEA to arouse public fear of the deviants in their midst.

Appendix I

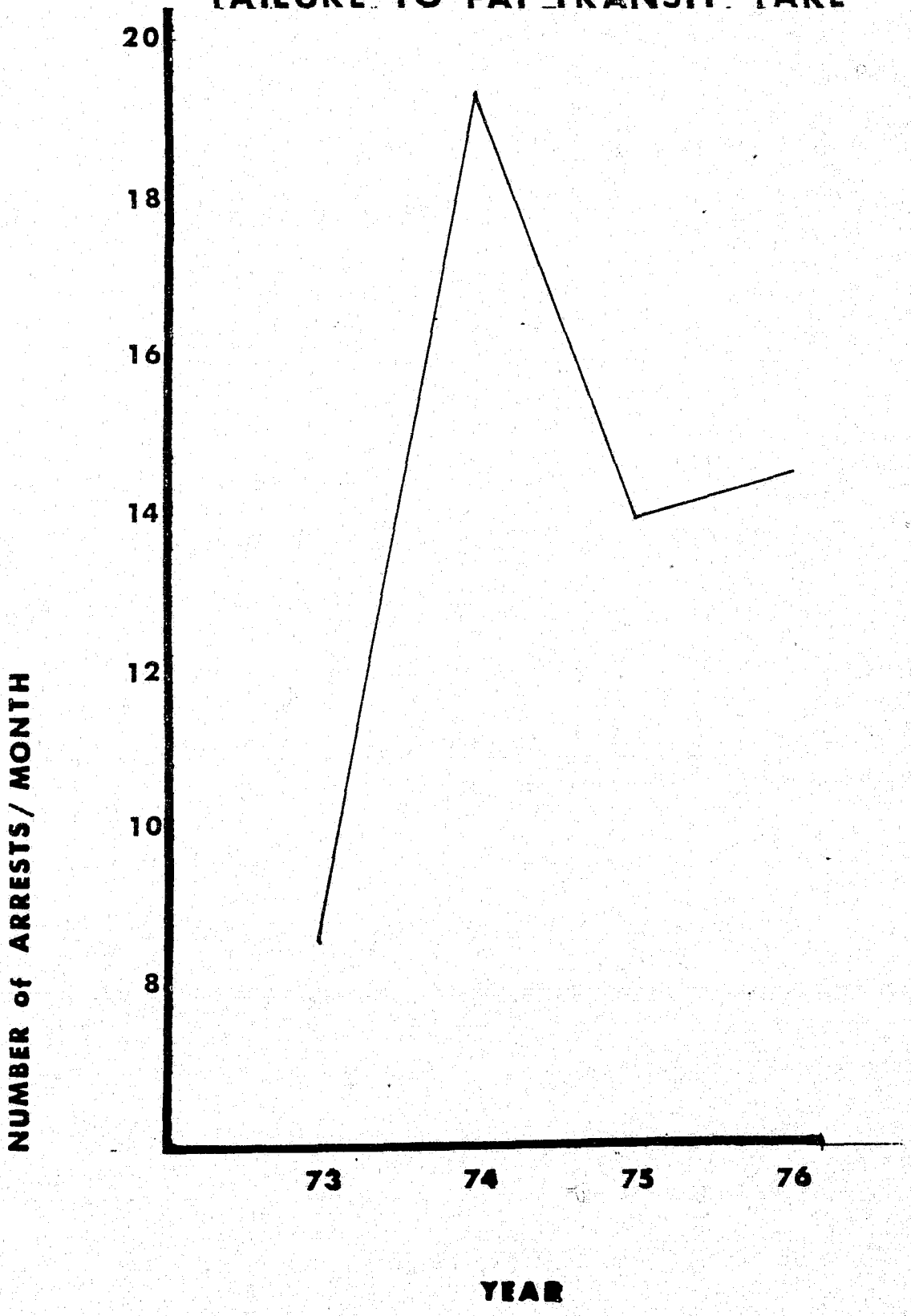
YEARLY AVERAGES OF ARREST RATES, 1973-1976

YEARLY AVERAGE, TERRORISTIC THREATS

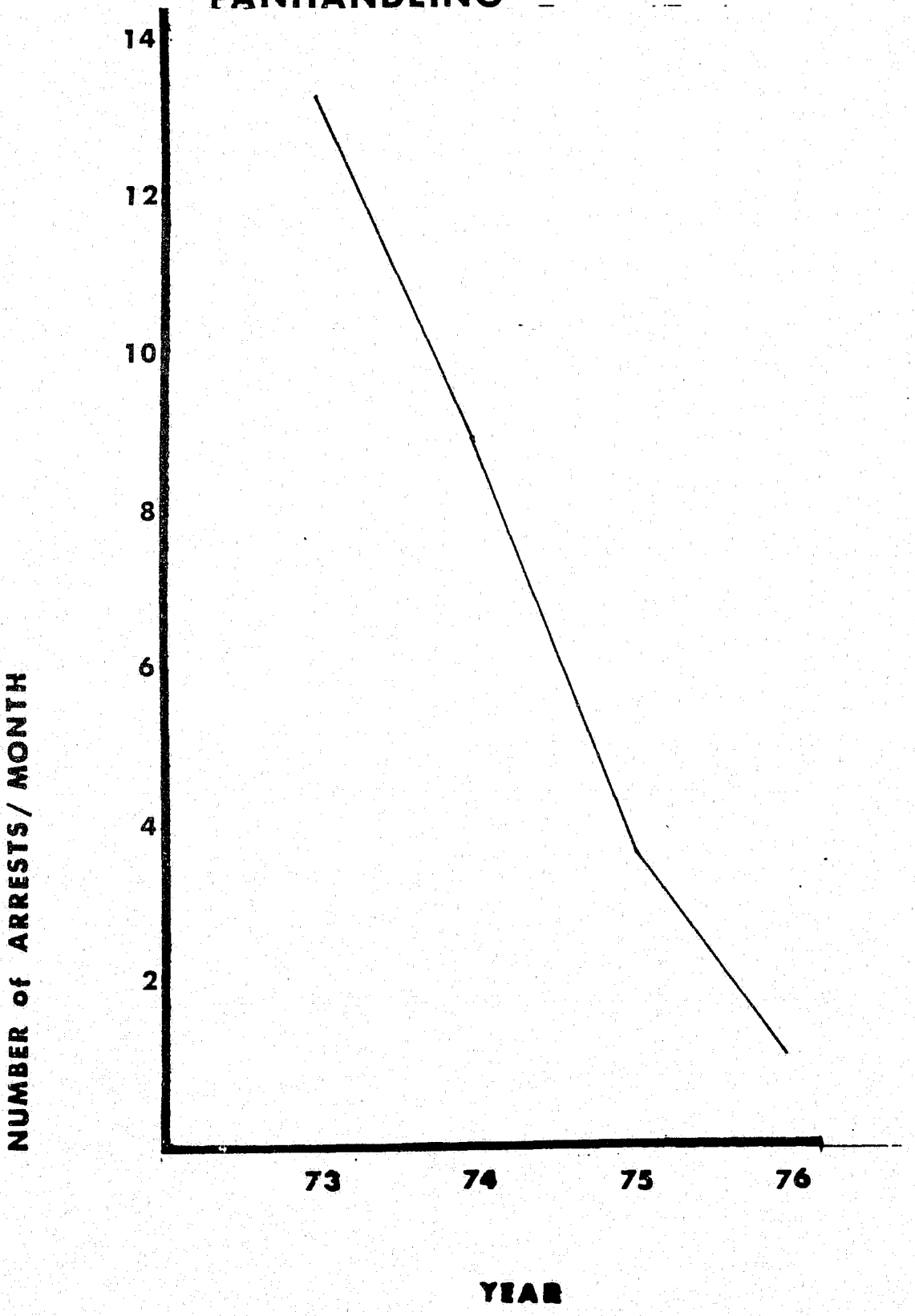



YEARLY AVERAGE,
TRESPASS
95
90
85
80
75
70
65
60
NUMBER of ARRESTS / MONTH
73
74
75
76
YEAR

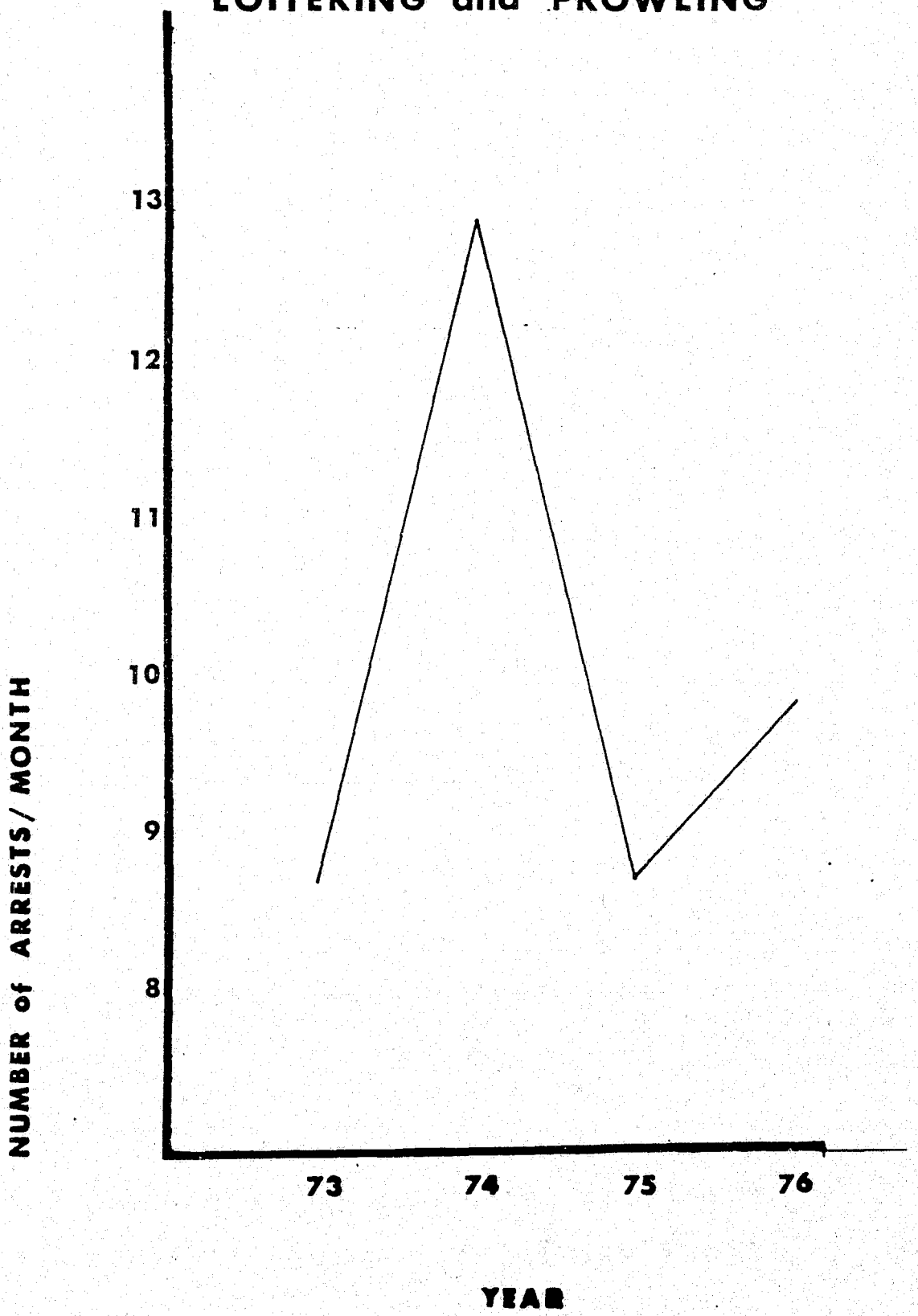
YEARLY AVERAGE, FAILURE TO PAY TRANSIT FARE



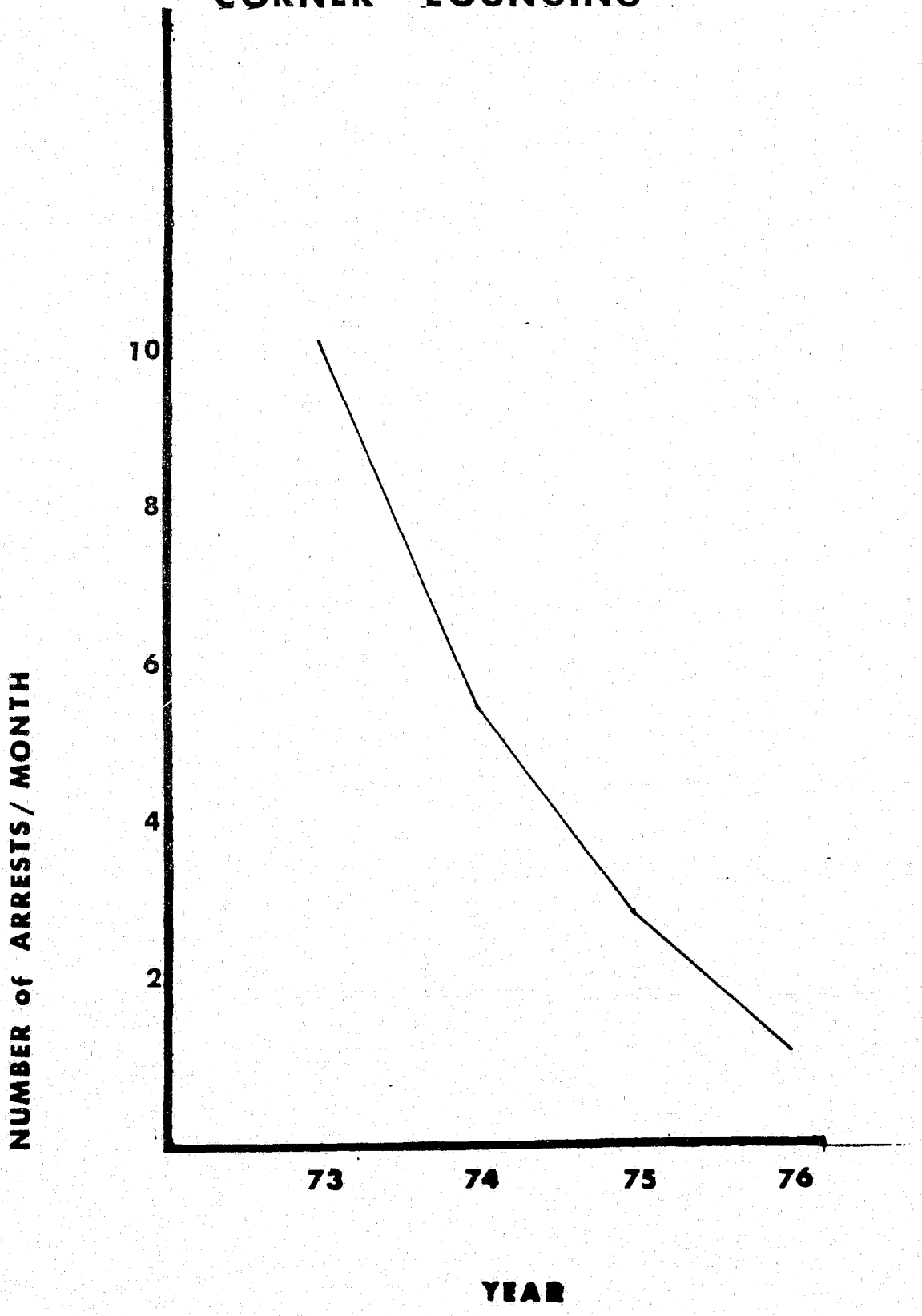
YEARLY AVERAGE, PANHANDLING



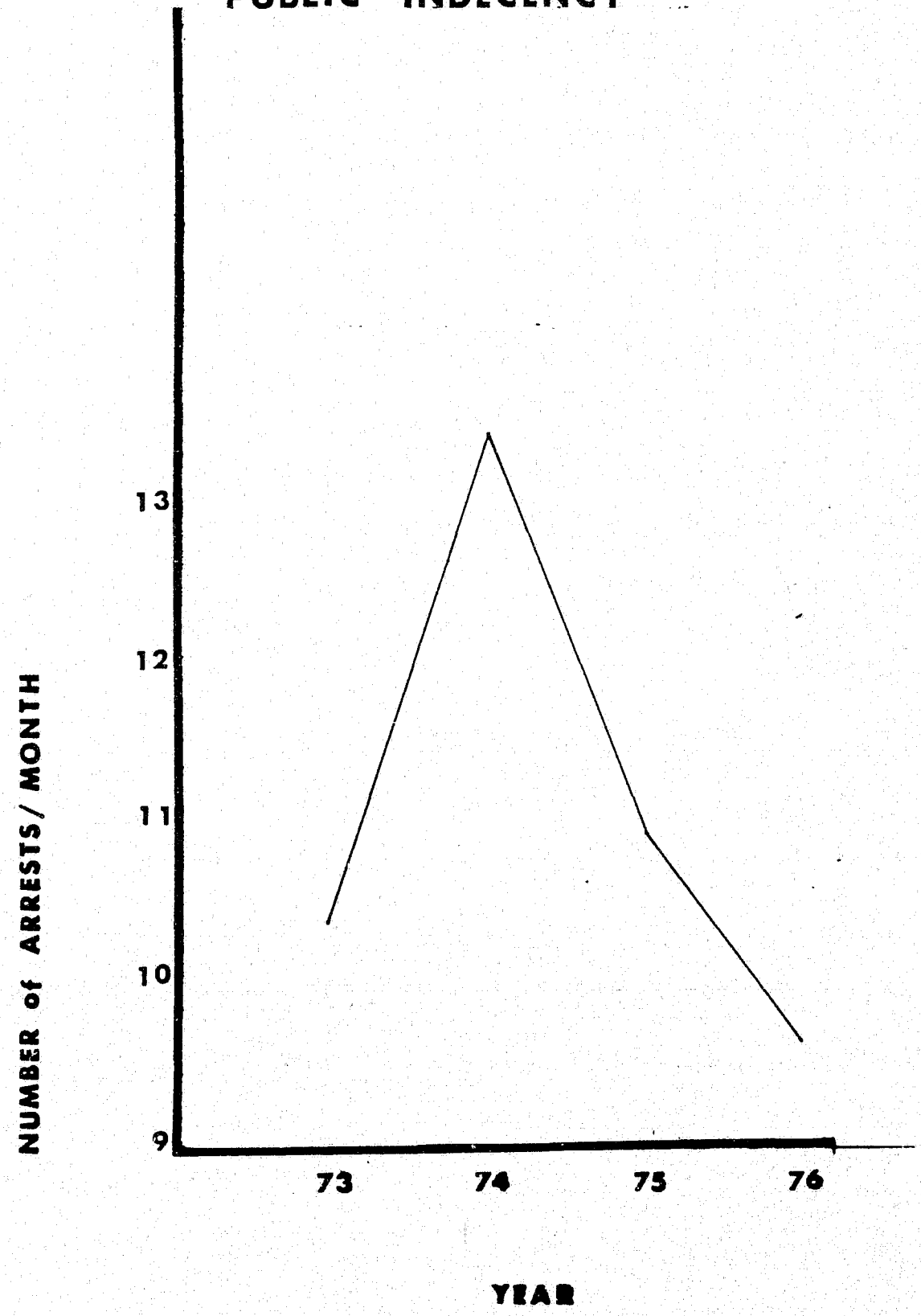
YEARLY AVERAGE, LOITERING and PROWLING



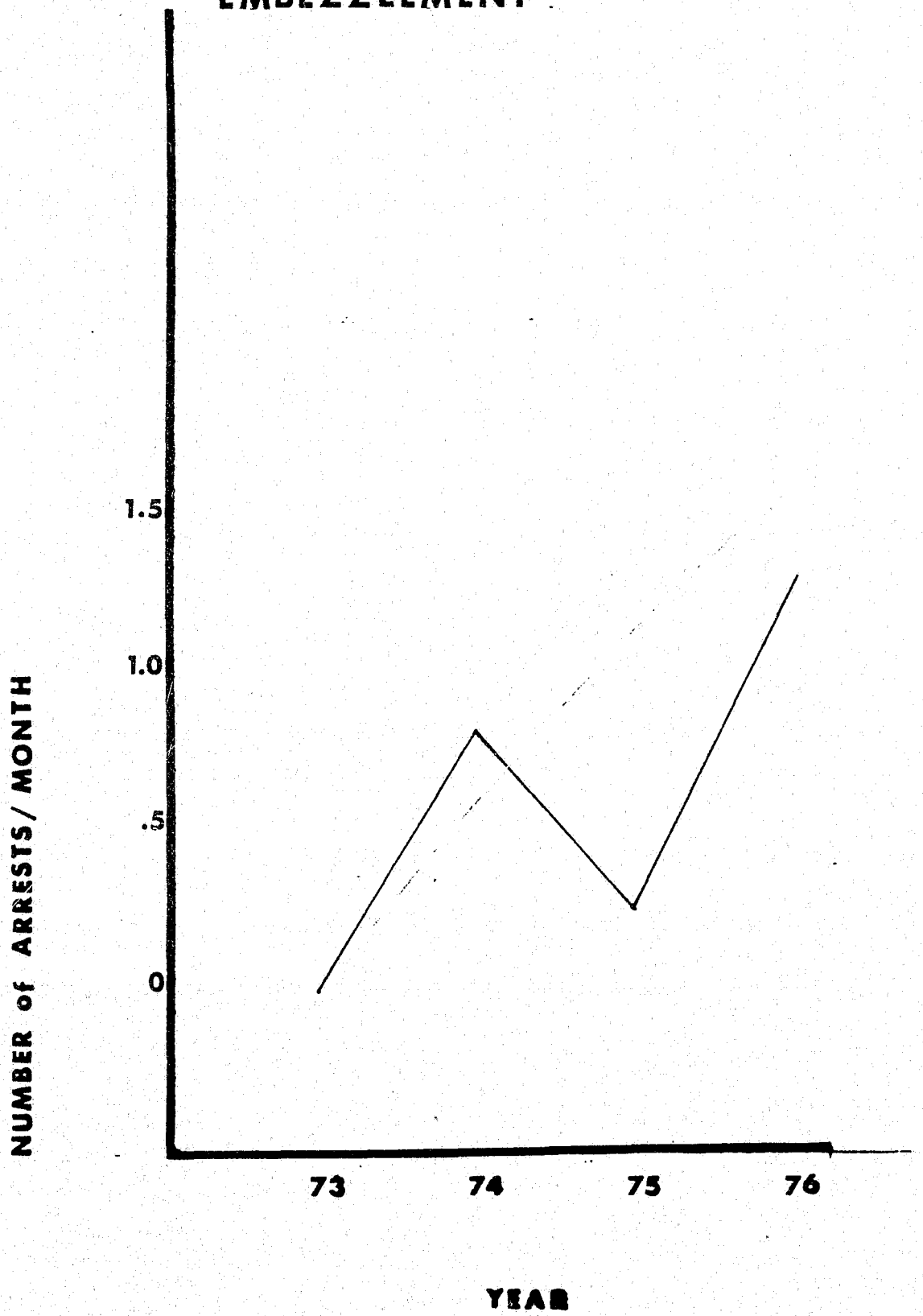
YEARLY AVERAGE, CORNER LOUNGING



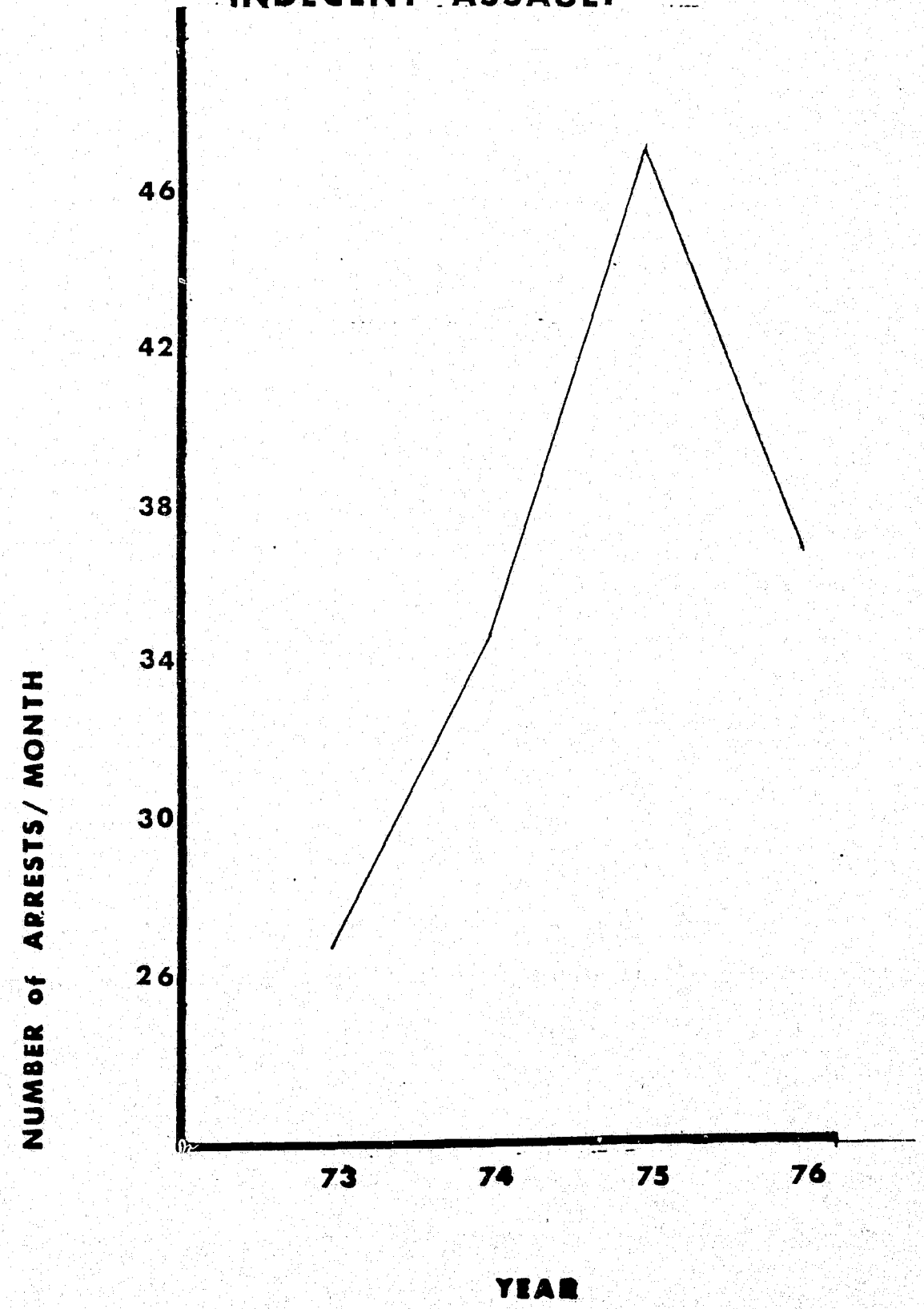
YEARLY AVERAGE, PUBLIC INDECENCY



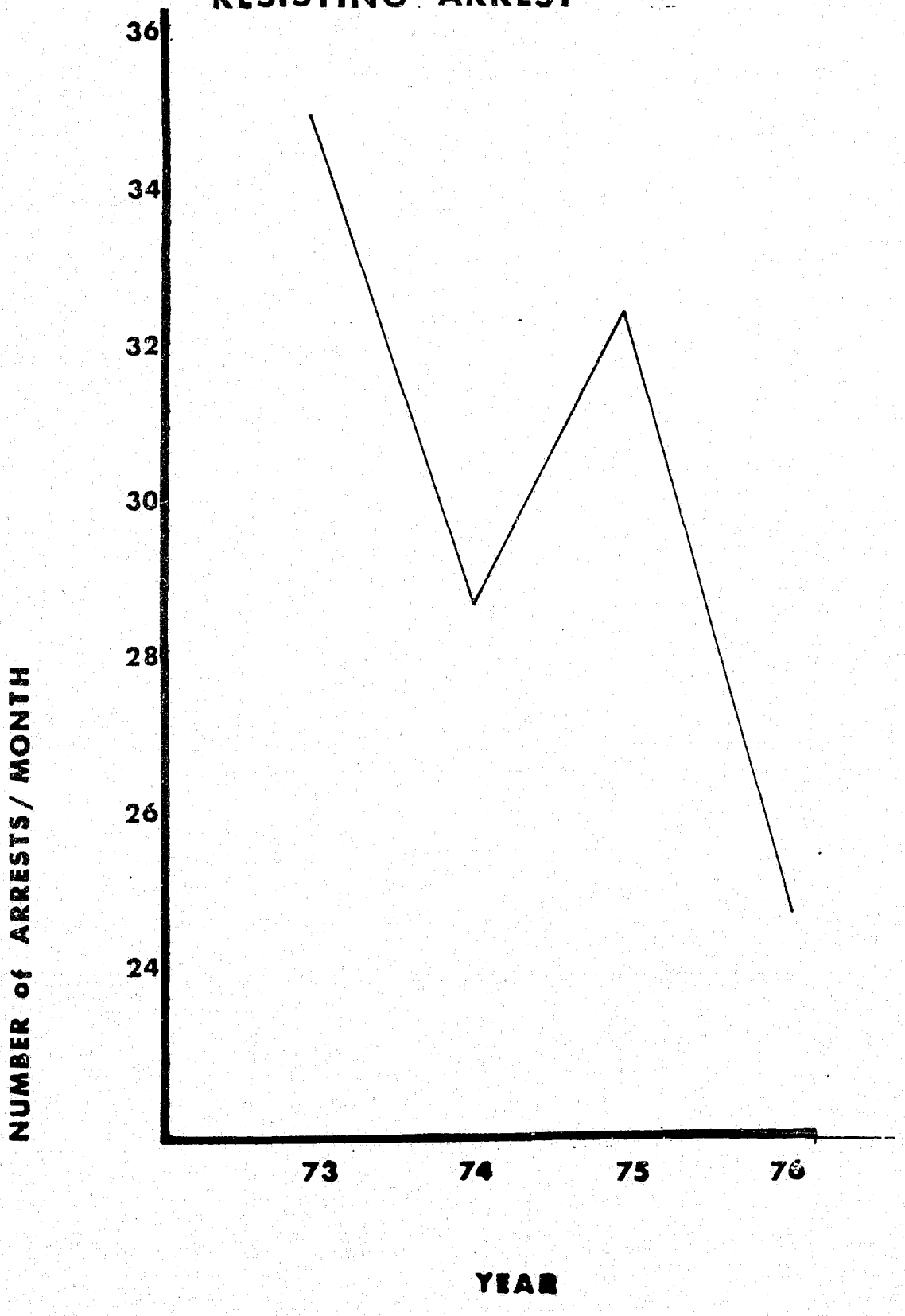
YEARLY AVERAGE, EMBEZZLEMENT

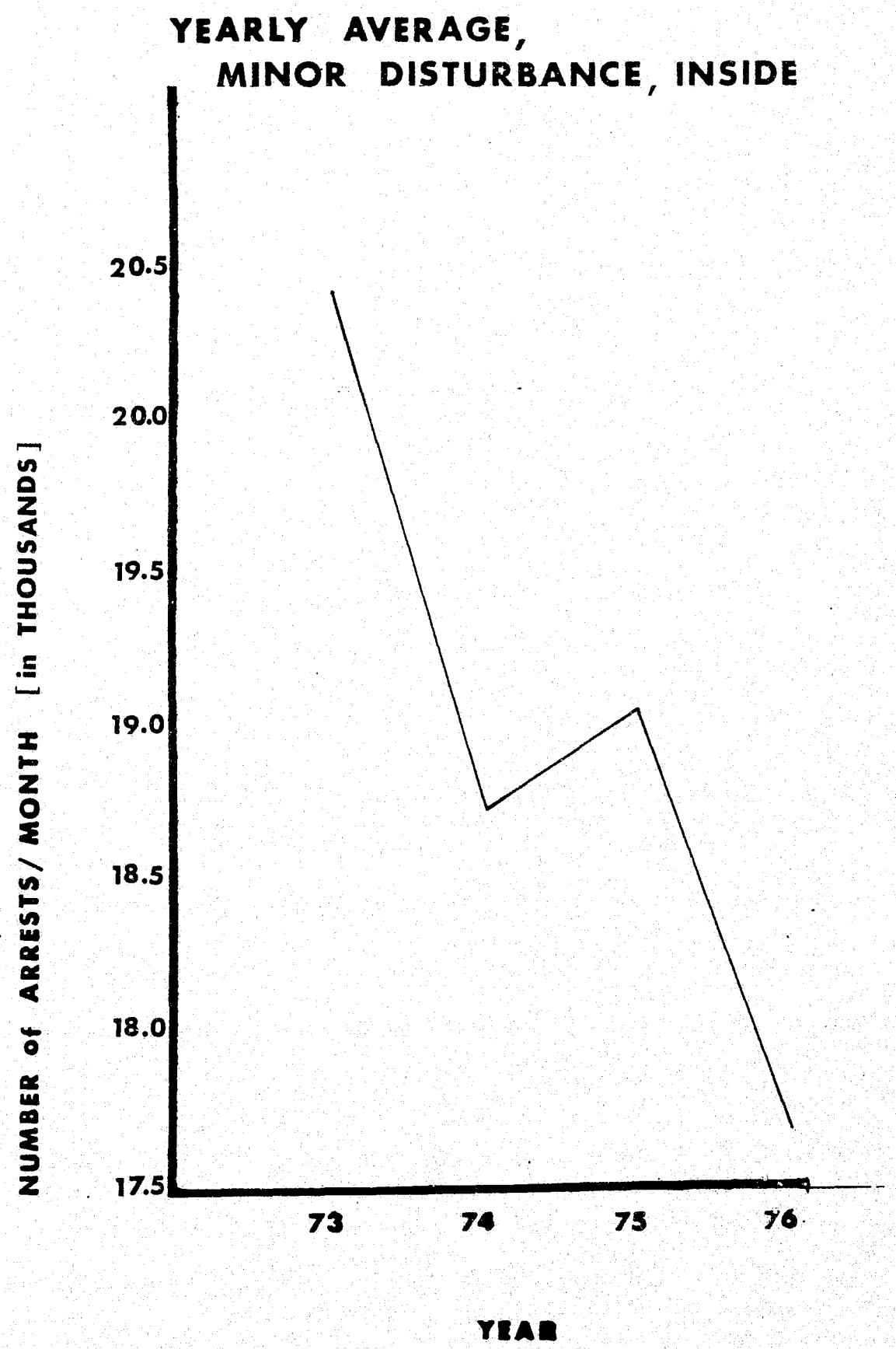


YEARLY AVERAGE, INDECENT ASSAULT

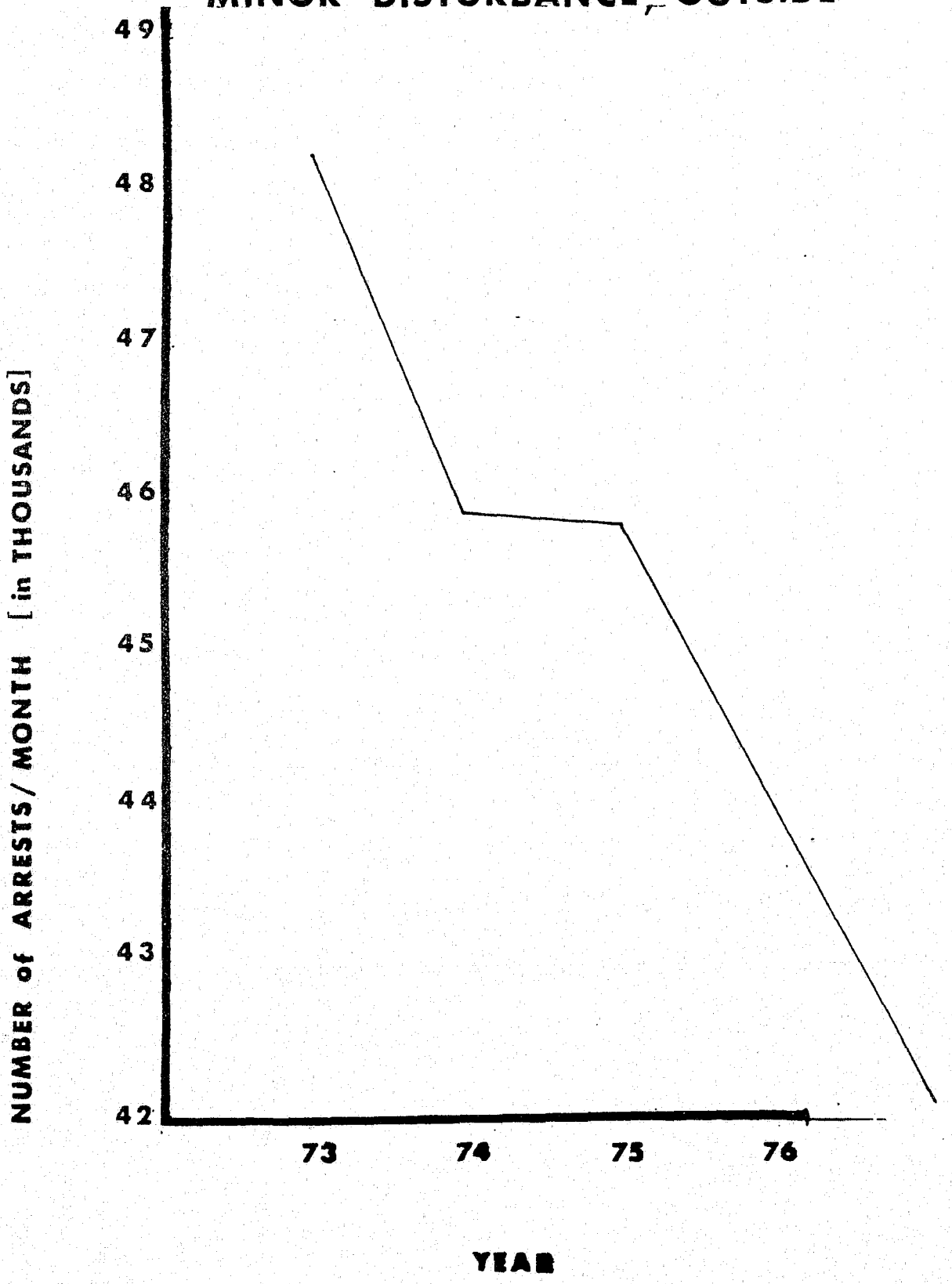


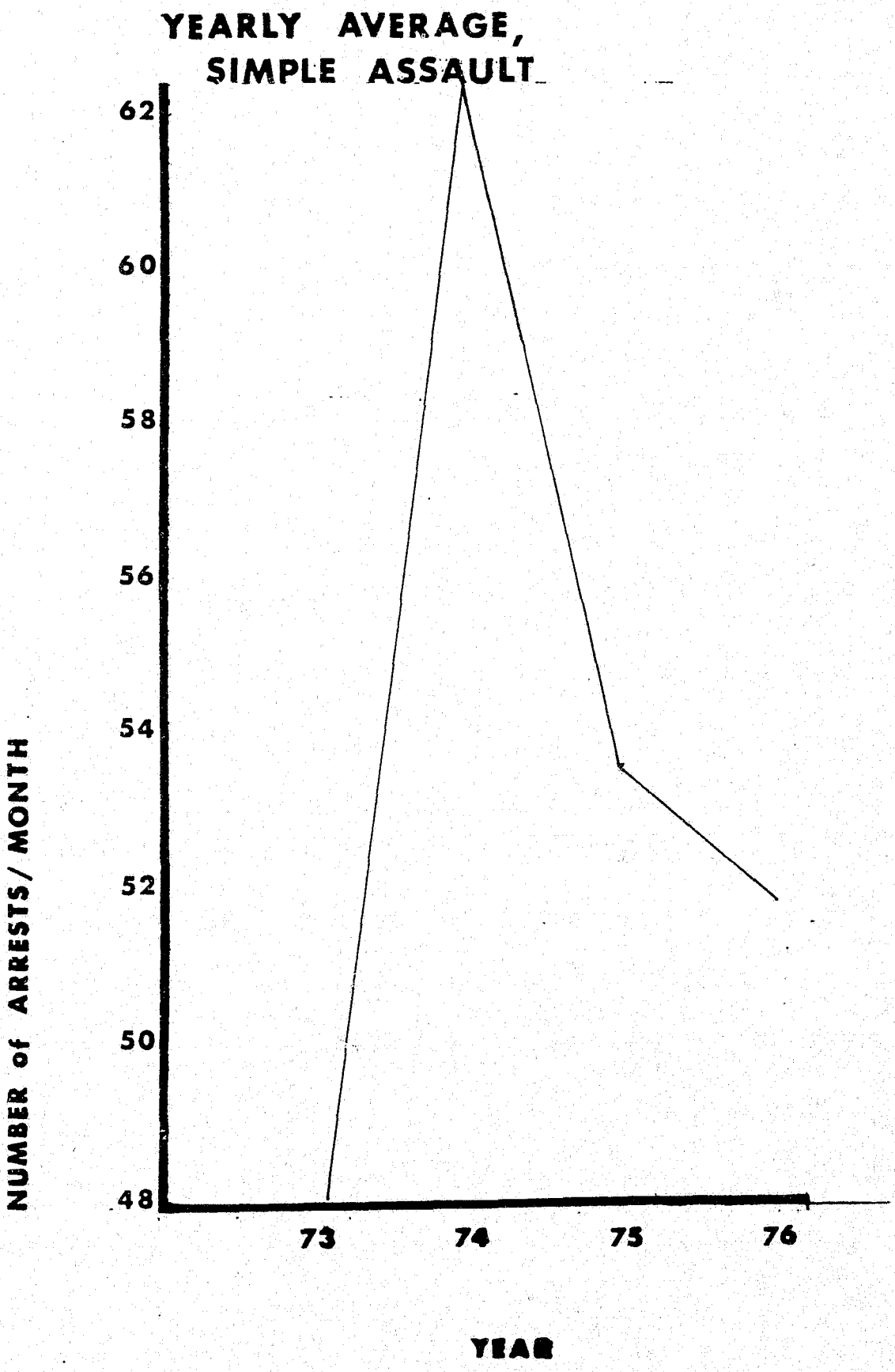
YEARLY AVERAGE, RESISTING ARREST



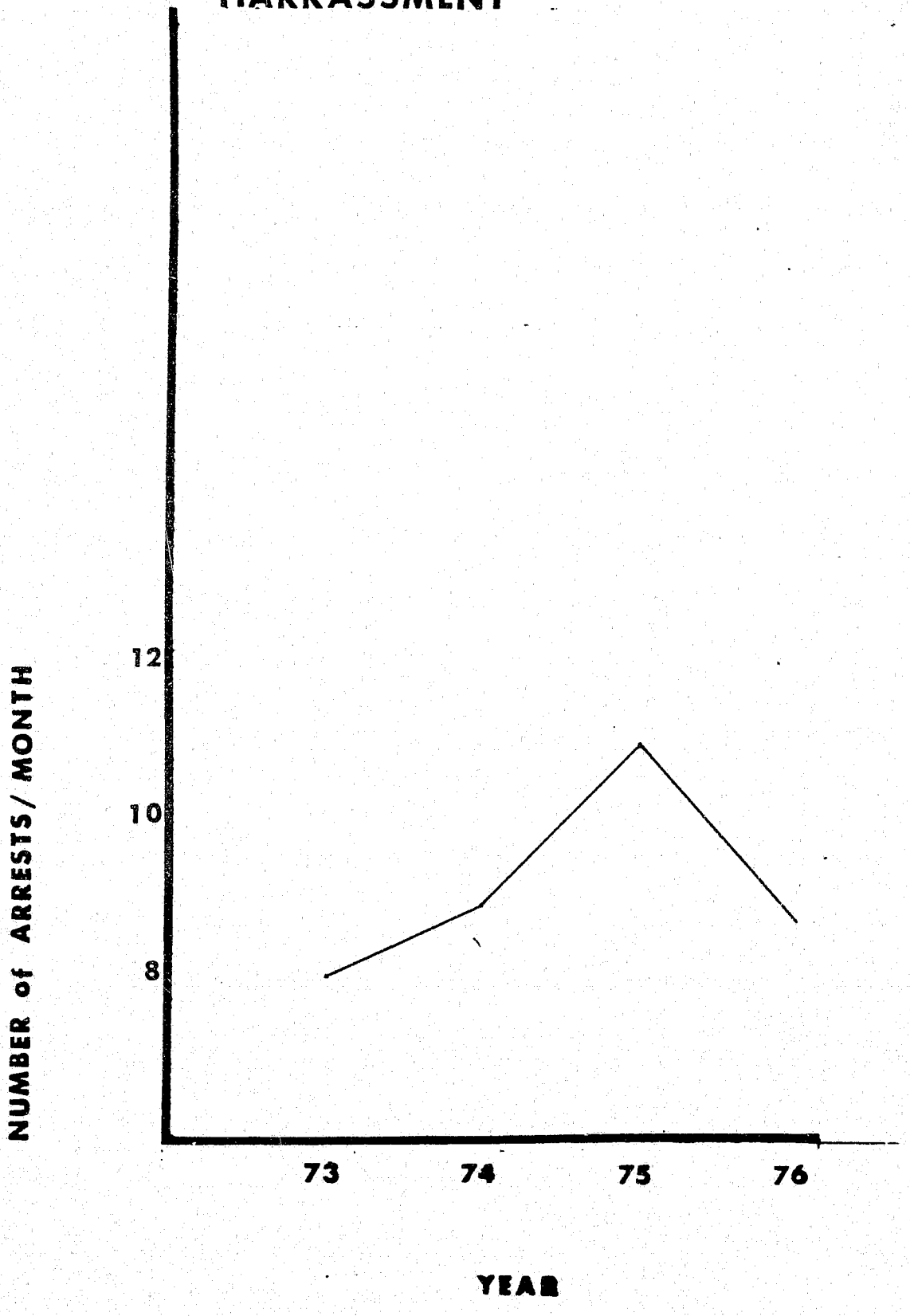

YEARLY AVERAGE,
MINOR DISTURBANCE, INSIDE
NUMBER of ARRESTS/MONTH [in THOUSANDS]
20.5
20.0
19.5
19.0
18.5
18.0
17.5
73
74
75
76
YEAR

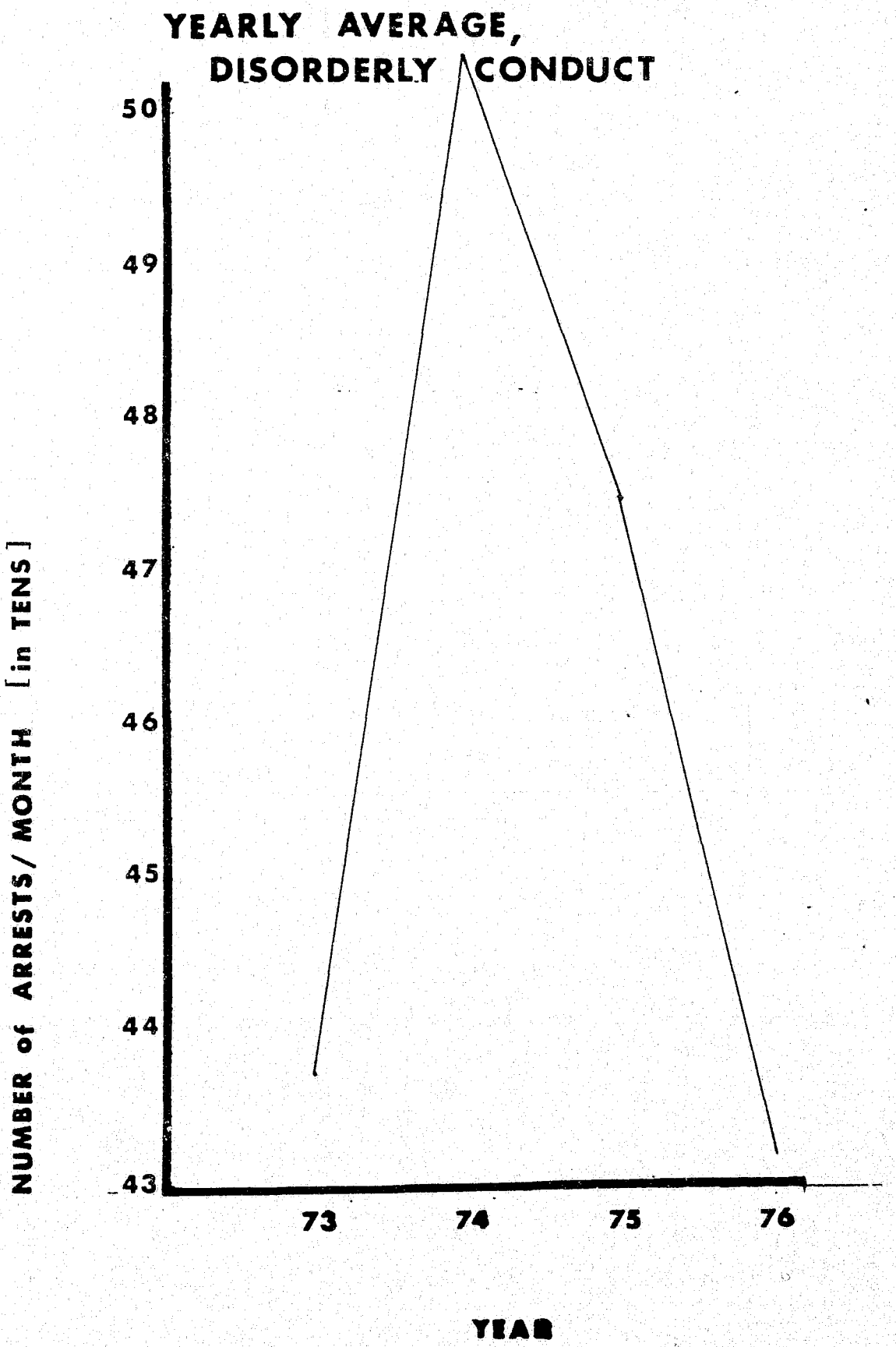
YEARLY AVERAGE, MINOR DISTURBANCE, OUTSIDE




YEARLY AVERAGE,
SIMPLE ASSAULT
62
60
58
56
54
52
50
48
NUMBER of ARRESTS/ MONTH
73
74
75
76
YEAR

YEARLY AVERAGE, HARRASSMENT



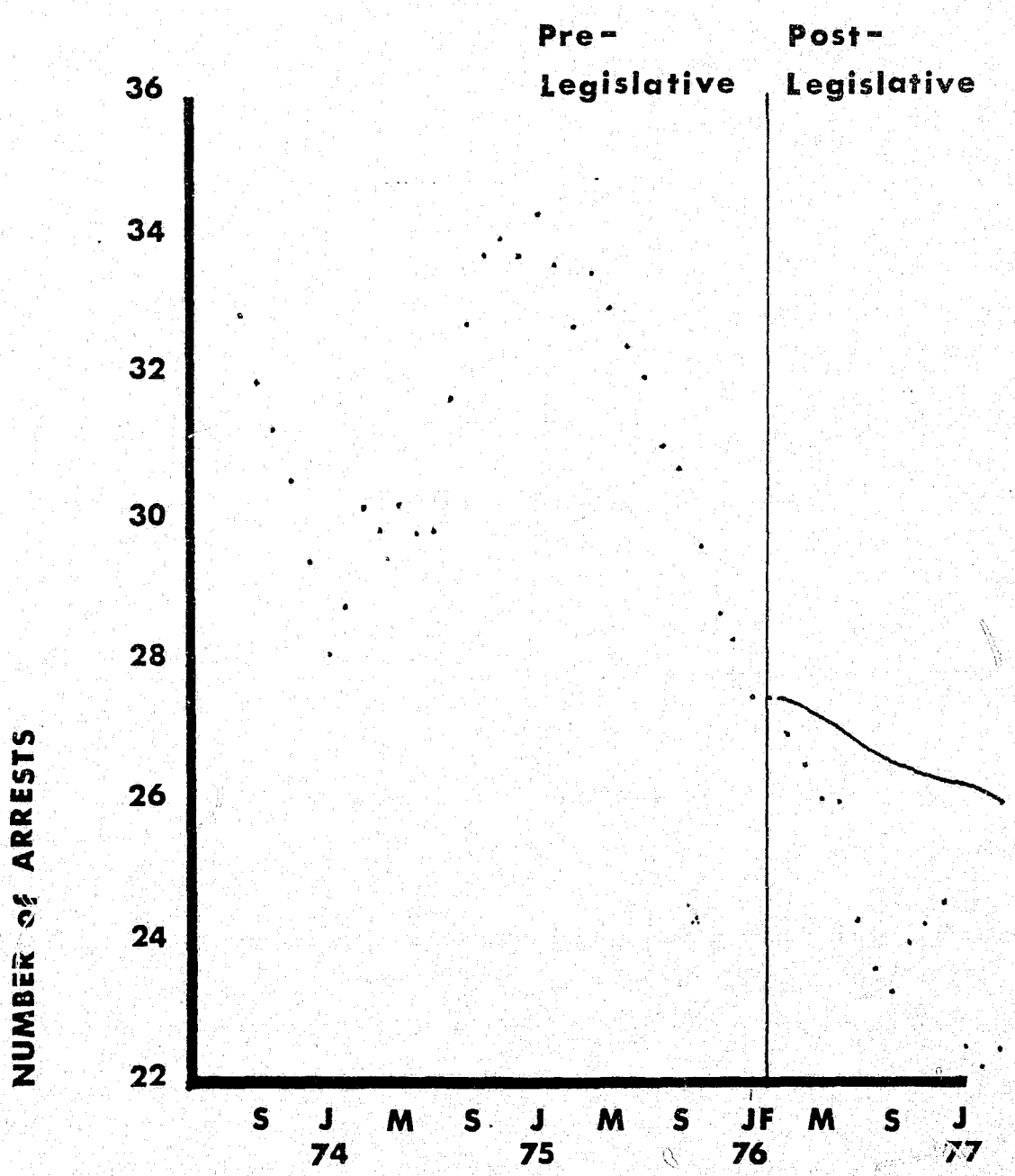

YEARLY AVERAGE,
DISORDERLY CONDUCT
50
49
48
47
46
45
44
43
NUMBER of ARRESTS / MONTH [in TENS]
73
74
75
76
YEAR

APPENDIX II

CENTERED AVERAGES OF ARREST RATES AND PROJECTIONS, 1973-1977

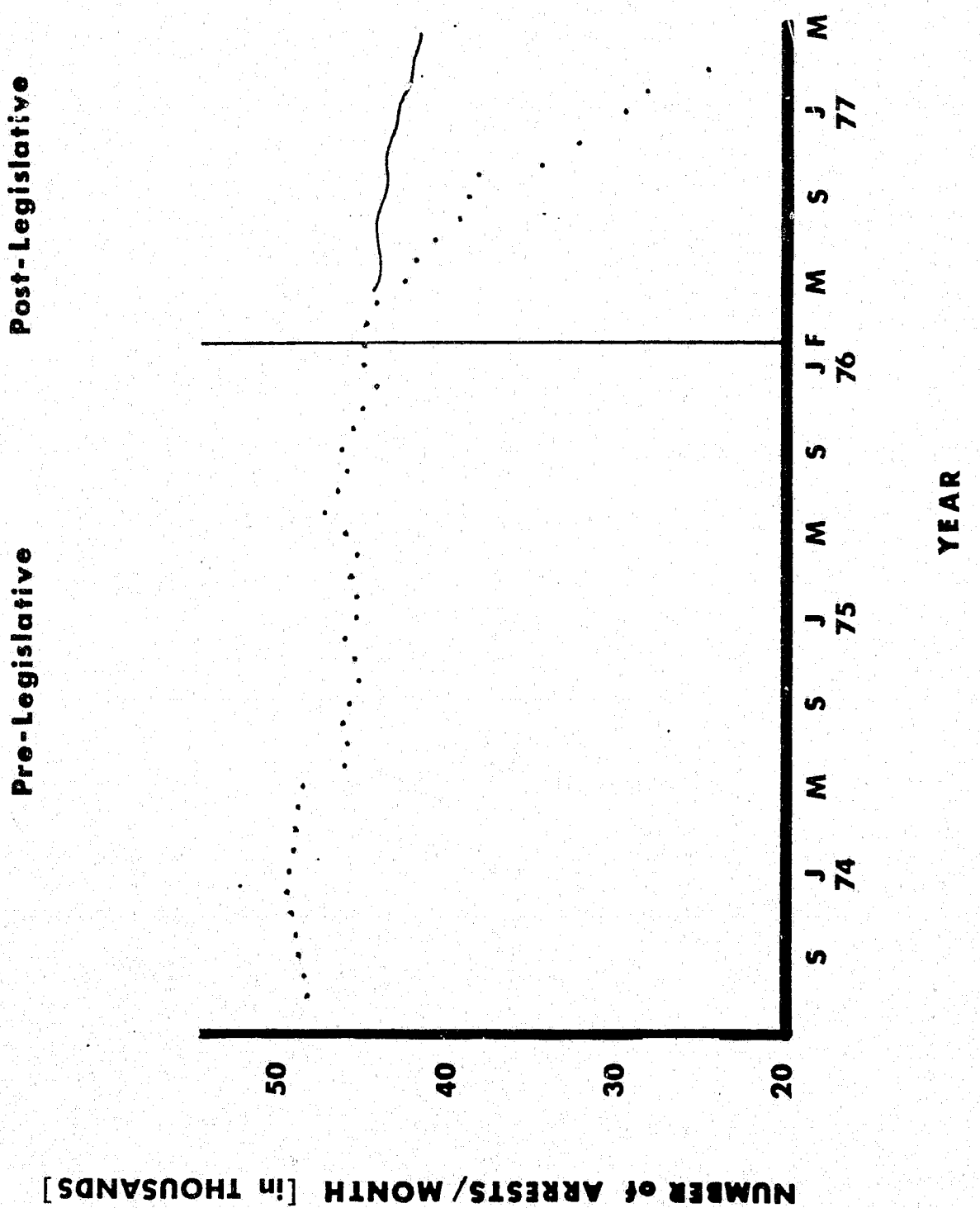
CENTERED AVERAGE & PROJECTION
RESISTING ARREST

actual data ≡·
projected data ≡—



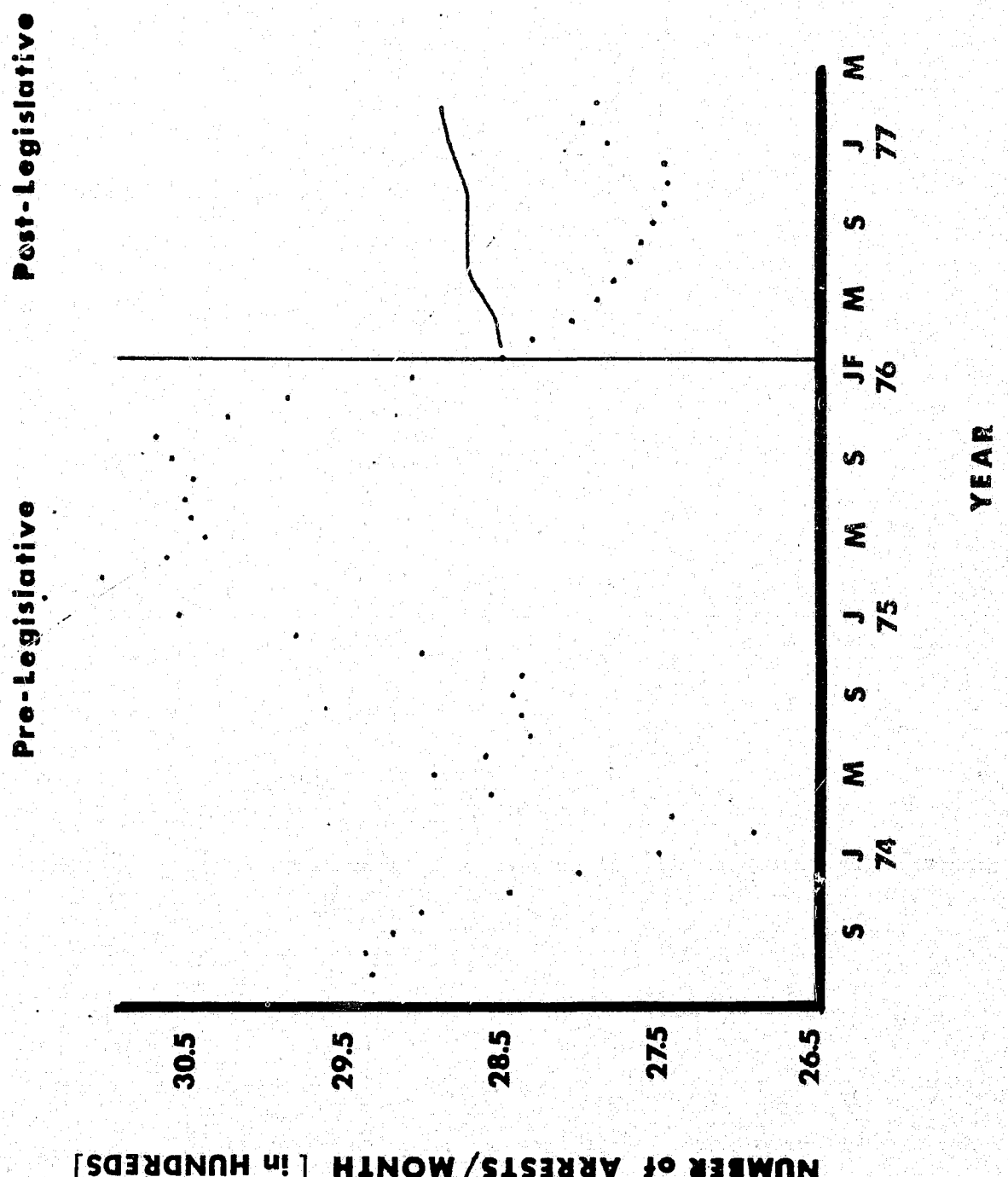
CENTERED AVERAGE & PROJECTION, MINOR DISTURBANCE, OUTSIDE

actual data = •
projected data = —



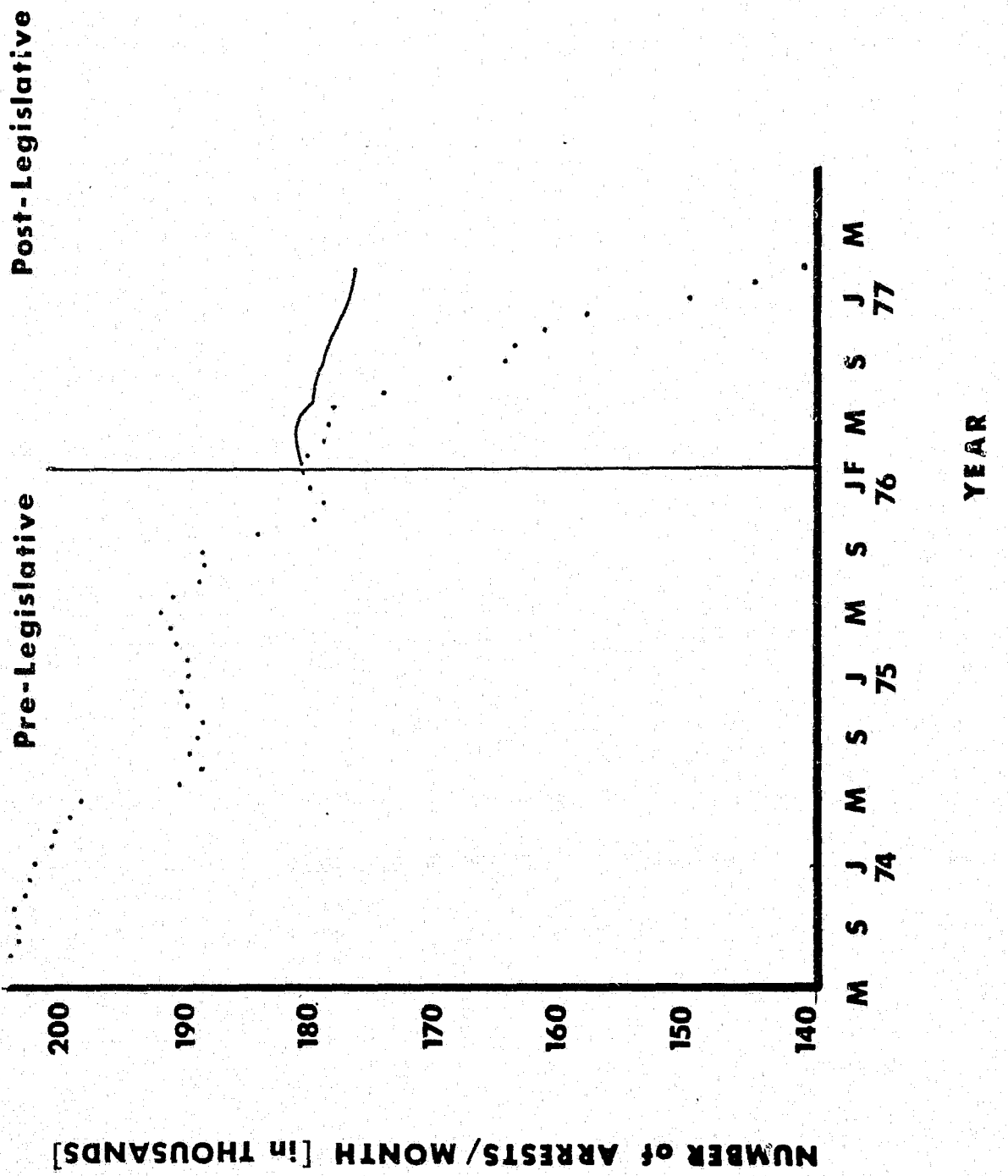
CENTERED AVERAGE & PROJECTION, PUBLIC DRUNKENESS

actual data = .
projected data = –



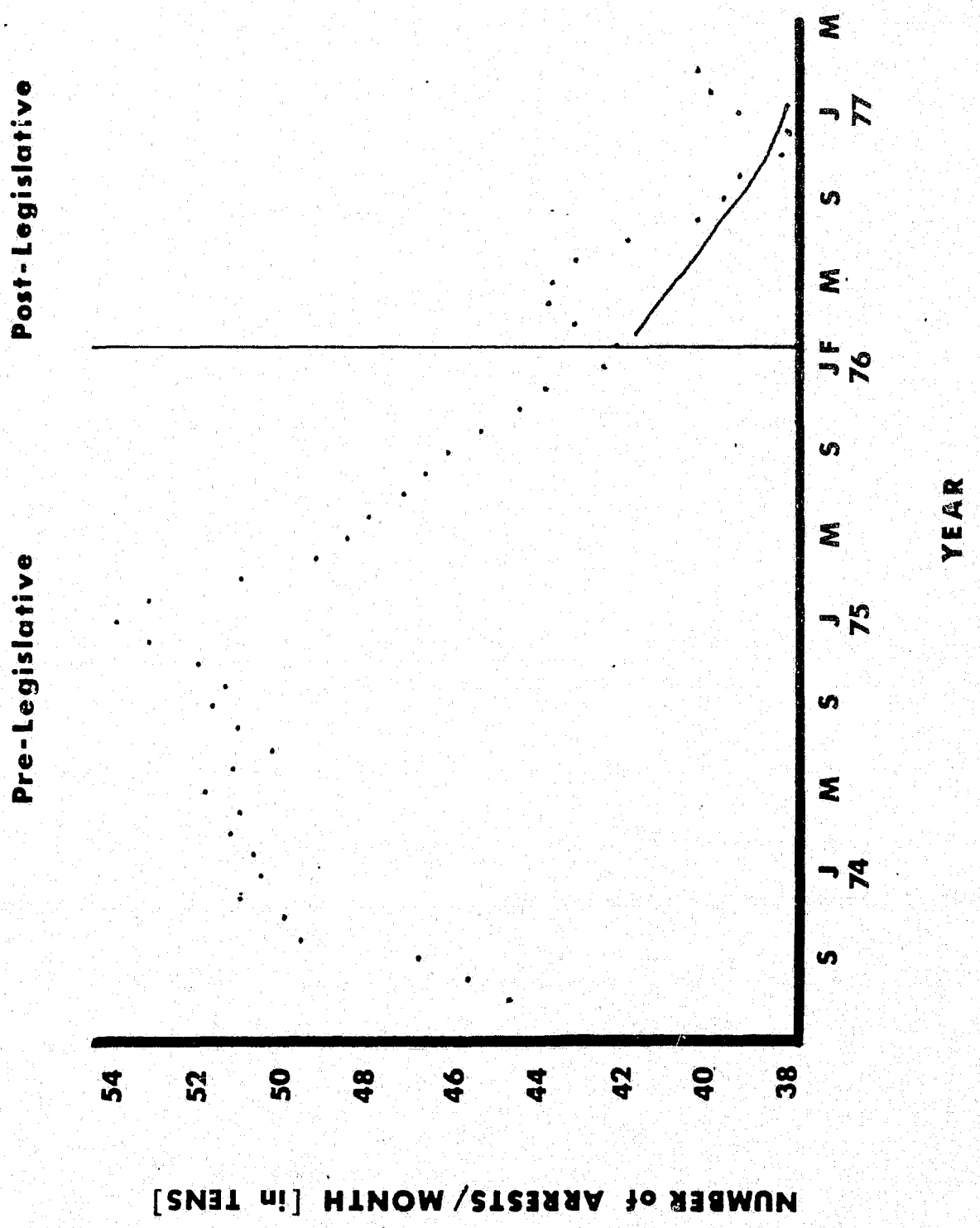
CENTERED AVERAGE & PROJECTION, MINOR DISTURBANCE, INSIDE

actual data = .
projected data = —



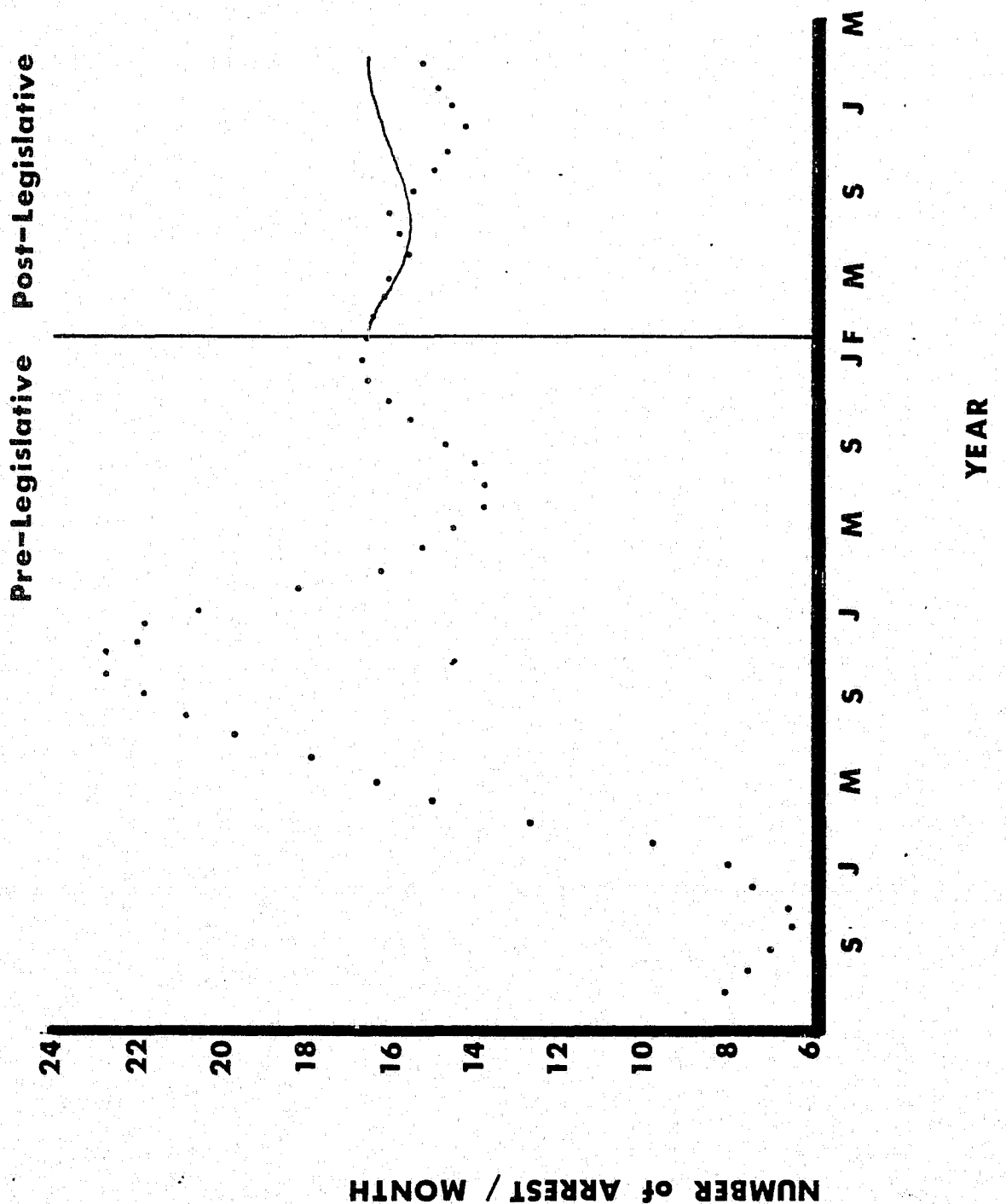
CENTERED AVERAGE & PROJECTION, DISORDERLY CONDUCT

actual data = •
projected data = —



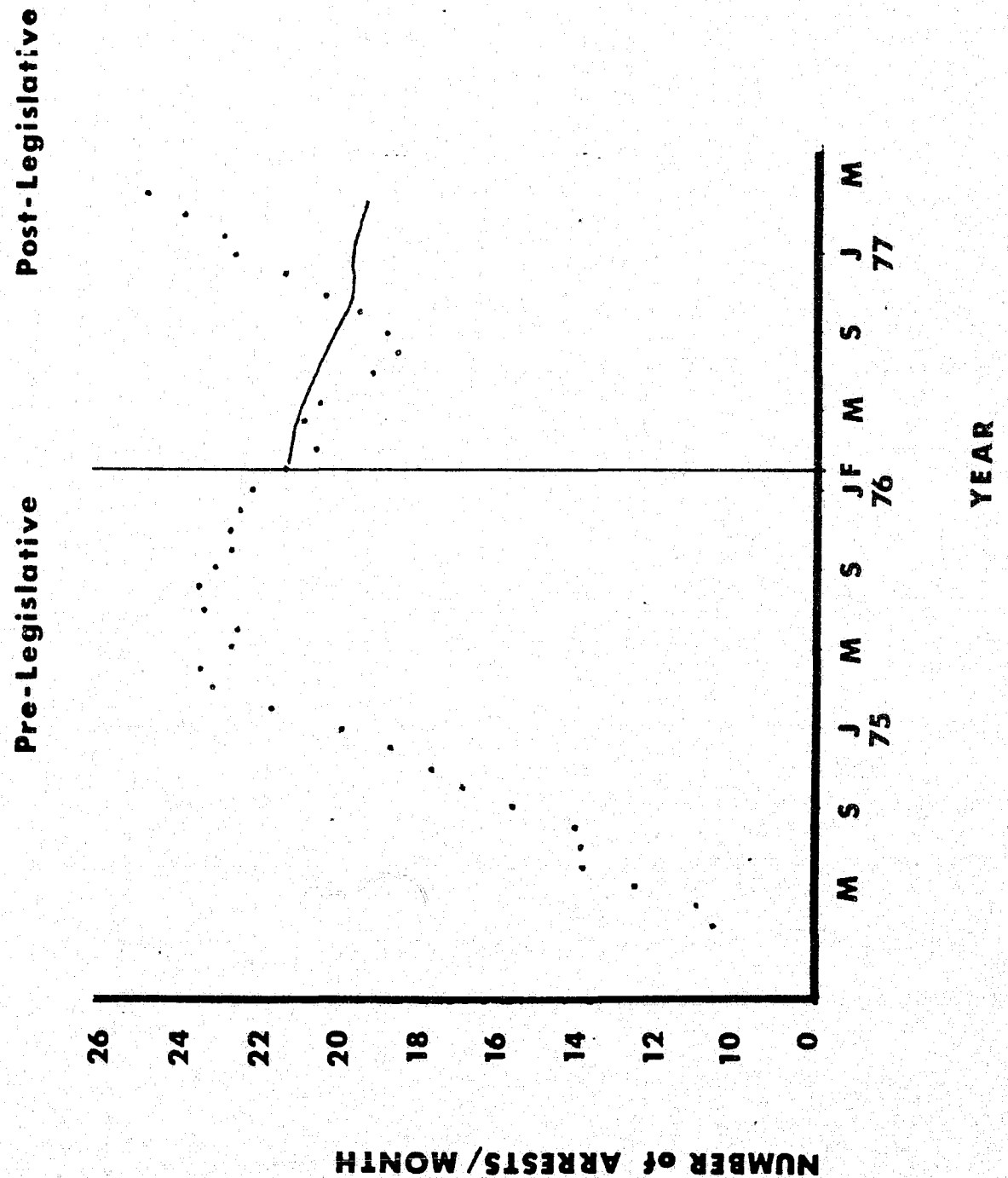
CENTERED AVERAGE & PROJECTIONS, FAILURE TO PAY TRANSIT FARE

actual data =·
projected data =—



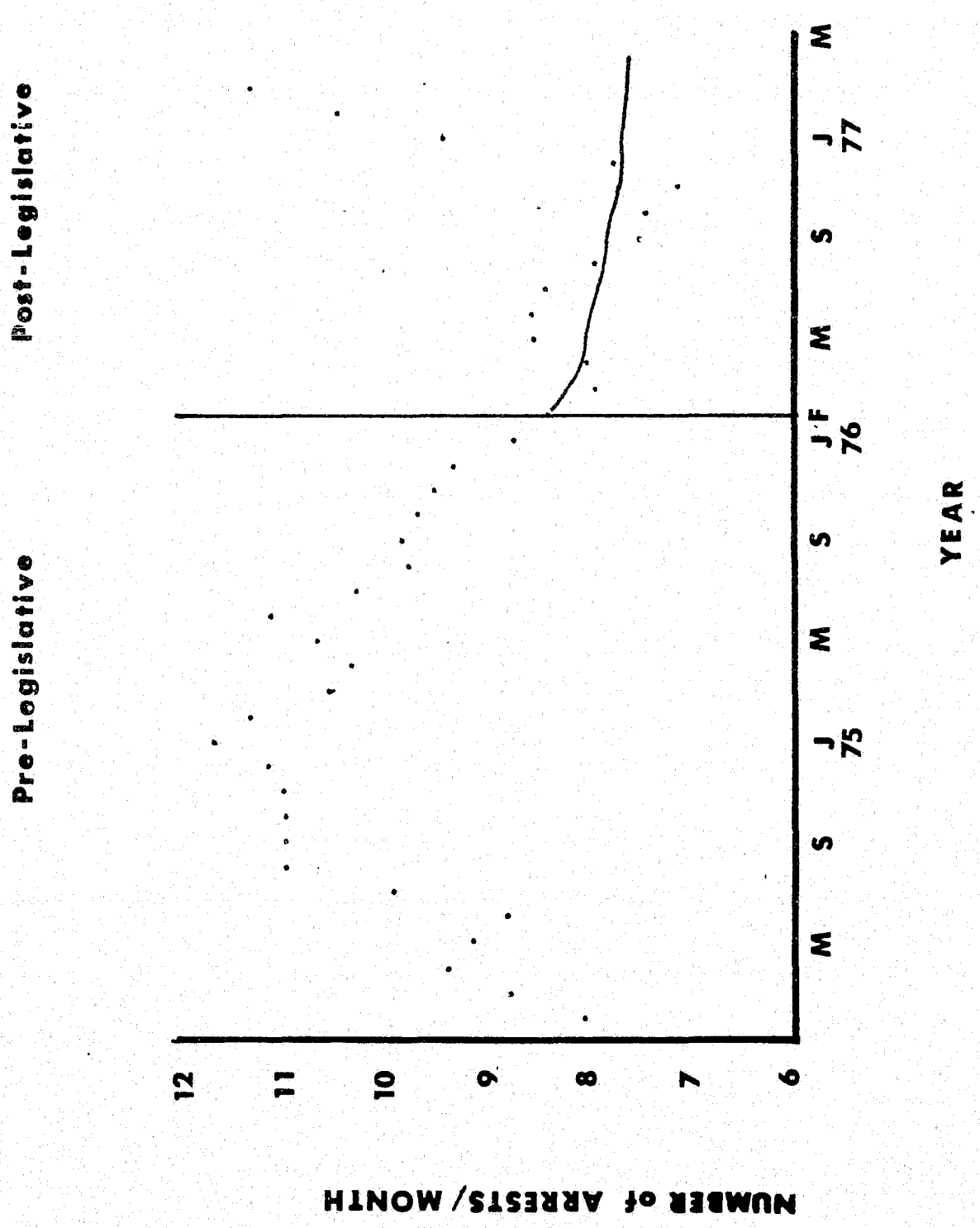
CENTERED AVERAGE & PROJECTION, TERRORISTIC THREATS

actual data = .
projected data = —



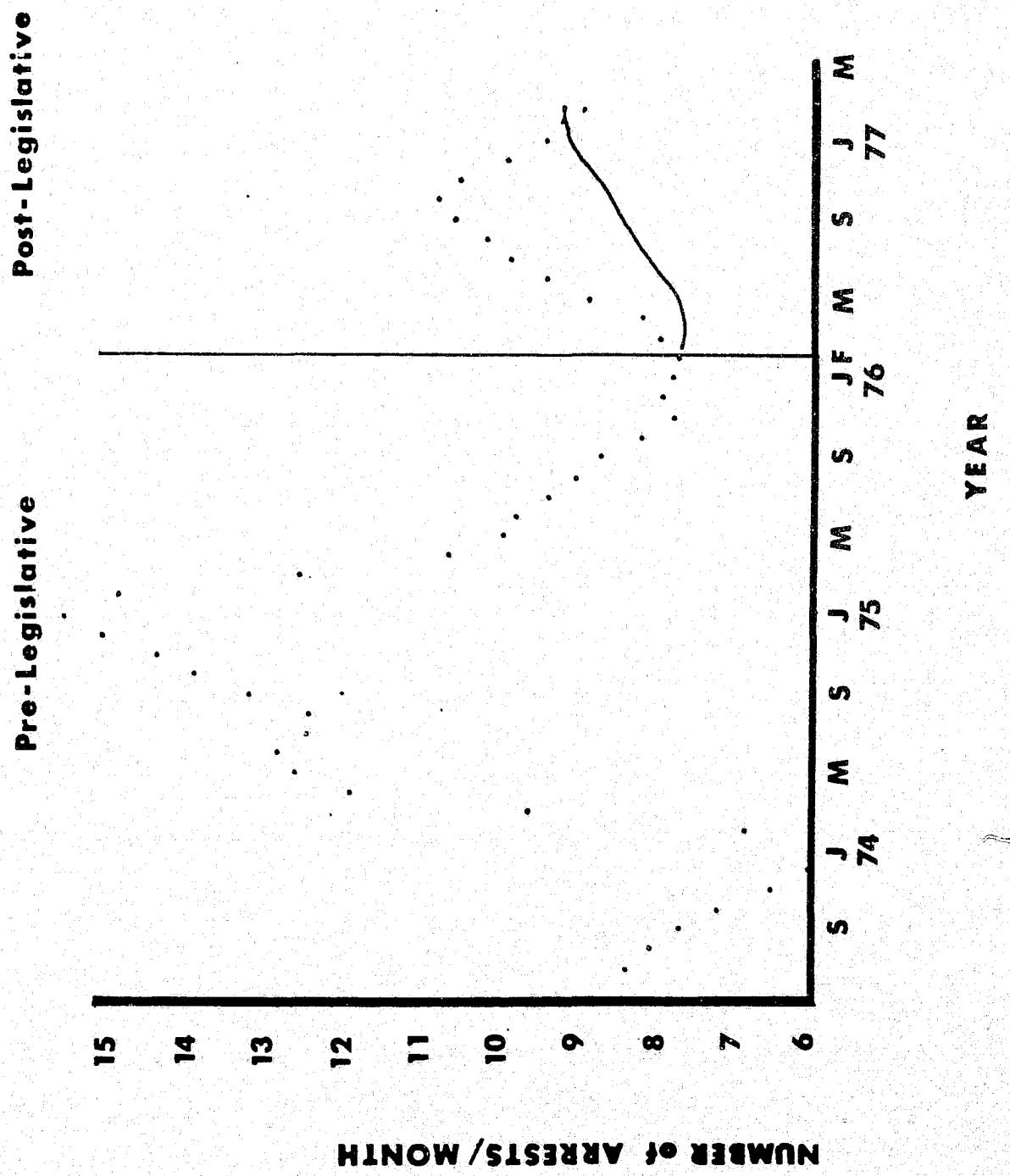
CENTERED AVERAGE & PROJECTION, HARASSMENT

actual data = •
projected data = —



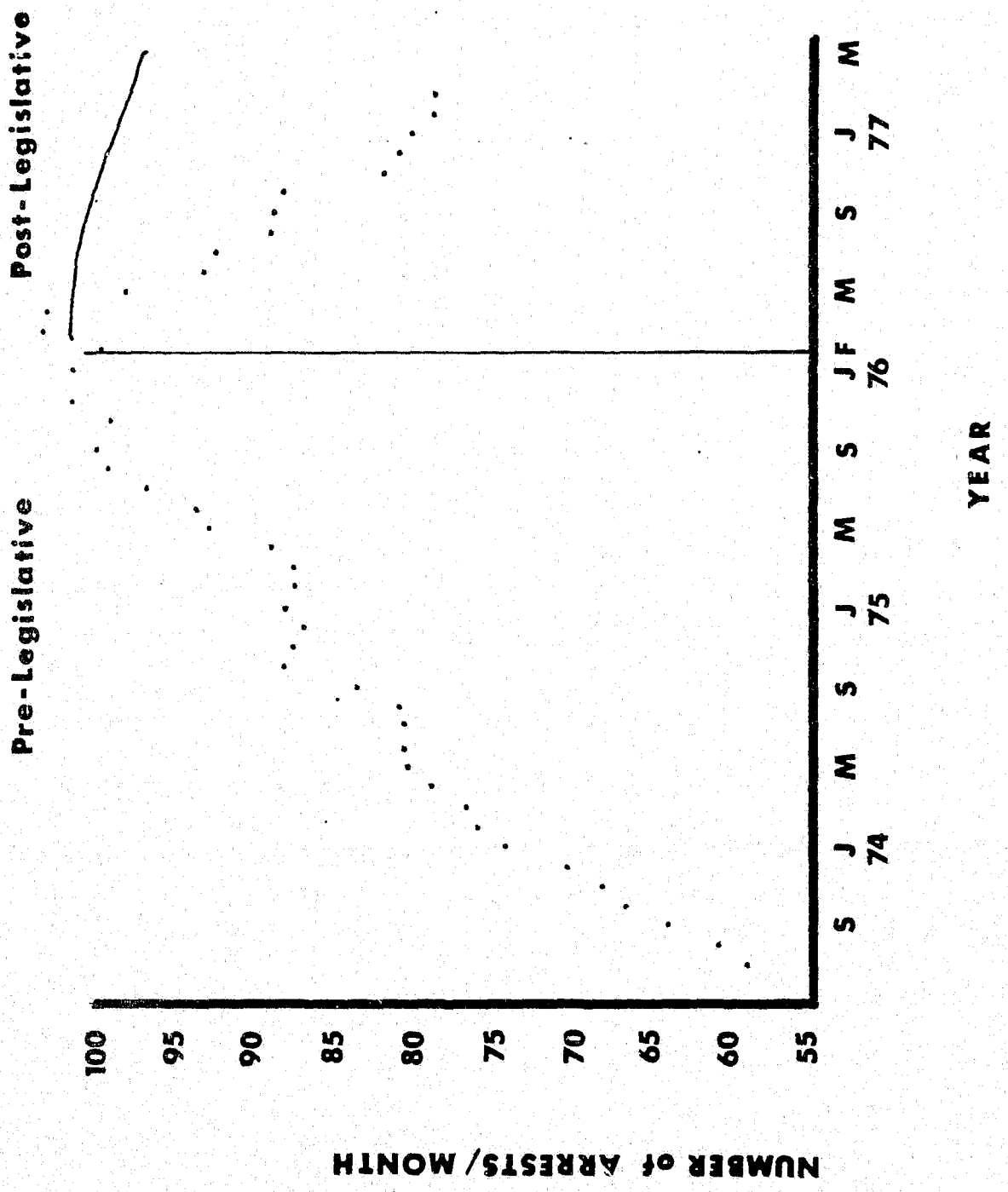
CENTERED AVERAGE & PROJECTION, LOITERING & PROWLING

actual data =·
projected data =—



CENTERED AVERAGE & PROJECTION, TRESPASS

actual data = •
projected data = —



CENTERED AVERAGE & PROJECTION, SIMPLE ASSAULT

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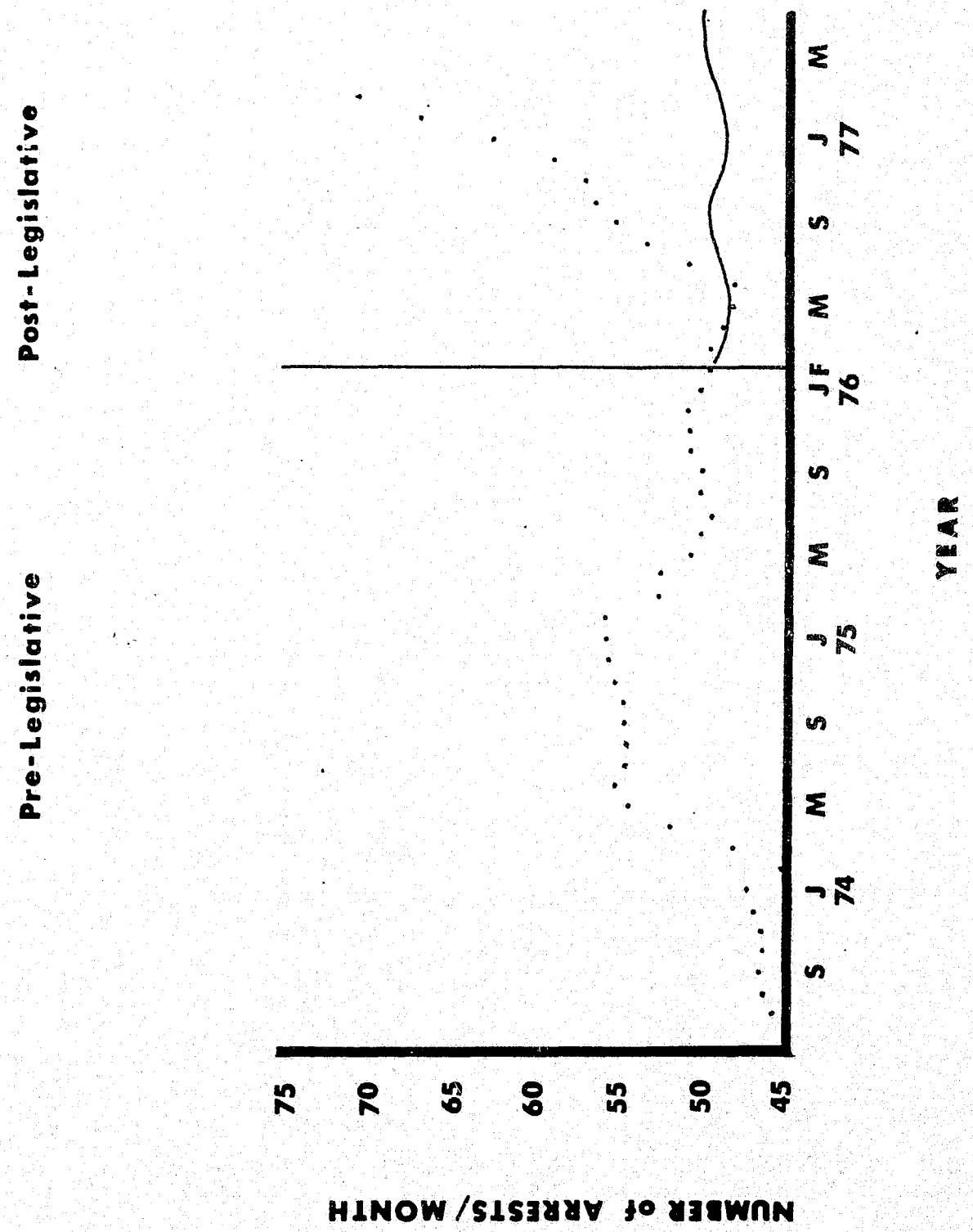
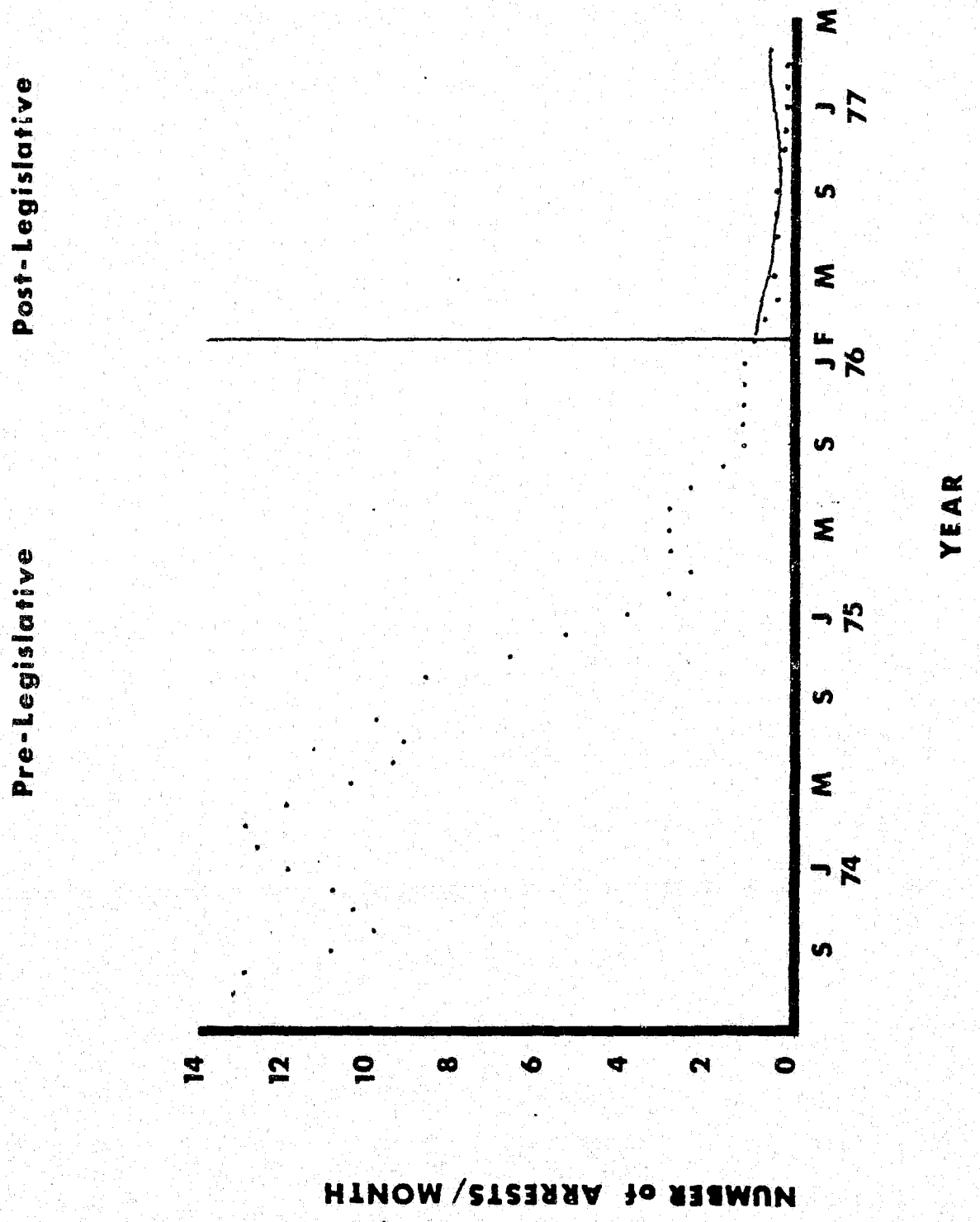
projected data = —



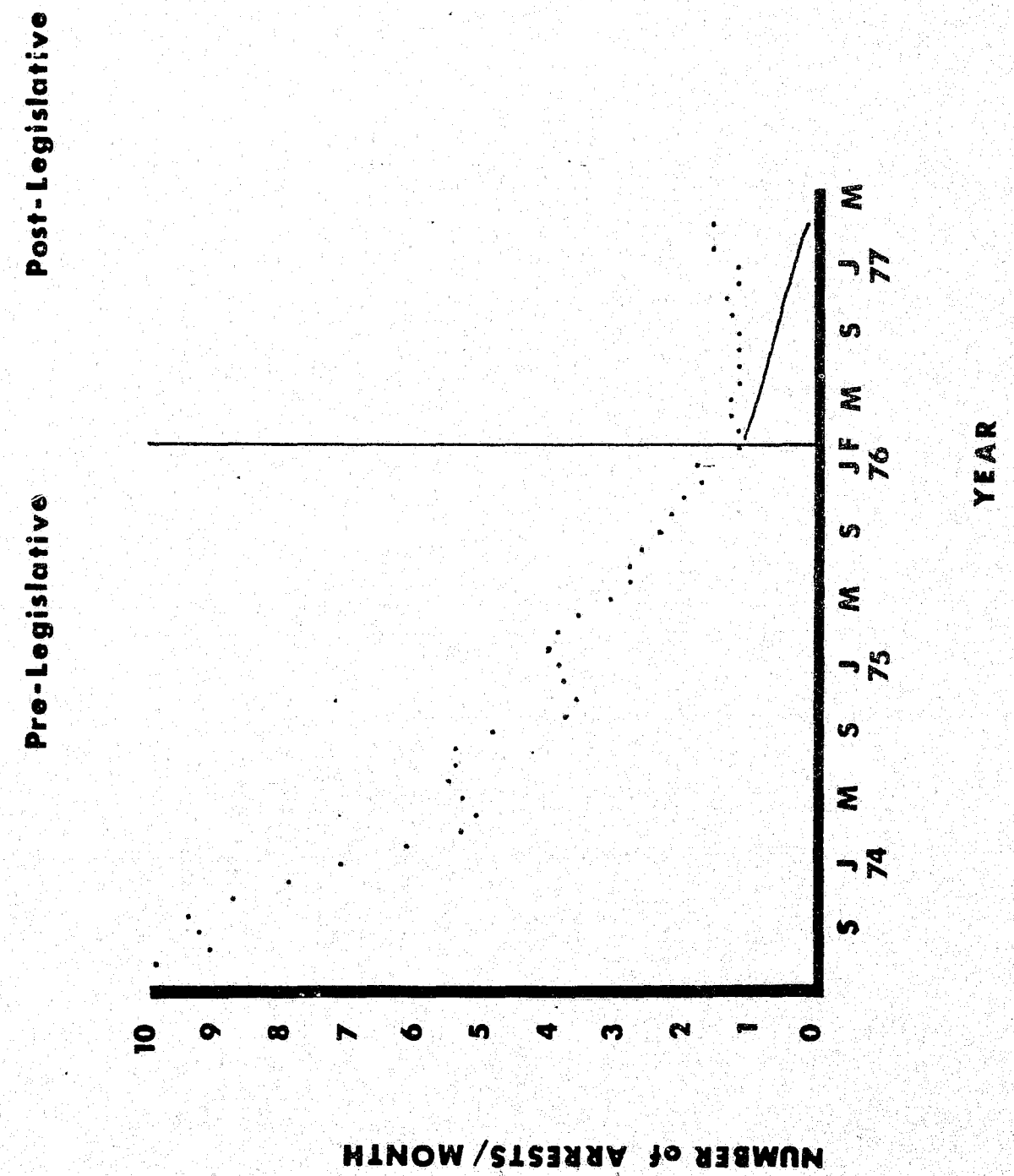
CENTERED AVERAGE & PROJECTION, PANHANDLING

actual data = •
projected data = —



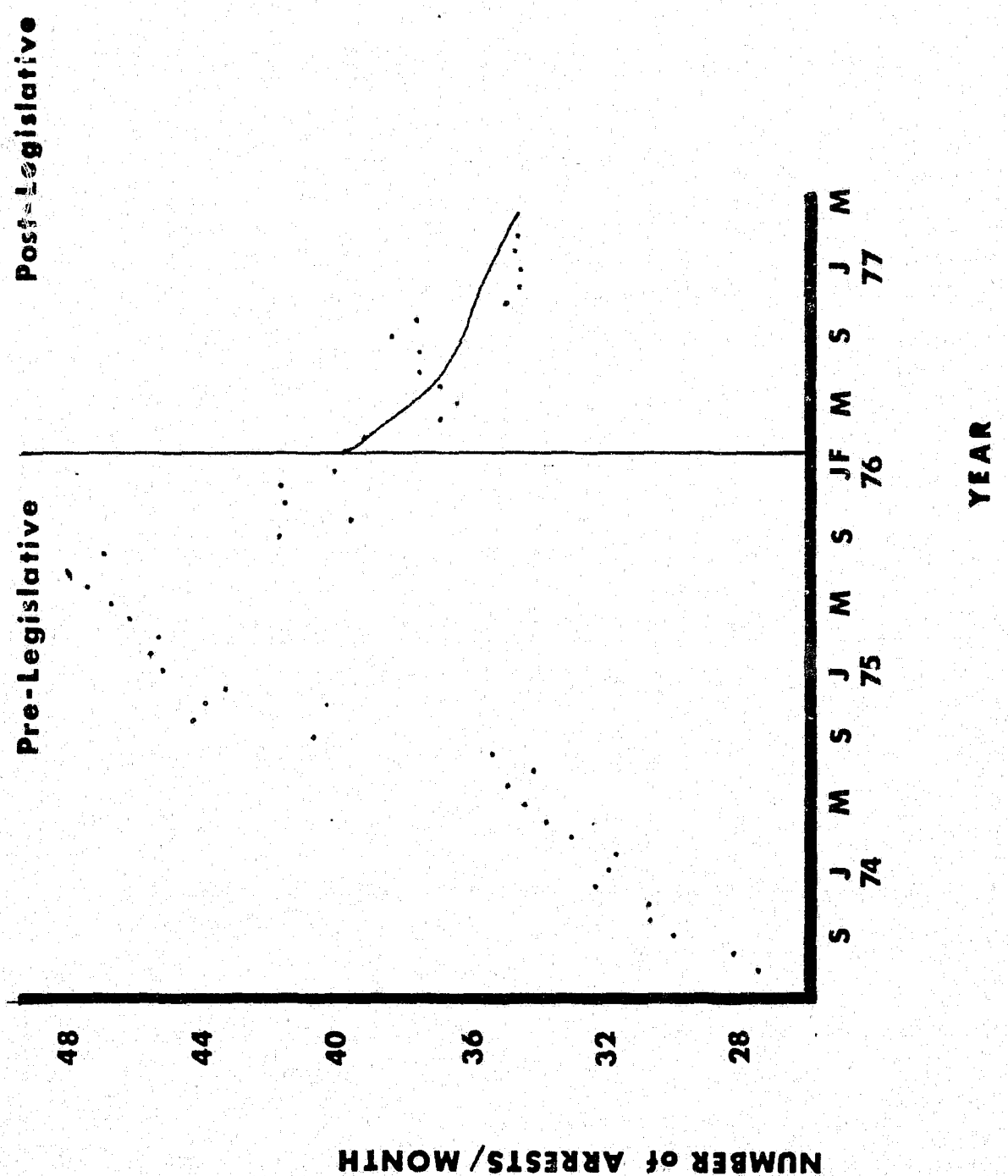
CENTERED AVERAGE & PROJECTION, CORNER LOUNGING

actual data = .
projected data = —



CENTERED AVERAGE & PROJECTION, INDECENT ASSAULT

actual data = •
projected data = —



CENTERED AVERAGE & PROJECTION, PUBLIC INDECENCY

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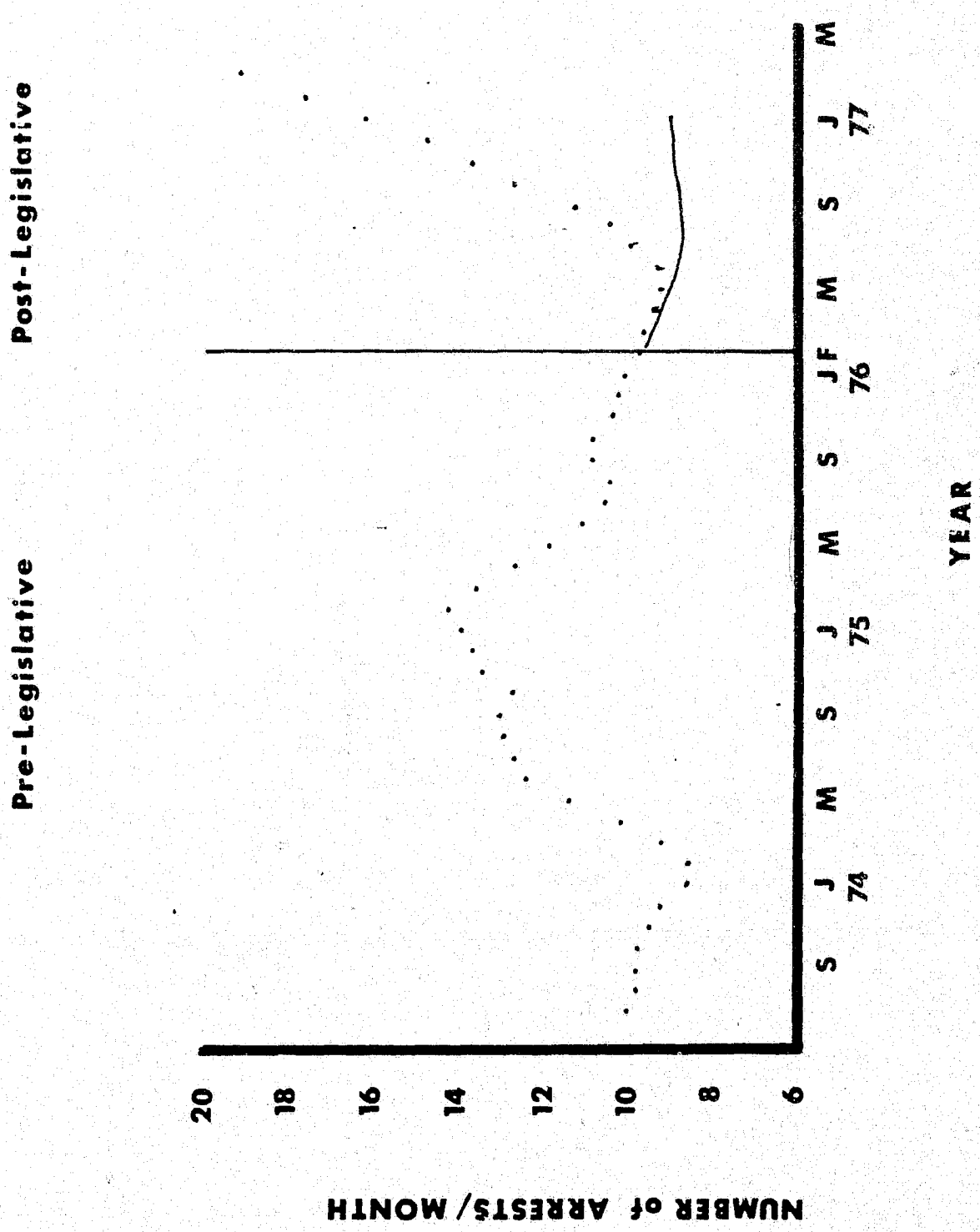
projected data = —



APPENDIX III

Frequencies of Offenses Committed Pre- and Post-Legislation

Offense Category	Pre-Legislation Total	Pre-Legislation Per Cent	Post-Legislation Total	Post-Legislation Per Cent
Part I, Index, Person				
Homicide	3		2	
Aggravated assault	18		4	
Robbery	10		2	
Rape	4		1	
	35	13.26	9	26.47
Part I, Index, Property (excluding auto theft)				
Burglary	18		3	
Grand larceny	1		0	
	19	7.14	3	8.8
Non-Index, Person				
Simple assault	10		2	
Other sexual	4		0	
	14	5.26	2	5.88
Non-Index, Property				
Larceny/theft	24		5	
Receiving stolen goods	44		1	
Possession tools of burglary	1		0	
Arson	3		1	
Breaking and entering	2		0	
Forgery	2		0	
	36	13.53	7	20.58
Auto Theft	15	5.63	1	2.94
Morals				
Contributing to delinquency of minor	2		0	
Indecent exposure	3		1	
Obscene letter	1		0	
Public indecency	1		0	
Prostitution	10		1	
	17	6.39	2	5.88

Offense Category	Pre-Legislation Total	Pre-Legislation Per Cent	Post-Legislation Total	Post-Legislation Per Cent
Offenses against the Public Order				
Frequenting disorderly house	4		0	
Disorderly conduct	16		0	
Inciting riot	1		0	
Terroristic threats	2		0	
Harrassment	0		1	
Suspicious person	7		0	
Trespass	12		0	
Vagrancy	4		0	
Loitering	2		0	
Theft of services	1		1	
Breach of peace	3		0	
False fire alarm	2		0	
Criminal mischief	1		0	
	55	20.67	2	5.88
Traffic (includes drunken driving)	12	4.51	0	0.00
Substance Abuse				
Alcohol	11		0	
Drugs	16		3	
	27	10.15	3	8.82
Law Enforcement Related				
Contempt of court	8		4	
Weapons Offense	9		1	
Non-compliance	2		0	
Parole violation	2		0	
	27	7.89	5	14.71
Miscellaneous				
Military	3		0	
Violation unemployment laws	1		0	
Conspiracy	2		0	
	6	3.38	0	0.00
Gambling	9	3.38	1	2.94
TOTAL	266	100.00	34	100.00

INDEX

BIBLIOGRAPHY

Abramson, Marc F. "The Criminalization of Mentally Disordered Behavior." Hospital and Community Psychiatry 23 (1972):101-105.

Ahmed, Paul and Plog, Stanley, eds. State Mental Hospitals. New York: Plenum, 1976.

American Bar Association, Mental Health and Retardation Services Project. Handbook: Legal Principles for Representing the Mentally Different" (mimeo). Seattle, Washington, 1975.

Ashley, Maurice C. "Outcome of 1,000 Cases Paroled from Middletown State Homeopathic Hospital." State Hospital Quarterly 8 (Nov., 1922):64.

Aubert, Vilhelm. Sociology of Law. Harmondsworth, England: Penguin, 1969.

Aviram, Uri and Segal, Steven. "Exclusion of the Mentally Ill." Archives of General Psychiatry 29 (July, 1973):126-131.

_____. "Community-Based Sheltered Care." In P. Ahmed and S. Plog, eds., State Mental Hospitals. New York: Plenum, 1976.

Aviram, Uri; Syme, S. Leonard; and Cohen, Judith B. "The Effects of Policies and Programs on Reduction of Mental Hospitalization." Social Science and Medicine 10 (1976):571-577.

Bardach, Eugene. The Skill Factor in Politics: Repealing the Mental Commitment Laws in California. Berkeley: University of California Press, 1972.

_____. The Implementation Game: What Happens after a Bill Becomes a Law. Cambridge, Mass.: MIT Press, 1977.

Beigel, Allan. "Law Enforcement, the Judiciary, and Mental Health: a Growing Partnership." Hospital and Community Psychiatry 24 (1973):605-609.

Bernstein, Charles M. "Client Flow in the County Mental Health System under Act 143," Paper presented at the 3rd annual conference of the Mental Health Evaluation, Philadelphia, May 20, 1977.

Biles, David and Mulligan, Glen. "Mad or Bad? The Enduring Dilemma." British Journal of Criminology 13 (1973):275-279.

Bittner, Egon. "Police Discretion in the Apprehension of Mentally Ill Persons." Social Problems 14 (1966-67):278.

Blalock, Hubert M. L. Social Statistics. 2d ed. New York: McGraw-Hill, 1972.

Blomberg, Thomas. "Diversion and Accelerated Social Control." Journal of Criminal Law and Criminology 68 (1977):274-282.

Bloom, Bernard L. Changing Patterns of Psychiatric Care. New York: Human Sciences Press, 1975.

Blumberg, Abraham S. "The Practice of Law and Confidence Game: Organizational Cooptation of a Profession." Law and Society Review 1 (1967):15-39.

Brenner, Harvey M. Mental Illness and the Economy. Cambridge: Harvard University Press, 1973.

_____. "Estimating the Social Costs of National Economic Policy: Implications for Mental and Physical Health and Criminal Aggression." Joint Economic Committee, U.S. Congress, Washington, D.C., 1976.

Brill, H. and Malzberg, B. "Criminal Acts of Ex-Mental Patients." American Psychiatric Association, Mental Hospital Service, Supplemental Mailing #153, August, 1962.

Britton, Karl. John Stuart Mill. London: Penguin, 1953.

Brown, G. Schizophrenia and Social Care. London: Oxford University Press, 1966.

California Conference of Local Mental Health Directors, Santa Barbara, California, June 15-16, 1972 (mimeo).

California Department of Mental Hygiene. "The Impact of the L-P-S Act on the Number of Admissions by Penal Code Commitment to State Hospitals for the Mentally Ill." Bureau of Biostatistics, Sacramento, Calif., vol. 13, no. 12, June, 1970.

California Legislative Assembly. "The Dilemma of Mental Commitments in California." Sacramento, Calif, 1966 (mimeo).

California Legislation. "Final Report: Senate Select Committee on Proposed Phaseout of State Hospital Services." Sacramento, Calif., March 14, 1974.

California State Employees Association (CSEA). "Where Have All the Patients Gone: a CSEA Report on the Crisis of Mental Health Care in California." Sacramento, Calif., January, 1972.

Chatfield, Christopher. The Analysis of Time Series: Theory and Practice. London: Chapman and Hall, 1975.

Cohen, Louis H. and Freeman, Harry. "How Dangerous to the Community are State Hospital Patients?" Connecticut State Medical Journal 9 (1945):697.

Cooke, Gerald; Johnston, Norman; and Pogany, Erve. "Factors Affecting Referral to Determine Competency to Stand Trial." American Journal of Psychiatry 130 (19):870-875.

Dinitz, Simon. "Policy Implications of an Experimental Study in the Home Care of Schizophrenics." Sociological Forces 1 (Winter, 1967):1-19.

_____ and Beran, Nancy. "Community Mental Health as a Boundaryless and Boundary Busting System." Journal of Health and Social Behavior 12 (June, 1971):99-108.

Durkheim, Emile. Sucide: a Study in Sociology (1897). Trans. by John A. Spaulding and G. Simpson. New York: Free Press, 1951.

_____. The Division of Labor in Society. New York: Macmillan, 1933.

Eizenstat, S. "Mental Competency to Stand Trial." Harvard Civil Rights-Civil Liberties Law Review 4 (1968):379-413.

ENKI. "A Study of California's New Mental Health Law, 1969-71. Chatworth, Calif.: ENKI Corp., 1972.

Eyton, J. Ronald and Roseman, Curtis C. "An Introduction to Multivariate Analysis with Applications to Spatial Problems." Urbana, Ill., 1971.

Ennis, Bruce. Prisoners of Psychiatry. New York: Harcourt, Brace, 1972.

Fingarette, Herbert. The Meaning of Criminal Insanity. Berkeley: University of California Press, 1972.

Foley, H. Community Mental Health Legislation: the Formative Process. Lexington, Mass.: Lexington Books, 1975.

Fox, Richard G. and Erikson, Patricia G. "Research Report: Apparently Suffering from Mental Disorders: an Examination of the Exercise of Police Power under S10 of the Mental Health Act of Ontario." Centre of Criminology, University of Toronto, 1972 (mimeo).

Frederick, Virginia; Coltrane, Frances; and Griffin, Lewis. "Developing a Partnership between a Court and Community Agencies to Reduce Involuntary Commitments." Hospital and Community Psychiatry 24 (1976):689.

Friedman, Julian and Daly, Robert W. "Civil Commitment and the Doctrine of Balance: a Critical Analysis." Santa Clara Lawyer 13 (1973):503-536.

Friedrich, Otto. Going Crazy: an Inquiry into Madness in Our Time. New York: Simon and Schuster, 1976.

Giovannoni, Jeanne M. and Gurel, Lee. "Socially Disruptive Behavior of Ex-Mental Patients." Archives of General Psychiatry 17 (1967):146.

Goffman, Erving. Asylums: Essays on the Social Situation of Mental Patients and Other Inmates. Garden City: Anchor Books, 1961.

Goldstein, Herman. "Police Discretion: the Ideal vs. the Real." Public Administration Review 23 (Sept., 1963):40.

Gove, Walter R. and Howell, Patricia. "Individual Resources and Mental Hospitalization." American Sociological Review 39 (1974): 86-107.

Greenley, James R. "The Psychiatric Patient's Family and Length of Hospitalization." Journal of Health and Social Behavior 13 (March, 1972):25-37.

Greer, Germaine. The Female Eunuch. New York: McGraw-Hill, 1971.

Guy, Edward B. "The Impact of New Legislation on Mentally Ill Offenders Entering the Philadelphia Prison System." Paper presented at the 3rd annual conference, Mental Health Evaluation, Philadelphia, May 20, 1977.

Grad, J. "A Two-Year Follow-Up." In R. H. Williams and L. D. Ozarin, eds., Community Mental Health: an International Perspective. San Francisco: Jossey-Bass, 1970.

Harrington, Michael. The Other America. Baltimore: Penguin, 1963.

Hollingshead, August B. and Redlich, Frederick C. Social Class and Mental Illness. New York: Wiley, 1958.

Jacoby, Joseph. "The Dangerousness of the Criminally Insane." Ph.D. dissertation, Department of Sociology, University of Pennsylvania, 1976.

Kittrie, Nicholas. The Right to be Different: Deviance and Enforced Therapy. Baltimore: Penguin, 1971.

Langsley, D. and Barter, J. "Treatment in the Community or State Hospital: an Evaluation." Psychiatric Annals 5 (May, 1975): 163-170.

Leifer, Ronald. In the Name of Mental Health: the Social Functions of Psychiatry. New York: Science House, 1969.

Lemert, Edwin. Human Deviance, Social Problems, and Social Control. Englewood Cliffs: Prentice-Hall, 1967.

_____. "Legal Commitment and Social Control." Sociology and Social Research 30 (1946):370-378.

Levine, David. "Criminal Behavior and Mental Institutionalization." Journal of Clincal Psychology 26 (1970):279-284.

Martinson, Robert; Palmer, Ted; and Adams, Stuart. "Rehabilitation, Recidivism, and Research." National Council on Crime and Delinquency, 1976.

Mechanic, David. Mental Health and Social Policy. Englewood Cliffs: Prentice-Hall, 1969.

Meisel, Alan. "The Rights of the Mentally Ill: the Gulf between Theory and Reality." Hospital and Community Psychiatry 26 (1965):429-453.

Modlin, Herbert C.; Porter, J.; and Benson, Richard E. "Mental Health Centers and the Criminal Justice System." Hospital and Community Psychiatry 27 (1976):716-719.

Monahan, John, ed. Community Mental Health and the Criminal Justice System. New York: Pergamon, 1976.

Morgan, David. "Explaining Mental Illness." European Journal of Sociology 16 (1975):262-280.

Morris, Grant H. and Luby, Elliot D. "Civil Commitment in a Suburban County: an Investigation by Law Students." Santa Clara Lawyer 13 (1973):518-536.

Morrow, William R. and Peterson, Donald B. "Follow-up of Discharged Psychiatric Offenders--'Not Guilty by Reason of Insanity' and 'Criminal Sexual Psychopaths'." Journal of Criminology, Criminal Law and Police Science 57 (1966):31-34.

McCord, Joan. "Patterns of Deviance." Paper presented at the 1976 annual meeting of the Society for Life History Research in Psychopathology, Fort Worth, Texas, October 6-8, 1976 (to be published in S. B. Sells, ed., Life History Research in Psychopathology. Minneapolis: University of Minnesota Press).

McGarry, A. Louis and Bendt, Richard. "Criminal vs. Civil Commitment of Psychotic Offenders: a 7-year Follow-up." American Journal of Psychiatry 125 (1969):93-100.

_____ and Parker, Laurence. "Massachusetts' Operation Baxtrom: a Follow-up." Massachusetts Journal of Mental Health 4 (1974):27-41.

_____. "The Fate of Psychotic Offenders Returned for Trial." American Journal of Psychiatry 127 (1971):9.

McHugh, Peter. "A Common-Sense Perception of Deviance." In Hans Peter Dreitzel, ed., Recent Sociology #2: Patterns of Communicative Behavior. New York: Macmillan, 1970.

New York Times. "Former Mental Patients a Source of Pity and Anger on Long Island." January 8, 1978.

National Institute of Mental Health. "Changes in the Age, Sex, and Diagnostic Composition of First Admissions to State and County Hospitals, United States, 1962-1972." Statistical Note #97. Washington, D.C., September, 1973.

Niedermayer, Gretchen. "Boarding Homes are Seen as Warehouses of the Helpless." Region, October, 1976, pp. 12-15.

Ohlbaum, Edward D. "The Gates of Cerberus: Involuntary Civil Commitment in Philadelphia." Temple Law Quarterly 49 (1976):323-384.

Packer, Herbert. "Two Models of the Criminal Process." University of Pennsylvania Law Review 113 (1964):1-68.

Parsons, Talcott and Shils, Edward, ed. Toward a General Theory of Action: Theoretical Foundations for the Social Sciences. New York: Harper and Row, 1962.

Pasamanick, Benjamin; Scarpitti, Frank R.; and Dinitz, Simon. Schizophrenics in the Community: an Experimental Study in the Prevention of Hospitalization. New York: Appleton-Century-Crofts, 1967.

Pennsylvania Senate. "Mental Health Procedures Act #143 of 1976."

Penrose, L. S. "Mental Disease and Crime: Outline of a Comparative Study of European Statistics." British Journal of Medical Psychology 28 (1939).

Peszke, Michael and Wintrob, Ronald M. "Emergency Commitments: a Transcultural Study." American Journal of Psychiatry 131 (1974): 36-40.

Petris, Nicholas C. "The Impact of L-P-S on the Patient." Paper prepared for the National Institute of Mental Health, n.d. (mimeo).

Philadelphia Bulletin, September 26, 1976; January 2, 1977.

Philadelphia Inquirer, March 5, 1958; October 10, 1976; June 26, 1977.

Philadelphia Police Department. Directive #136, 1971 and 1977 (mimeo).

Pittenger, Donald B. Projecting State and Local Populations. Cambridge, Mass.: Ballinger, 1976.

Piven, Frances Fox and Cloward, Richard A. Regulating the Poor: the Functions of Public Welfare. New York: Vintage Books, 1971.

Platt, Anthony M. The Child Savers: the Invention of Delinquency. Chicago: University of Chicago Press, 1969.

Platt, Jerome J. "Staff Perceptions of the Impact of Act 143 upon Clinical Service Delivery in a Community Mental Health Center." Paper presented at the 3rd annual conference, Mental Health Evaluation, Philadelphia, May 20, 1977.

Pollock, Horatio M. "Is the Parole Patient a Menace to the Community?" Psychiatric Quarterly 12 (1938):236.

Price, Richard H. and Denner, Bruce, eds. The Making of a Mental Patient. New York: Holt, Rinehart & Winston, 1973.

Public hearings on Act 143, Pennsylvania Senate, Harrisburg, March 25, 1977.

Reich, Robert and Segal, Lloyd. "Psychiatry under Siege: the Chronically Mentally Ill Shuffle to Oblivion." Psychiatric Annals 3 (1973):35.

Rappeport, Jonas M. and Lassen, George. "Dangerousness: Arrest Rate Comparisons of Discharged Patients and the General Population." American Journal of Psychiatry 121 (1965):776-783.

_____. "The Dangerousness of Female Patients: a Comparison of the Arrest Rate of Discharged Psychiatric Patients and the General Population." American Journal of Psychiatry 123 (1966):413-419.

Reid, Sue Titus. Crime and Criminology. Hinsdale, Ill.: Dryden, 1976.

Riedel, Marc and Thornberry, Terence, eds. Crime and Delinquency--Dimensions of Deviance. New York: Praeger, 1974.

Riesman, David; Glazer, Nathan; and Denney, Reuel. The Lonely Crowd. New Haven: Yale University Press, 1950.

Rock, Ronald S.; Jacobson, Marcus A.; and Janopaul, Richard H. Hospitalization and Discharge of the Mentally Ill. Chicago: University of Chicago Press, 1968.

Rogler, Lloyd H. and Hollingshead, August B. Trapped: Families and Schizophrenia. New York: Wiley, 1965.

Rothman, David. The Discovery of the Asylum: Social Order and Disorder in the New Republic. Boston: Little, Brown, 1971.

Rusche, G. and Kirchheimer, O. Punishment and Social Structure. New York: Russell and Russell, 1968.

Santiestevan, Henry. "Deinstitutionalization: Out of Their Beds and into the Streets." Washington, D.C.: American Federation of State, County, and Municipal Employees, December, 1976.

Scheff, Thomas J. Being Mentally Ill. Chicago: Aldine, 1966.

_____, ed. Mental Illness and Social Processes. New York: Harper & Row, 1967.

_____. "The Societal Reaction of Deviance: Ascriptive Elements in the Psychiatric Screening of Mental Patients in a Midwestern State." Social Problems 11 (1964):401-413.

Scull, Andrew T. Decarceration. Englewood Cliffs: Prentice-Hall, 1977.

_____. "The Decarceration of the Mentally Ill: a Critical View." Politics and Society 6 (Summer, 1976).

_____. "From Madness to Mental Illness: Medical Men as Moral Entrepreneurs." European Journal of Sociology 16 (1975): 218-261.

_____ and Spitzer, Steven. "Social Control in Historical Perspective: from Private to Public Response to Crime." In David Greenberg, ed., Corrections and Punishment. Beverly Hills: Sage Publications, 1974.

Segal, Steven P. and Aviram, Uri. The Mentally Ill in Community-Based Sheltered Care. New York: Wiley, 1978.

_____; Baumohl, Jim; and Johnson, Elsie. "Falling through the Cracks: Mental Disorder and Social Margin in a Young Vagrant Population." Social Problems 24 (1977):387-400.

Sellin, Thorsten. "Recidivism and Motivation." Nationa Probation and Parole Association Journal 4 (1958):241-250.

_____ and Wolfgang, Marvin E. The Measurement of Delinquency. New York: Wiley, 1964.

Shah, Saleem A. "Community Mental Health and the Criminal Justice System: Some Issues and Problems." In John Monahan, ed., Community Mental Health and the Criminal Justice System. New York: Pergamon Press, 1976, pp. 279-292.

Singleton, Royce, Jr. and Turner, Jonathan H. "Racism: White Oppression of Blacks in America." In Don H. Zimmerman, D. Lawrence Wieder, and Sui Zimmerman, eds., Understanding Social Problems. New York: Praeger, 1976, pp. 130-160.

Smith, Kathleen; Pumphrey, Muriel W.; and Hall, Julian C. "The 'Last Straw': the Decisive Incident Resulting in the Request for Hospitalization in 100 Schizophrenia Patients." American Journal of Psychiatry 120 (1963):228-233.

Sosowsky, Larry. "Crime and Violence among Mental Patients Reconsidered in View of the New Legal Relationship between the State and the Mentally Ill." American Journal of Psychiatry 135 (1978):33-42.

Spring, Joel. "Education as Social Control." In Clarence Karier, Paul Violas and Joel Spring, eds., Roots of Crisis: American Education in the Twentieth Century. Chicago: Rand-McNally, 1973.

Steadman, Henry. "The Psychiatrist as a Conservative Agent of Social Control." Social Problems 20 (1972):263-270.

_____ and Braff, Geraldine. "Incompetency to Stand Trial: the Easy Way in?" In Marc Riedel and Terence Thornberry, eds., Crime and Delinquency--Dimensions of Deviance. New York: Praeger, 1974.

_____ and Cocozza, Joseph J. Careers of the Criminally Insane: Excessive Social Control of Deviance. Lexington, Mass.: Lexington Books, 1974.

_____; Cocozza, Joseph J.; and Melick, Mary Evans. "Explaining the Increased Crime Rate of Mental Patients: the Changing Clientele of State Hospitals." American Journal of Psychiatry (forthcoming in 1978).

Steinberg, Thomas. "The Effects of Act 143 upon Philadelphia State Hospital: a First Look." Paper presented at the 3rd annual conference, Mental Health Evaluation, Philadelphia, May 20, 1977.

Stone, Alan A. Mental Health and Law: a System in Transition. Rockville, Md.: NIMH Monograph, 1975.

Sutherland, Edwin and Cressey, Donald. Criminology. 8th ed. Philadelphia: Lippincott, 1970.

Szasz, Thomas. Law, Liberty & Psychiatry. New York: Macmillan, 1963.

_____. The Myth of Mental Illness. New York: Dell, 1961.

Temple University. Center for Social Policy and Community Development. "Boarding Homes in Philadelphia." 1978 (mimeo).

Third Annual Conference, Mental Health Evaluation. "The Impact of Act 143 on the Quality of Care and Patients Rights." Philadelphia, May 20, 1977.

Thornberry, Terence P. and Jacoby, Joseph E. The Criminally Insane: a Community Follow-up of Mentally Ill Offenders. 1978 (forthcoming).

Tong, John E. and McKay, G. W. "A Statistical Follow-up of Mental Defectives of Dangerous or Violent Propensities." British Journal of Delinquency 9 (1959):276-284.

United States. President's Commission on Law Enforcement and the Administration of Justice. Washington, D.C.: U.S. Government Printing Office, 1967.

University City Newsletter 6 (1977) (Philadelphia).

Wilson, James Q. Varieties of Police Behavior: the Management of Law and Order in Eight Communities. New York: Atheneum Press, 1971.

Wirth, Louis. "Urbanism as a Way of Life." In Paul Hatt and Albert Reiss, Jr., Cities v. Society. Glencoe, Ill.: Free Press, 1951.

Wolfgang, Marvin E. "Changing Perceptions in Crime and Criminal Justice." Daedalus 107 (1978):143-158.

_____. Patterns in Criminal Homicide. Philadelphia: University of Pennsylvania Press, 1957.

_____; Figlio, Robert M.; and Sellin, Thorsten. Delinquency in a Birth Cohort. Chicago: University of Chicago Press, 1972.

Wolpert, Eileen and Wolpert, Julian. "The Relocation of Released Mental Hospital Patients into Residential Communities." Princeton University, 1974 (mimeo).

Wright, R. L. D. Understanding Statistics: an Informal Introduction to the Behavioral Sciences. New York: Harcourt, Brace, 1976.

Yarrow, Marian Radke; Schwartz, Charlotte G.; Murphy, Harriet S.; and Deasy, Leila C. "The Psychological Meaning of Mental Illness in the Family." In Thomas Scheff, ed., Mental Illness and Social Processes. New York: Harper and Row, 1967, pp. 32-48.

Zitrin, Arthur; Hardesty, Ann S.; Burdock, Eugene I.; and Drossman, Ann K. "Crime and Violence among Mental Patients." American Journal of Psychiatry 133 (1976):142-149.

Zola, I. "Medicine as an Institution of Social Control." Sociological Review, 1972, p. 487.

* * * * * * *

Bartley v. Kremens, 402 F.Supp. 1039 (E.D. Pa. 1975).

Baxtrom v. Herold, 383 U.S. 107, 86 S.Ct. 760 (1966).

Bolton v. Harris, 395 F.2d 642.

Brown v. Board of Education, 347 U.S. 483, 74 S.Ct. 686 (1954).

Burchett v. Bowser, 355 F.Supp. 1278 D.C. Ariz. 1973.

Commonwealth v. John Roland Collello, 9 Mercer County Law Journal, 220 (1970).

Commonwealth of Pennsylvania v. McQuaid, 347 A.2d 465 (Re. 1975).

Commonwealth exrel Di Emilio v. Shovlin, 295 A.2d 329, 449 Pa. 177 (1972).

Commonwealth of Pennsylvania, Title 18, Crimes and Offenses, Act #334, 1972.

Covington v. Harris, 419 F.2d 617 (D.C. Cir. 1969).

Davis v. Watkins, 384 F.Supp. 1196 (1974).

Dixon v. Attorney General of the Commonwealth of Pennsylvania, 325 F.Supp. 966, 974 (M.D. Pa. 1971).

Donaldson v. O'Connor, 493 F.2d 507 (5th Cir. 1974).

Frontiero v. Richardson, 411 U.S. 677 (1973).

Goldy v. Beal, C.A. #75-791 (M.D. Pa. 1976).

Halderman v. Pennhurst, 74-1345 (M.D. Pa. Filed March 17, 1978).

Heryford v. Parker, 396 F.2d 393 (10th Cir. 1968).

In re Ballay, 482 F.2d 648 (D.C. Cir. 1973).

Jackson v. Indiana, 406 U.S. 715, 724, 92 S.Ct. 1845, 1851 (1972).

Lake v. Cameron, 364 F.2d 657 (D.C. Cir. 1966).

Lessard v. Schmidt, 349 F.Supp. 1078 (E.D. Wisc. 1972).

Miller v. Overholster, 206 F.2d 415 (D.C. Cir. 1953).

O'Connor v. Donaldson, 95 S.Ct. 2486 (1975).

Souder v. Maguire, 516 F.2d 820 (3rd Cir. 1975).

United States ex Rel McGurrin v. Shovlin, 455 F.2d 1278 (3rd Cir. 1972) 407 U.S. 913.

Wyatt v. Stickney, 325 F.Supp. 781 (M.D. Ala. 1971).

"The Matter of Josial Oakes." Law Reports (Mass.) 8 (1845):123.

END